1/28/09 PRESENTATION: HEALTH REFORM IN ALASKA

Lynda Zaugg

Subject: Senate HESS
Location: State Capitol

Start: Wed 1/28/2009 1:30 PM
End: Wed 1/28/2009 3:00 PM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Required Attendees: Don Burrell; Lynda Zaugg

When: Wednesday, January 28, 2009 1:30 PM-3:00 PM (GMT-09:00) Alaska.
Where: State Capitol

1:15 - 3:15

~~*~*~*~*~*~*~*~*

Contact; Shelly Hughes 841-1634

Health Reform in Alaska: A seminar for Legislators and Staff (Alaska Primary Care)

Speakers:
Rod Betit, ASHNHA
Alice Rarig, HP &SD/DHSS

Jenny Lounsbury 929-2729 (dir)

Keynote:
Enrique Martinez-Vidal, Vice-President, AcademyHealth

Panel: Rod Betit, Alice Rarig, Enrique Martinez-Vidal, Linda Hall (Director, Division of Insurance), DHSS Commissioner Bill Hogan.

Matthew Johnson / John Davis

Chuck Wes Keller off (13)
Bob Herron off -- (415)

1) ? co chair Sen D.
WK - what ever Sen D. would like us/from

Contacts

Lynda Zaugg

From: Jenny Lounsbury, APCA [JennyL@alaskapca.org]
Sent: Thursday, January 22, 2009 2:44 PM
To: Lynda Zaugg
Subject: RE: Health Reform Briefing- Hosted by Sen. Davis

Hi Lynda,

Do you know if we will have access to a projector and screen in the Fahrenkamp-Butrovich Room?

Jenny~

From: Lynda Zaugg [mailto:Lynda_Zaugg@legis.state.ak.us]
Sent: Wednesday, January 21, 2009 3:36 PM
To: Jenny Lounsbury, APCA
Subject: RE: Health Reform Briefing- Hosted by Sen. Davis

Jenny, we'll check with the Sen. when she arrives. Lynda

From: Jenny Lounsbury, APCA [mailto:JennyL@alaskapca.org]
Sent: Wednesday, January 21, 2009 1:20 PM
To: Lynda Zaugg
Subject: Health Reform Briefing- Hosted by Sen. Davis

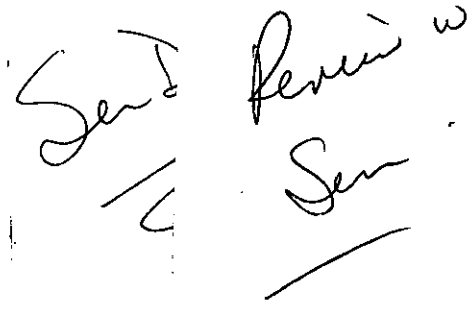
Hi Lynda,

Jenny again. The Primary Care Association is hosting a dinner on Tuesday, Jan 27th at 6pm at Zen Restaurant and we would like to extend an invitation to Sen. Davis. The health reform briefing keynote speaker will be at the dinner as well as Commissioner Bill Hogan. Please let me know if Sen. Davis is interested in joining us.

Thanks for your time,

Jenny Lounsbury

Jenny Lounsbury
Marketing and Events Coordinator
Alaska Primary Care Association
903 W. Northern Lights Blvd., Suite 200
Anchorage, AK 99503
Direct: 907-929-2729
www.alaskapca.org



Alaska State Legislature

Senator Bettye Davis, Chair
Senator Joe Paskvan, Vice Chair
State Capitol, Room 30
Juneau, Alaska 99801
Phone: (907) 465-3822
Fax: (907) 465-3756

Committee Members:
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

Senate Health & Social Services Committee

January 27, 2009

To: Sen. Davis, Sen. Paskvan, Sen Ellis, Sen.Thomas
Sen. Dyson, Rep. Keller, Rep. Herron

From: Lynda Zaugg, Aide Sen. Davis

Please find attached the back up information provided by The Primary Care Association in preparation for their presentation to the joint Senate and House H&SS meeting on Wednesday 1/28/09.

What You Need to Know: Health Reform for Alaska

A Briefing for Legislators & Staff

Hosted by Senate President Sen. Gary Stevens,
House Speaker Rep. Mike Chenault, Senate HSS Chair Sen. Bettye Davis,
House HSS Co-Chairs Rep. Wes Keller & Rep. Bob Herron

January 28, 2009

Nationally Recognized Expert, Enrique Martinez-Vidal
VP of AcademyHealth, Washington, D.C.

Your Choice of Identical Sessions:

Morning Briefing*: 7:30 a.m. - 9:30 a.m.
Baranof Hotel, Gastineau Suite

Afternoon Briefing: 1:15 p.m. - 3:15 p.m.**
Capitol Building, Fahrenkamp-Butrovich Room #203

*Breakfast Included **Refreshments Included

AHAAT ALASKA HEALTH ASSURANCE ADVOCACY TEAM

Alaska Primary Care Association

AARP

ASHNHA Alaska State Hospital and Nursing Home Association

ALASKA STATE CHAMBER OF COMMERCE

www.akhealthcoverage.org

WHAT YOU NEED TO KNOW: HEALTH REFORM FOR ALASKA
BRIEFING AGENDA
Wednesday, January 28, 2009

Choice of Briefing Sessions: Morning Session 7:30 – 9:30 a.m.
Afternoon Session 1:15 – 3:15 p.m.

MORNING SESSION – BARANOF HOTEL Gastineau Suite (breakfast served)

7:30 a.m. Welcome — Wayne Stevens, Alaska State Chamber of Commerce
Moderator — Rod Betit, Alaska State Hospital & Nursing Home Assn

7:40 a.m. Picture of Alaska Development — Alice Rarig, PhD Health Planning & Systems

8:00 a.m. What You Need to Know: Health Reform for Alaska
- Lessons from Other States and Issues to Consider -

Keynote Speaker: Enrique Martinez-Vidal
Vice President, AcademyHealth
Director, State Coverage Initiatives

9:00 a.m. Questions & Answers

Panel: Bill Hogan, Commissioner, DHSS
Linda Hall, Director, Division of Insurance, DCCED
Enrique, Martinez-Vidal, Vice President, Academy Health
Alice Rarig, PhD, Health Planning & Systems Development, HSS
Rod Betit, CEO/President, ASHNHA

9:30 a.m. Adjournment

Hosted by:
Senate President, Sen. Stevens; House Speaker, Rep. Chenault; Senate HSS Chair,
Sen. Davis; House HSS Co-Chairs, Rep. Keller and Rep. Herron

Sponsored by AHAAT, Alaska State Chamber of Commerce, Alaska Primary Care Association, Alaska State Hospital & Nursing Home Association and AARP-Alaska.

AHAAT ALASKA HEALTH ASSURANCE ADVOCACY TEAM

Co-Chairs:
Kip Knudson, Alaska State Chamber of Commerce
Shelley Hughes, Alaska Primary Care Association
Vice-Chair: Pat Luby, AARP-Alaska

Members:
AARP - Alaska
Alaska Association of Health Underwriters
All Alaska Pediatric Partnership
Alaska Native Tribal Health Consortium
Alaska Primary Care Association
Alaska State Chamber of Commerce

Alaska Behavioral Health Association
Alaska Center for Public Policy
Alaska Health Care Roundtable
Alaska Mental Health Trust Authority
Alaska Native Health Board
Alaska State Hospital and Nursing Home Association
American Cancer Society Cancer Action Network - Alaska
American Heart Association - Alaska
Anchorage Project Access

WHAT YOU NEED TO KNOW: HEALTH REFORM FOR ALASKA

BRIEFING AGENDA

Wednesday, January 28, 2009

Choice of Briefing Sessions: Morning Session 7:30 – 9:30 a.m.
Afternoon Session 1:15 – 3:15 p.m.

AFTERNOON SESSION – CAPITOL BUILDING Butrovich-Fahrenkamp Room 203 (refreshments served)

1:15 p.m.	Welcome Moderator	Wayne Stevens, Alaska State Chamber of Commerce Rod Betit, Alaska State Hospital & Nursing Home Assn
1:25 p.m.	Picture of Alaska Development	Alice Rarig, PhD Health Planning & Systems
1:45 p.m.	What You Need to Know: Health Reform for Alaska - Lessons from Other States and Issues to Consider -	
	Keynote Speaker: Enrique Martinez-Vidal Vice President, AcademyHealth Director, State Coverage Initiatives	
2:45 p.m.	Questions & Answers	
	Panel: Bill Hogan, Commissioner, DHSS Linda Hall, Director, Division of Insurance, DCCED Enrique, Martinez-Vidal, Vice President, Academy Health Alice Rarig, PhD, Health Planning & Systems Development, HSS Rod Betit, CEO/President, ASHNHA	
3:15 p.m.	Adjournment	

Hosted by:
Senate President, Sen. Stevens; House Speaker, Rep. Chenault; Senate HSS Chair,
Sen. Davis; House HSS Co-Chairs, Rep. Keller and Rep. Herron

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American Heart Association - Alaska
Anchorage Project Access

Enrique Martinez-Vidal
Vice President, Academy Health
Washington, D.C.

Keynote Speaker *January, 28, 2008*
What You Need to Know: Health Reform for Alaska

Enrique Martinez-Vidal is a Vice President at AcademyHealth and the Director of the Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program which works with state policy leaders to develop strategies to improve insurance coverage and foster broad health care reform. Enrique joined AcademyHealth in February 2005 as the deputy director of SCI.

He is currently the project director for the State Quality Improvement Institute, a project of the Commonwealth Fund to assist states that are ready to make substantial commitments to quality improvement and to facilitate development of concrete action plans for further progress. He also has worked on various projects under a contract with the federal Agency for Healthcare Research and Quality (AHRQ) including the oversight of a state-level environmental scan of quality initiatives to help determine how a partnership could be developed between AHRQ and states regarding quality improvement; and a pilot project that presented AHRQ's State Snapshots to four states in an effort to create an ongoing dialogue about how these reports can be used for state-level quality improvement.

Previously Mr. Martinez-Vidal was the deputy director for performance and benefits at the Maryland Health Care Commission, an independent state agency. There he was responsible for the oversight of Maryland's small group insurance market reforms; the annual evaluation of Maryland's mandated health insurance benefits; the collection and public dissemination of quality and performance information for hospitals, nursing homes and health plans; providing primary assistance on all legislative issues; and working on numerous other projects related to the affordability of health care, quality improvement, and patient safety.

Mr. Martinez-Vidal was formerly a policy analyst with the Maryland Department of Legislative Services for five years..During that time he staffed the House Economic Matters Committee and was involved with a number of health-care related issues. He has a B.A. in political science and international studies from Dickinson College and a master's degree in public policy from Georgetown University.

State Coverage Initiatives

Robert Wood Johnson Foundation

What You Need to Know: Health Reform for Alaska

Lessons Learned from Other States

A Briefing for Alaska Legislators and Staff

Juneau, AK
January 28, 2009

Enrique Martinez-Vidal
Vice President, AcademyHealth
Director, State Coverage Initiatives

AcademyHealth

Overview of Presentation

- Background
- What is driving state reform?
- State Reform Strategies
- States & the Health Workforce
- State Quality Reporting Activities
- State Health Policy Commissions and Authorities
- Lessons Learned from State Reforms
- Concluding Thoughts

State Coverage Initiatives (SCI)

- An Initiative of the Robert Wood Johnson Foundation

Community of State Officials

- Convening state officials

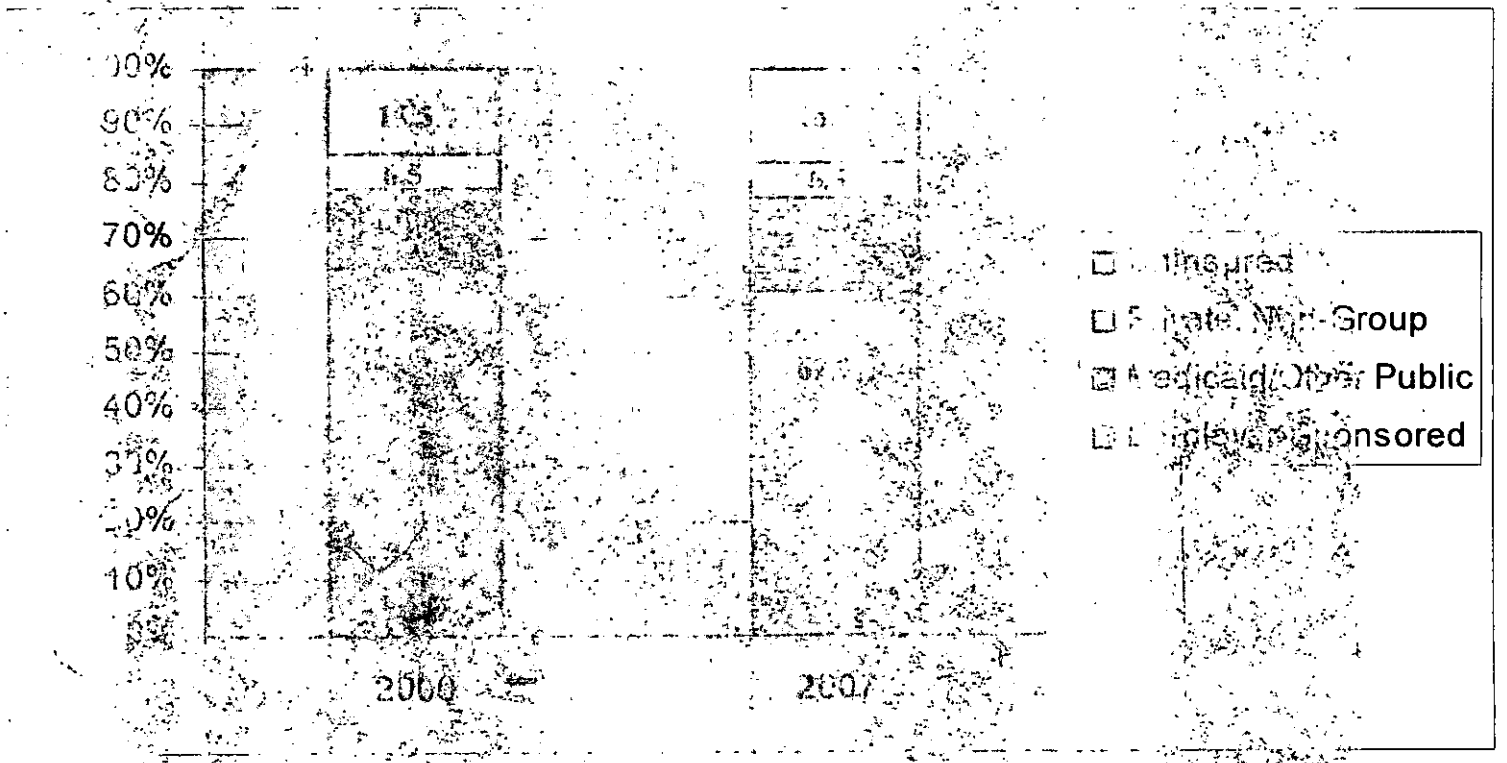
Resources and Information

- Web site: www.statecoverage.org
- State Profiles
- Publications/*State of the States*

Direct technical assistance to states

- State-specific help, research on state policymakers' questions
- Grant funding/Coverage Institute

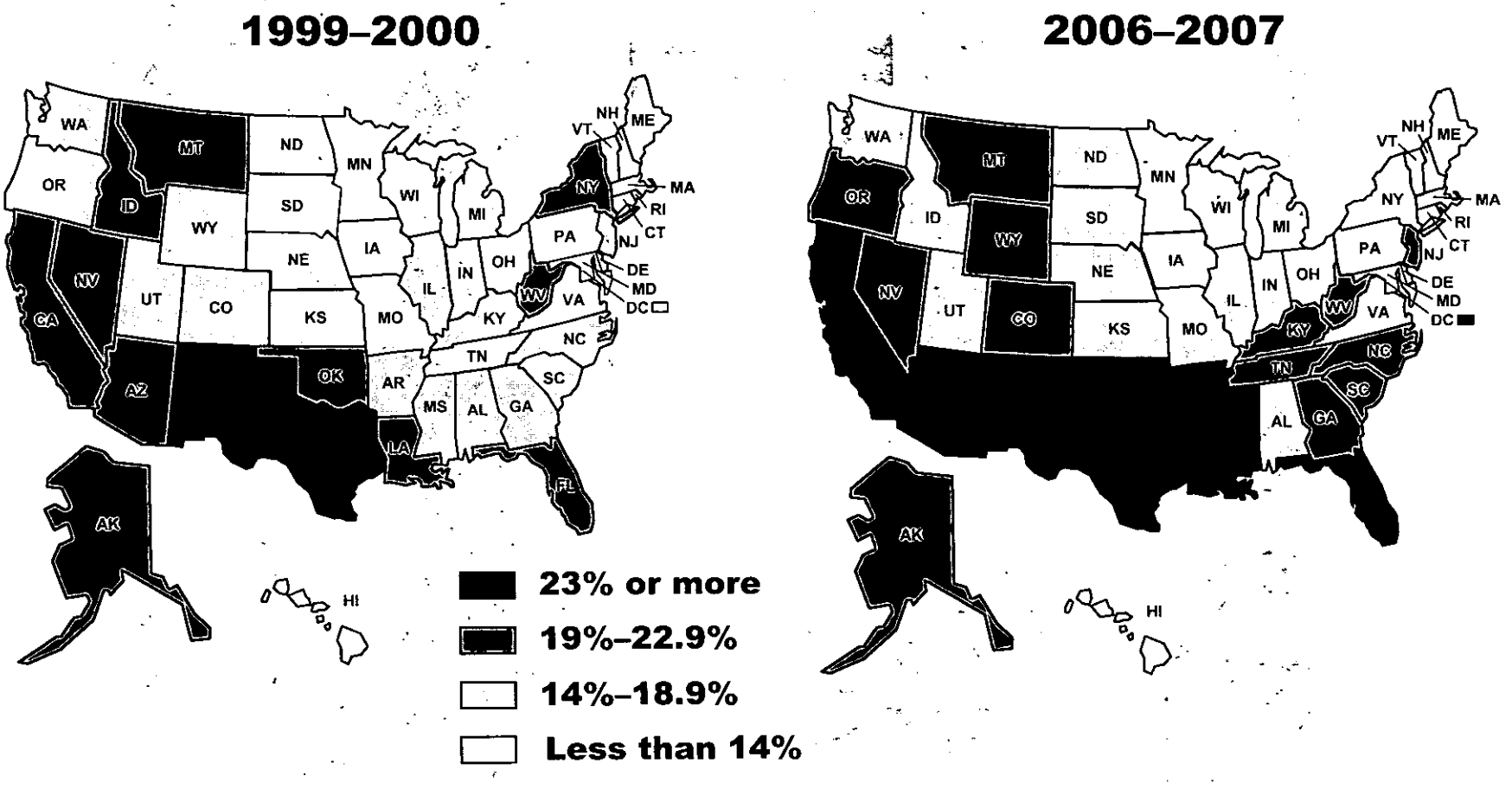
Health Insurance Coverage Changes Among Non-Elderly, 2000-2007



Census Bureau, ...es,. August 2008.

Percent of Uninsured Adults Ages 18–64

(Source: The Commonwealth Fund, 2008)



State Coverage Initiatives

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Data: Two-year averages 1999–2000, updated with 2008 CPS correction, and 2006–2007 from the Census Bureau's March 2000, 2001 and 2007, 2008 Current Population Surveys.

Percent of Uninsured Adults Ages 18–64

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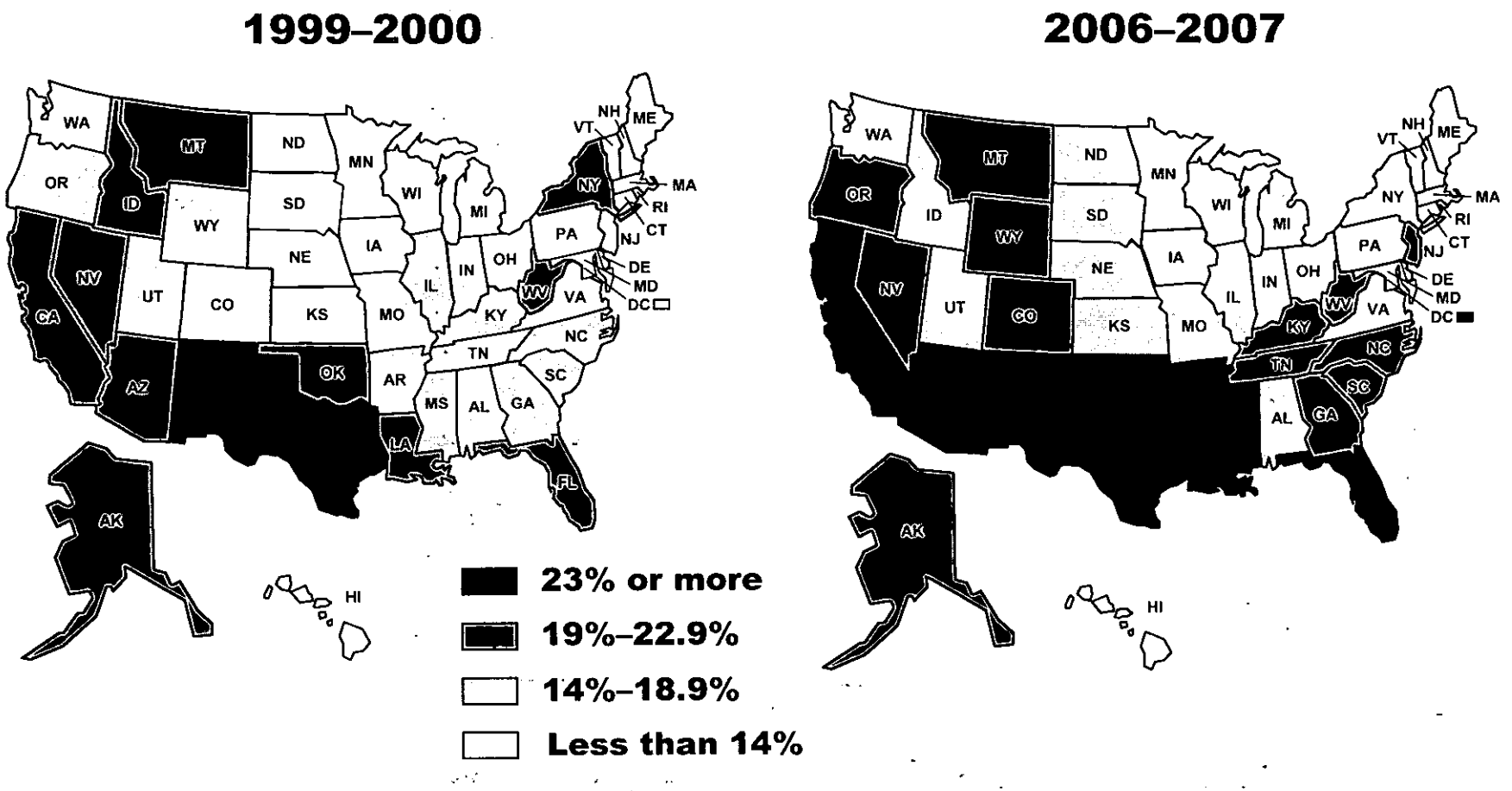

State Coverage Initiatives

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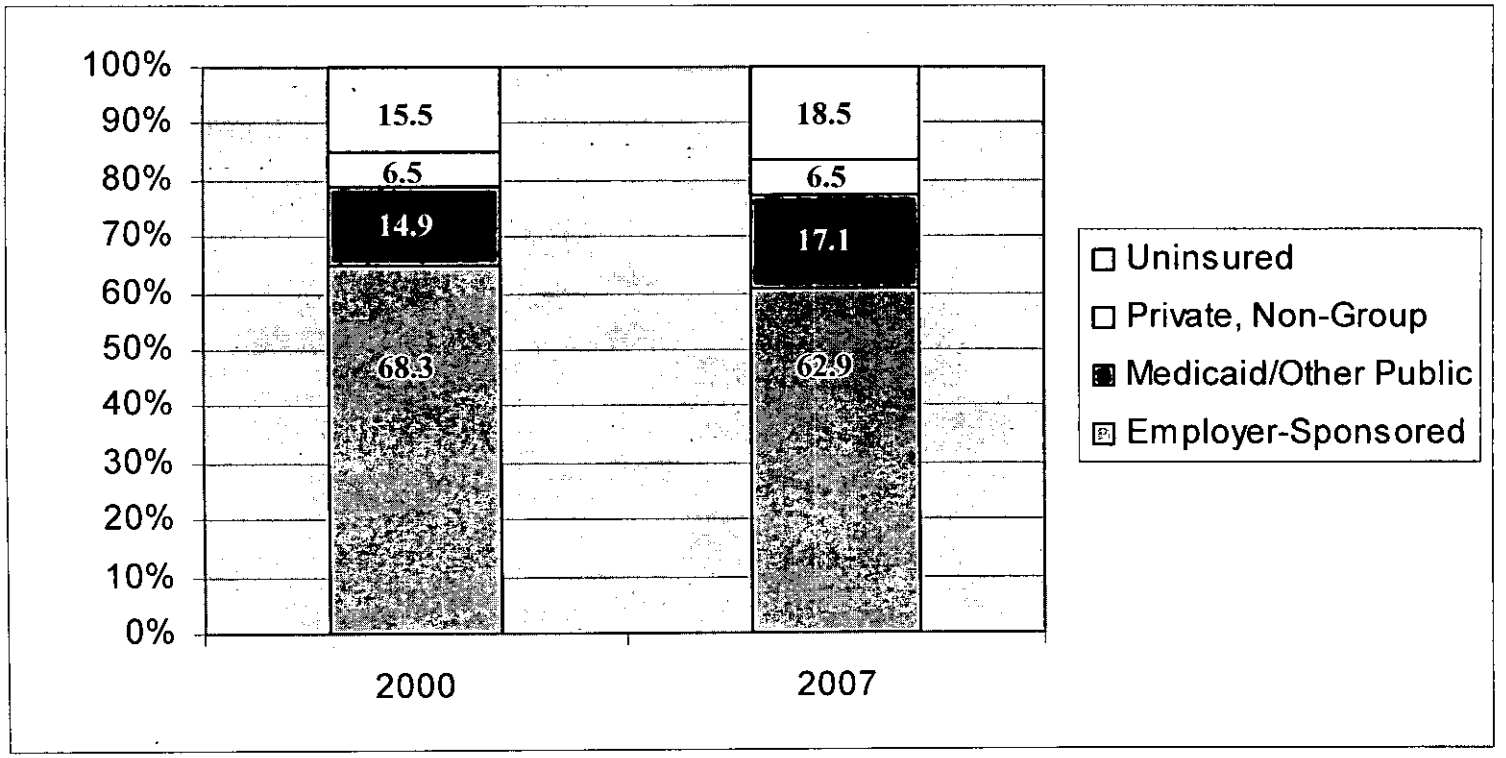
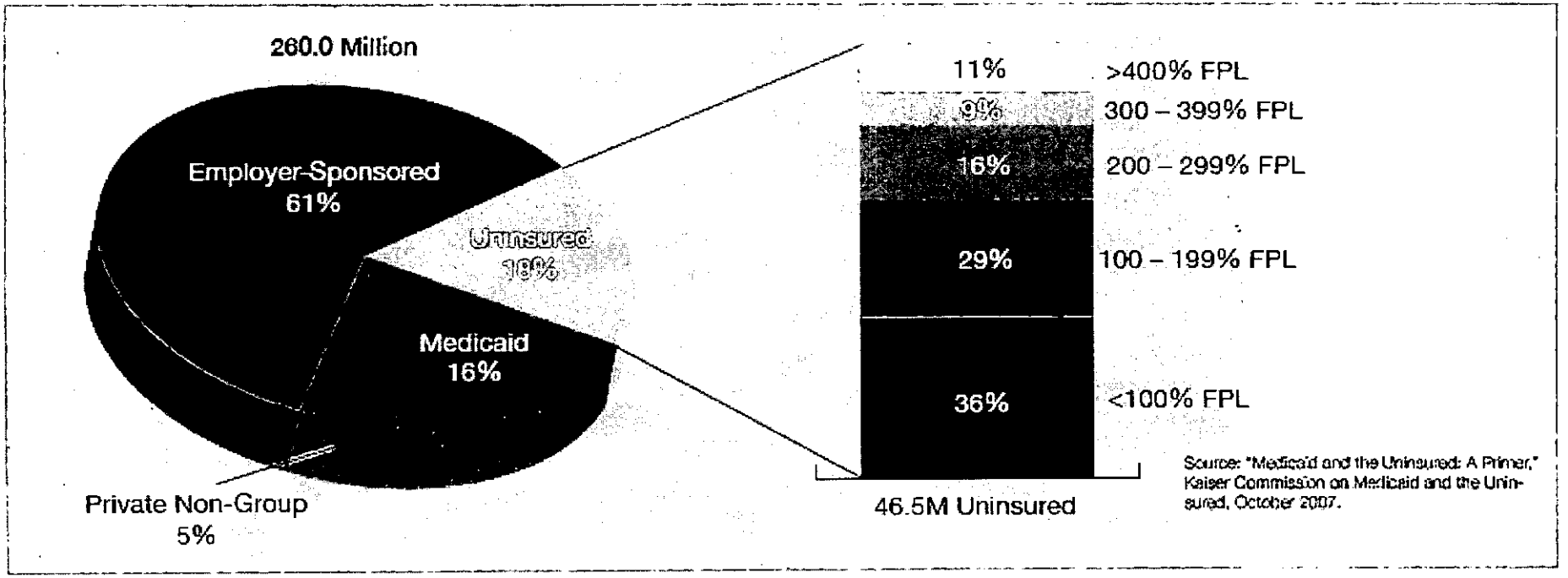
Health Insurance Coverage Changes Among Non-Elderly, 2000-2007



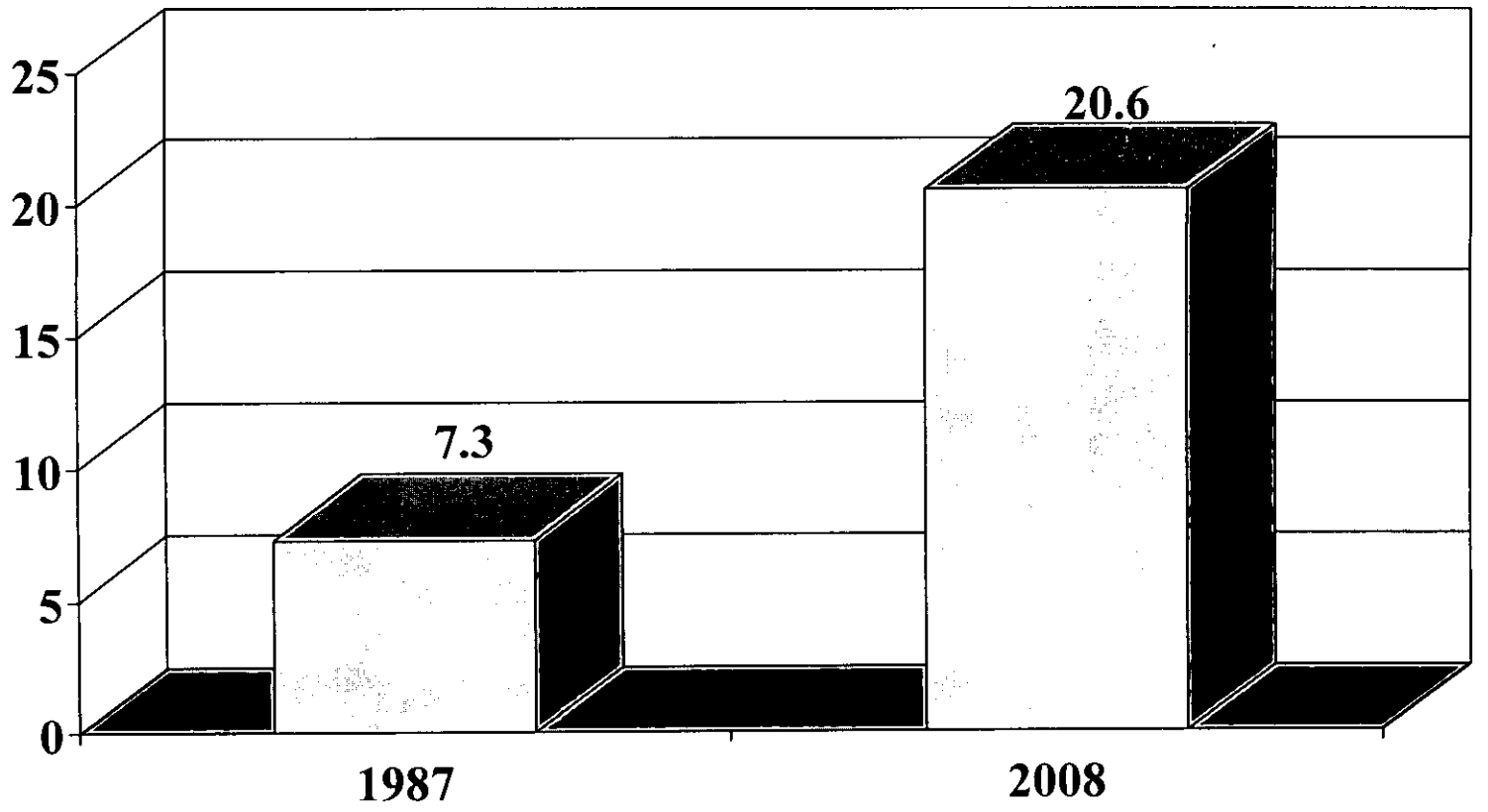
State Coverage Initiatives
Robert Wood Johnson Foundation

Note: Data from Current Population Survey, Census Bureau, Historical Health Insurance Tables,. August 2008.

The Non-Elderly as a Share of the Population and by Poverty Level, 2006



Percent of Median Family Income Needed to Buy Family Health Insurance



State Coverage Initiatives
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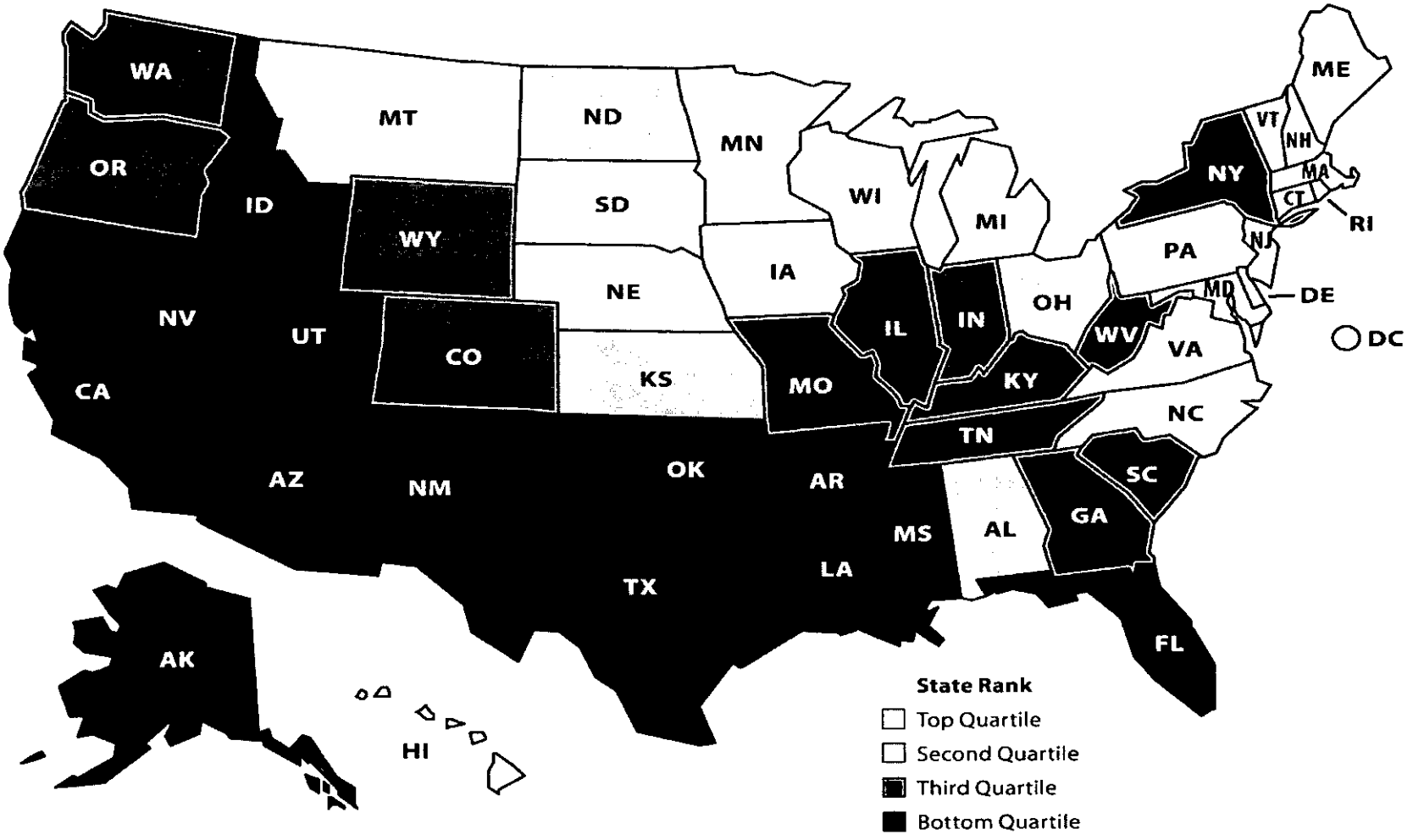
Source: Calculations by Len Nichols (1987) and AcademyHealth (2008), using KFF and AHRQ premium data, CPS income data.

State Ranking on Quality Dimension



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

2166

Drivers of State Health Reform Efforts

- Uninsured still high
- Employer-sponsored insurance down
- Costs/premiums increasingly unaffordable – Indiv; Families; Govt
- Coverage needed for effective and efficient health care system
- Lack of national consensus – future?
- Greater political will at state level

Key Policy and Design Issues

- Different Populations Require Different Solutions
- Subsidies and Financing: Who will pay? Who will benefit?
- Should Health Insurance Coverage Be Required?
- What is Affordable Coverage?
- What is the Most Appropriate Benefit Design?
- Do Insurance Markets Need to be Reformed/Reorganized?
- Best Mechanisms for Cost Containment/Systems Improvement

"One size fits all" approach won't work

- Those with few resources to bring to private insurance market
  - Ceiling = eligibility for public programs
  - Children: 100-300% FPL
  - SCHIP Parents/Childless Adults: Vary from 12-275% FPL
- Those with some resources but cannot bear the full cost of insurance premiums
  - Subsidies and other methods to reduce premiums
- Those who have sufficient incomes to participate in market on their own
  - Encourage voluntary participation or mandate coverage

No Free Solutions: Who Will Pay? Who Will Benefit?

- Shared responsibility – Who will help cover the costs?
  - Individuals; Employers; Federal government; State government; Health plans/insurers; Providers
- Enough money in current system?
  - If yes, then – Redistribution (Who will pay? Who will get paid?)
  - If not, then need new forms of revenue: Sin taxes; Provider taxes; Payroll taxes; Lease the lottery; Slots revenues; Gross Receipts Tax

Should Health Insurance Coverage Be Required?

- Unenforceable? Impingement on individual freedom?

- Does your state have money for subsidies to help lower-income uninsured (or an exemption process)?

What is Affordable Coverage?

- Related to overall benefit design
- Related to subsidies being considered
- Could be related to individual mandate
- General agreement that levels of both premium and out-of-pocket costs should somehow be related to income and ability to pay

Benefit Design

- Services included/excluded; cost-sharing; structure of access to providers
- Not just cost of coverage but value of the benefit plan – what set of services are purchased for specific amount of money
- Before – limit benefits; raise cost-sharing; limit networks (value issue)
- Levers within benefit design:
  - reduce premiums
  - encourage efficient/appropriate consumer behavior
  - change carrier and provider behavior
- Evidence-based benefit design? MN
- Consumer-driven health plans? IN
- First-dollar benefits? TN
- Direct consumer behavior change? RI

Don't Forget the Delivery System

- Prevention/primary care/wellness
- Chronic care management and coordination
- Public health initiatives
- Value-based purchasing/payment reforms
- Medical error reduction
- Health-acquired infection reduction/patient safety
- Price and quality transparency
- Heath information technology and exchange
- Administrative and regulatory efficiencies

What is a Medical Home?

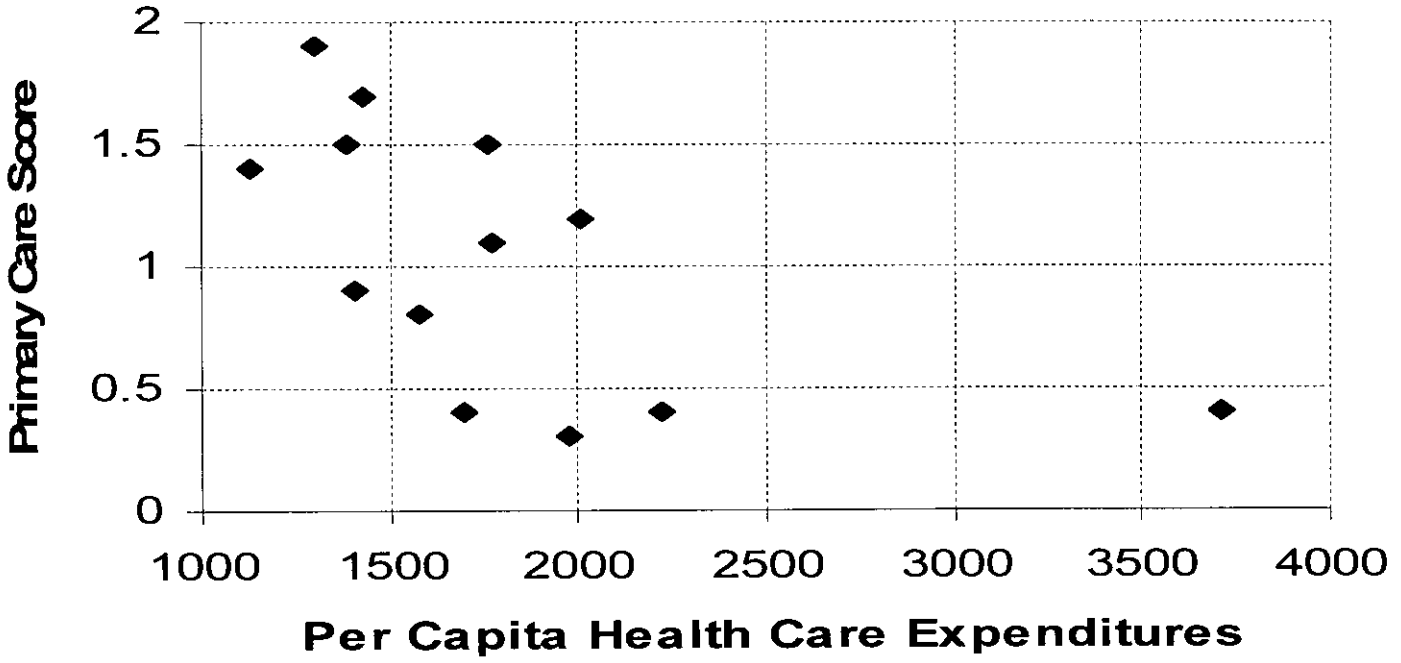
The Joint Principles of the Patient-Centered Medical Home, developed by the leading physician groups

- **Personal Relationship**
- **Team Approach**
- **Comprehensive**
- **Coordination**
- **Quality and Safety**
- **Expanded Access**
- **Payment for Added Value**

Other "Medical Home" Definitions

- NCQA – Has a 3-level standard being used or adopted by several states
  - Based on the Joint Principles
  - Utilized in Vermont, Rhode Island Medicaid and elsewhere
- Health Disparities Collaboratives, the "Wagner Model" or chronic disease management programs
  - A system change model that emphasizes:
    - Using best practice standards of care for specific chronic diseases
    - Use of quantitative process and outcome measures
    - Team approach to care
    - Patient education and self-management
  - Implemented in Community Health Centers around the country
  - Implemented in Washington, Rhode Island, Pennsylvania, and elsewhere
- Primary Care Case Management (PCCM)

High Access to Primary Care Correlates with Low Health Care Spending



Source: Based on The Commonwealth Fund 2006 International Health Policy Survey of Primary Care Physicians in Seven Countries

State Medical Home Programs

- 31 states have implemented programs to advance Medical Homes in Medicaid
- States working across payers on Medical Homes Programs include Colorado, Louisiana, Maine, New Hampshire, Pennsylvania, Rhode Island, and Vermont
- States with model Medical Homes programs include Vermont, North Carolina, Rhode Island and Pennsylvania

Comprehensive Efforts

Enacted

Maine ('03)

Massachusetts ('06)

Vermont ('06)

Significant Proposals

California – failed

Kansas – some pieces

New Mexico – very small pieces

Pennsylvania – in process

Strategies for Comprehensive Reform

	Maine	Massachusetts	Vermont
Individual Mandate	*No*	Yes	*No* *Will consider if coverage targets not met*
Purchasing Mechanism	DirigoChoice	Health Insurance Connector	Catamount Health
Subsidies for Low-Income	Up to 300% FPL	Up to 300% FPL	Up to 300% FPL
Public Program Expansion	Parents <200% FPL Childless Adults <125% FPL	Adults <100% FPL Children <300% FPL	*Builds upon previous expansions* *Children <300%* *Parents <185%* *Childless Adults <150% FPL*
Employer Requirements	*Voluntary* *Participating employers must pay 60% of premium*	$295/employee fee for non-offering. Must offer §125 Plan	$365/FTE fee for non-offering

Massachusetts Pillars of the Reform

- Employer Responsibilities
  - Section 125 Plan Requirement
  - Offer Coverage or Be Assessed
- Personal Responsibility/Individual Mandate
- Expansion of Publicly-subsidized Programs
- Major Changes to Insurance Market
  - Merged Small Group and Individual Markets
  - Raising age of dependents – up to 25
  - Connector

Current State of the Commonwealth

- More than 439,000 newly-insured between June 2006 and March 31, 2008
- 191,000 more in private coverage (no public $$) – more than 40% of all newly covered have no subsidies
- Employer-sponsored insurance remains predominant source of coverage (82% of non-elderly): no crowd-out
- Non-group premiums are down over 40% and membership has grown over 50%
- Approximately 1-2% of the MA population or 60,000 persons may be exempted from the mandate

Vermont - Blueprint Components

Public Policy	▪Blueprint legislation and funding ▪Executive Director at Governor's Office level ▪Integration with Public Health Disease Prevention Programs
Community	▪Community Grants ▪Environmental and Policy Strategies, Smart Planning ▪211 as statewide resource tool
Self-Management	▪Healthier Living Workshop—All conditions - Over 40 statewide; 500+ enrolled - +60% reduction in MD and ED visits post at one year ▪Patient portal planned
Information Systems	▪ Statewide RHIO, Health IT Plan ▪ Web-based chronic care information systems ▪ EMR
Physician Practices	▪Consensus treatment standards—7+ Diseases ▪Clinical Microsystems support in practices –training, coaching, peer support ▪75% participation in 6 Communities (HSAs)□200 practices
Health Systems	▪Required coordination across all payers in 3 pilots in 2008 ▪Contract with National Payment Reform Consultant

California Proposed Reforms

- **Shared Responsibility**
  - Individual mandate
  - Guaranteed issue
  - Financing: Government, Hospitals, Employers, Individuals
- **Prevention/Health Promotion/Wellness**
  - Tied to preventive health practices
  - Reducing medical errors (e-prescribing)
  - Obesity prevention
  - Tobacco cessation efforts
  - Health Care Cost and Quality Commission
- **Affordability & Cost Containment**
  - Subsidies for low-income adults and children
  - Section 125 plans/HSAs
  - Emphasis on HIT
  - Increase Medi-Cal reimbursement rates ('hidden tax')

Kansas – Summary of 2008 Legislative Action

Transforming Medical Care	Improving Public Health	Expanding Affordable Insurance
• Transparency project: Health care cost and quality (Kansas Health Online) • Health literacy • Medical home definition • Medicaid provider reimbursement • Community Health Record (HIE) • Insurance Form Standardization	→ Increase tobacco user fee → Statewide smoking ban → Partner with community organizations → Education Commissioner → Collect fitness data in schools → Promote healthy foods in schools → Promote fitness in schools → Wellness for small businesses → Healthier food for state employees → Dental care for pregnant women → Tobacco cessation in Medicaid (for pregnant women only) → Expand cancer screening	→ Aggressive outreach & enrollment of eligible children (target pop: 20,000) → Premium Assistance for low income adults without children (target population: 39,000) → Small Business Initiatives (target population: 15,000 young adults and 12,000 employees of small businesses)

Green – Passed with Funding, if Needed; Yellow – Passed with No Funding; Red – Did Not Pass

Health Solutions New Mexico Plan

What was Proposed:

- Insurance Reforms
- Phased-In Health Coverage Participation Reqmt
- Electronic Claims and Records
- Health Coverage Authority
- Evaluation

What Happened:

- Funding for eligible but not enrolled: $22.5 m.
- Treat developmentally disabled children: $10 m.

Pennsylvania Proposed Reforms:

Prescription for Pennsylvania

Rx for Affordability	Rx for Access	Rx for Quality
Cover All Pennsylvanians (now Access to Basic Care)	Health Care Workforce	**Hospital-Acquired Infections**
Coverage for College Students and Young Adults	**Removing Practice Barriers – Scope of Practice**	Quality Outcomes
Community Benefit Requirements	Cost-Effective Sites	Pay for Performance
Uniform Admission Criteria	Co-Occurring Disorders	Chronic Care – Exec Order
Fair Billing and Collection Practices	Governor may consider individual mandate if number of uninsured does not decline over next few years	Health Disparities
Capital Expenditures		Child and Adult Wellness
Small Group Insurance Reform		Long Term Living
Health Information Exchange – Exec Order		End of Life and Palliative Care

State Coverage Initiatives
Robert Wood Johnson Foundation

Source: Presentation by Ann S. Torregrossa, Deputy Director & Director of Policy GOHCR. Alliance for Health Reform Briefing, October 26, 2007

Substantial Reforms

Enacted

Indiana - 2007
Iowa – 2008
Maryland - 2007
Minnesota - 2008
New Jersey - 2008
Washington - 2007
Wisconsin - 2007

Indiana: Healthy Indiana Plan (HB 1678)

- Increases tobacco taxes by $0.44 per pack; $0.33 will be used for:
  - Covering adults up to 200% FPL + Immunization programs

- The remaining $0.11 will be distributed as follows:
  - Three cents will increase physician/dentist Medicaid reimbursement rates;
  - Three cents will provide a tax credit to employers that establish Section 125 plans - for employers not offering a fully insured health plan that satisfies Section 125 of the IRS code, the state will provide the lesser of $50 per employee or $2,500 for 2 years if the employer establishes Section 125 plan; and
  - The remaining 5 cents will be used to increase tobacco prevention and cessation programs and for other health programs.

- **A key aspect of HIP is that it utilizes the HSA model combined with comprehensive insurance coverage above the deductible. Individuals will annually receive $500 of pre-deductible, free preventive care and have a $1,100 deductible.**

Iowa Reforms

- Coverage for children up to 300% of FPL (with a sliding scale premium between 200-300% FPL) + one-year continuous eligibility
- Directs an advisory group to develop a plan for full health coverage in five years
- A Medicaid buy-in option for those with disabilities
- A Medical Homes Initiative
- Healthy Communities Initiative, Quality improvement council, transparency, electronic health plan to be developed

Maryland Working Families and Small Business Health Coverage Act

- Provides subsidies to small employers (2-9 employees) and employees of small employers if the employer:
  - has not offered a health benefit plan within the prior 12 months;
  - meets certain low-wage requirements to be established through regulation;
  - establishes a Section 125 payroll deduction plan to allow for pre-tax premium contributions; and
  - agrees to offer a wellness benefit that is designed to prevent disease, reduce poor clinical outcomes, and promote health behaviors and lifestyle choices.
- Expands Medicaid eligibility up to 116% FPL for parents/caretaker relatives.
- Phase-in over four years of Medicaid eligibility up to 116% FPL for childless adults—enrollment may be capped and benefits may be limited based on available funding.
- Financing: combination of general funds, hospital uncompensated care savings, a one-time surplus from high risk pool, and federal funds.

Minnesota – Coverage and Cost

- **Childless Adults to 250%**
- **Section 125 Plans**
- **"Essential Benefit Set"**
- **Easier enrollment and more seamless transitions**
- **Directs development of proposal to promote access to affordable employer-sponsored health care through tax credits and deductions**

Children	275% FPL
Pregnant Women	275% FPL
Childless Adults	175% FPL
SSI Disabled	100% FPL

Minnesota Payment Reform and Quality Improvement

- Establishes a single statewide transparent system for quality-based incentive payments
  - Public reporting on risk-adjusted quality measures
- Establishes new payment system based on "baskets" of care and then allows consumers to compare prices across providers
- Establishes standards for state certification of health care homes (to receive care coordination payments)
- Administrative Efficiency
  - Requirement that all EHRs [Electronic Health Records] be consistent with federal interoperability standards and that all prescriptions are ordered electronically by 2011
  - Uniform methods of claims process
- Public health programs to reduce obesity and cut tobacco use

New Jersey: Phases of Reform

Phase I

- Familycare Buy-in
  - Passed Into Law – 12/1/07
- "Kids First" Mandate
- Familycare Expansion
- Market Reform
  - Signed by Governor 7/8/8
  - Implementation 9/1/08

Phase II

- Creation of Garden State AllCare
- Individual Mandate
- Sliding Scale Subsidies
- Section 125 Mandate
- Charity care/related hospital subsidies redirected over time to premium assistance
- Collaborative Care System Creation/Medical Homes

Washington State Reforms

- Provides access to coverage for all children by 2010 (SB 5093)
- Intensive education/outreach/admin simplification to enroll the currently eligible
- Expands SCHIP to children up to 300% FPL (now 250%) in 2009
- Children above 300% FPL – full cost buy-in
- Creates Washington Health Insurance Partnership (Connector) (SB 1569)
  - Targets small employers w/low-income workers
  - Sliding scale premium subsidies for those <200% FPL
- Provides high quality, affordable health care based on recommendations of the Blue Ribbon Commission in Health Care Costs and Access (SB 5930)
  - Reimbursement Changes
  - Chronic Care Projects/Medical Homes
  - Washington State Quality Forum
  - Health Information Technology
  - Appropriate Care Settings
  - Wellness Programs

Wisconsin Reforms

- BadgerCare Plus: Merge Family Medicaid, BadgerCare (SCHIP - covers children and parents to 185 percent FPL), and Healthy Start:
  - Cover all children (families above 200% FPL can purchase basic health coverage for their children for $10 to $68.53 per child per month, depending on income)
  - Provide coverage/enhanced benefits for pregnant women up to 300% FPL
  - Simplify the program
  - Promote prevention and healthy behaviors (member agreements; incentives for MCOs; incentives for individuals; health literacy/education)
  - Financed through increase by $1 per pack cigarette tax

- New Policy Goals (2008+)
  - Ensure 98% of Wisconsin's population has access to health insurance by expanding to childless adults through **BadgerConnect**, a new online gateway to health care
  - One-stop shop for health care access for low-income families
  - Increase business participation and health insurance portability
  - Use evidence-based medicine to design benefits and control costs

Wisconsin's BadgerCare Plus: Streamlining and Outreach

- Simplified & standardized eligibility rules
  - For example, the state reduced the number of earned income disregards and increased the income limit
  - The goal was to make the program easy to understand for both enrollees and staff

- Invested in outreach & focused on the community level
  - 42 agencies within the state received $25,000 to build the infrastructure needed to help people apply for the program
  - Statewide ad campaign—called the children's coverage expansion an "all kids" program

Wisconsin's BadgerCare Plus: Streamlining and Outreach

- Made online application process easier & more accessible
  - ➢Supported and promoted online applications
  - ➢Simplified the online application and trained community workers around the state to use it
  - ➢During the first few months of the program, online applications increased from about 25 to 50 percent of total applications

- Invested in more staff
  - ➢Increased size of staff statewide, especially in Milwaukee
  - ➢Developed a new processing center in Milwaukee to approve applications and send cards to enrollees within one week

Substantial Reforms

States with Recommendations for 2009 Session

Connecticut
Kansas
Ohio
Oklahoma
Oregon
Utah

HealthFirst Connecticut Authority Recommendations

- Expanded Medicaid/SCHIP eligibility for all residents with family incomes below 300 percent FPL, with sliding scale cost-sharing and premium assistance for those with ESI.
- Access to a restructured Charter Oak program - currently allows families to buy health insurance regardless of their health status at premiums tied to income.
- A Connecticut Health Partnership, using the state employee health benefit plan as a base, will be available to all residents and employers in order to improve employer offer rates and employee take-up rates, and to offer coverage to those in the non-group market.
- Multiple recommendations for containing costs and improving quality.
- Data collection and analysis to drive policy development, implementation, and evaluation.
- Public entity assigned or developed to oversee the proposed reforms and better coordinate state spending on health care.

Kansas 2009 Health Reform Priorities – Kansas Health Policy Authority

- Statewide Clean Indoor Air
- Increased Tobacco User Fees
- Increased Access to Affordable Health Care and Health& Wellness
  - Medicaid Expansion to Parents up to 100% FPL
  - Convene panel to develop proposals to assist small employers and young adults afford health insurance
  - Tobacco Cessation for Medicaid
  - Expand Cancer Screening for Low-Income and Uninsured
  - HIT - Statewide Community Health Record
  - Workplace Wellness Grants for Small Businesses
  - Expand Kansas Coordinated School Health Program

Ohio State Coverage Initiatives Recommendations

- Requiring employers to establish §125 Plans
- Reinsurance for individuals and small businesses
- Extend group coverage to dependents up to age 29
- Premium assistance for low income workers
- Enrolling more Ohioans in Medicaid and expanding Ohio's Medicaid to high income levels
- Allowing non-Medicaid eligible adults to enroll in Medicaid managed care plans
- Reforms to the individual health insurance market (GI; Mandate; Subsidies; Admin Efficiencies)
- Connector

Blueprint for Oklahoma – Draft Report

- Maximizing enrollment in public programs for those eligible but not yet subscribed
- Developing an affordable basic health benefits plan
- Generating sufficient public revenue
- Encouraging the take-up of private coverage

Oregon Health Fund Board Report

- Improve access for children and low-income
- Cost containment and quality improvement mechanisms
- Purchasing strategies and insurance market reforms
- Encourage new models of care delivery
- Ensure health equity for all
- Train new health care workers
- Federal-state relationship

Utah Legislative Health System Reform Task Force Legislation

- Insurance market reforms:
  - Creates new basic benefit plan called the Utah NetCare Basic Health Care Plan
  - Allows mandate-free benefit plans to be offered in certain circumstances
  - Establishes Internet portal for the purchase of these new plans
  - Sole proprietors included in the small group market pool
  - Establishes a reinsurance pool
- Streamlines and standardizes various aspects of provider, insurer, and consumer interactions and communications.
- Framework for demonstration projects for delivery and payment systems reforms.
- Requires certain contractors who do business with the state to offer health insurance to their qualified employees.

Incremental Approaches

Cover All Children

Purchasing Pools/Mechanisms

Increasing Dependent Coverage

New Benefit Design

Reinsurance

Creative Uses of Medicaid
(public/private)

Rhode Island ('07): HealthPact

- Includes coverage for physician visits, hospitalization, preventive services, and prescription drugs
- Design is intended to give incentives to enrollees to be more actively engaged in managing their own health care
- Proposes to achieve significant cost savings though financial incentives for enrollees who improve and maintain their health through **five key wellness initiatives**
- For enrollees who choose to participate in the wellness programs, it is proposed that deductibles, co-pays and co-insurance will be reduced to amounts normally seen in plans with much higher premiums

Cover Tennessee ('07)

- Affordable healthcare coverage
  - Premiums shared equally by employer, individual and state
  - Individual's monthly premium share ranges between $37 and $109
  - Premiums vary depending on age, tobacco use, and obesity
  - No deductibles; reasonable co-pays
  - Maximum Benefit amount: $25,000
- Portable – Individual Product
  - Owned by the individual
  - Individual can keep coverage even if they leave an employer
  - Provides continued coverage during brief periods of unemployment
- Basic – Provides most services most people need

States & the Health Workforce

State Coverage Initiatives
Robert Wood Johnson Foundation

States & the Health Workforce

- States have strong influence over the development and practice of the health workforce.
  - Education, financing and regulation
- State action is critical for current shortages & for the future.
- States are faced with current or imminent health workforce shortages due to multiple factors:
  - Aging population
  - Changing educational & practice environments
  - Limited pipeline of people entering health professions

State Action on Workforce Issues

- Data collection and analysis: State nursing centers, centers for health workforce studies, university centers
- Pipeline development: Health career websites, K-12 outreach programs, scholarships/loan repayment programs
- Retention (geared towards nurses): Career ladder programs, abolish mandatory overtime, pass minimum staffing ratios
- Licensure and Credentialing: Scope of practice changes, Nurse Licensure Compact (currently 23 states)
- Educational capacity building: Faculty scholarships and loan repayments, increasing educational capacity, innovation in educational delivery

Massachusetts (Enacted 8/08)

- Passed comprehensive plan to strengthen primary care infrastructure
  - Creates new Health Care Workforce Center within the Department of Public Health
  - State authority to establish a medical home demonstration project
  - Directs MassHealth Payment Policy Advisory Board to study methods to improve payments or bonuses for primary care providers
- For health care professionals who practice in underserved areas:
  - Loan forgiveness program
  - Affordable housing pilot
- Requires health insurers to recognize and reimburse nurse practitioners as primary care providers

Oregon (11/08 Recommendations)

- Released blueprint for comprehensive health care system reform - one key "building block" is to train a new health care workforce.
- Action steps include:
  - Collecting data through the licensure process to provide an on-going database about current workforce and analyze future workforce needs
  - Implementing strategies to train, attract and retain an appropriate supply of primary care providers in all areas of Oregon
  - Develop direct reimbursement and a certification system for Community Health Workers

Pennsylvania (Enacted 2008)

- Passed a series of measures over the last few years to expand the scope of practice for physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives and dental hygienists
- Generally, the laws allow fewer doctors to oversee these health care providers and expand the types of settings where they can provide health care services

Iowa (Enacted 5/08)

- Requires that the Department of Public Health expand efforts to guarantee a stable & well-qualified workforce
- Creates a Direct Care Worker Advisory Council to continue work on education and certification issues
- Instructs the Department of Human Services (DHS) to maintain an ongoing report that measures direct care worker turnover in nursing facilities
- Directs DHS to design a premium assistance demonstration project to provide health coverage for up to 150 direct care workers and their dependents

Vermont (Enacted 2006)

Workforce measures to increase provider availability:

- Loan repayment program for health care providers & educators
  - Available to primary care doctors, nurses, dentists, and nurse educators/faculty
  - Must agree to serve patients enrolled in Medicare, Medicaid, or other state health benefit plans
- Loan forgiveness program for nurses and dental hygienists
- Tele-psychiatry pilot to fill the state's gap in available child psychiatrists
- Provider reimbursement surveys
  - Examine the adequacy of reimbursement rates and understand impact of rates on recruitment and retention of health care professionals
- Conduct Nurse Authority Study
  - Establish a work group to study and make recommendations on whether an advanced practice nurse need not be required to work in a collaborative practice with a physician

State Quality Reporting Activities

Using Performance Measurement to Improve Quality

- Public Reporting
  - Health Plans
  - Hospitals
  - Nursing Homes
  - Ambulatory Settings
- Purchasing to Improve Quality
  - Value-based purchasing/payment reform
  - Tiered networks
  - To drive delivery system reform
- To Drive Consumer Choice and Internal Quality Improvement

Public Reporting on Health Plan Performance

- Measures
  - HEDIS: Clinical Measures (Administrative/Medical Records)
  - CAHPS: Patient Satisfaction (Survey)
  - Complaints
  - NCQA Accreditation

- **26 States have public reports using HEDIS, CAHPS or both**

- Some Medicaid Programs publicly report as well

Public Reporting on Hospital Performance

- Descriptive Measures: Administrative
  - Volume/Utilization/LOS/Readmission
  - Number of beds; Services available; Financials; etc
- Process Measures: Clinical (CMS/JCAHO)
  - Heart Attack/Congestive Heart Failure/Pneumonia/SIP
- Outcome Measures: Clinical
  - Mortality (CABG/PCI) – risk adjustment
- Patient Satisfaction: Survey
- **15 States publicly report one or more of these measures**

Public Reporting on Nursing Homes

- Structural/Descriptive Measures: Administrative
  - Number of Beds
  - Staffing Info: Number of Nurses; Turnover; Wages
  - Financial/Cost
- Quality Measures: Clinical (CMS)
  - Quality Measures
  - Deficiency/Complaints
- Patient/Family Satisfaction
- **States generally publicly report deficiency/complaint information**

Public Reporting of Healthcare-Acquired Infections (HAI)

- Public Disclosure:
  - 2003: IL (reworked in 2005)
  - 2004: FL, MO, PA
  - 2005: NY, VA
  - 2006: CO, CT, MD, NH, OH, OK, SC, TN, VT
  - 2007: DE, MN, NJ, TX, WA
  - 2008: CA, MA, OR, RI, WV
- Study Bills: TX (2005/public disclosure in 2007), GA (2006), AK (2006 - resolution)
- Pilot Project: NM (2007)
- Confidential Reporting: NE, NV (2005)

Report Card Authors Face Numerous Choices

Choice	Approach	Issues
Source of data	Claims	Easy and cheap to obtain, but less accurate
	Chart review	More accurate, but expensive
	Surveys	Consumers like, but expensive
Level of reporting	Hospital Level	Facility information, not care by specific practitioner
	Large groups of physicians	Heterogeneous, more valid statistically, less useful to patients
	Individual physician	Numbers of procedures too small, hard to do risk adjustment, most useful to patients
Display of data	Stars or bar graphs	Intuitive and familiar to consumers but can be misleading
	Statistical ranges	Closer to "truth," but more difficult to explain

Common Principles in Performance Reporting

- Steering committee of interested parties
- Pilot first then full implementation
- Reduce duplication of effort by carriers, facilities, and practitioners
- Continuous revision and improvement as measurement techniques advance
- Focus on the Positive
- Web-based application

State Health Policy Commissions and Authorities

State Coverage Initiatives
Robert Wood Johnson Foundation

Delaware Health Care Commission - 1990

- Independent public body reporting to the Governor and the Delaware General Assembly
- Policy-setting body rather than a service-delivery body
- **Mission**: To promote accessible, affordable, quality health care for all Delawareans.
  - **Access**- Promote access to health care for all Delawareans.
  - **Cost**- Promote a regulatory and financial framework to manage the affordability of health care.
  - **Quality**- Promote a comprehensive health care system assuring quality care for all Delawareans.
- Uninsured Action Plan
- Information & Technology
- Health Professional Workforce Development
- Research & Policy Development
- Specific Health Care Issues & Affiliated Groups

Delaware Health Care Commission

- Chair is Lt Gov
- Four government officials (ex officio)
  - Secretary of Finance
  - Secretary of Health & Social Services
  - Secretary of Children, Youth & Their Families
  - Insurance Commissioner
- Six private citizens appointed either by the Governor, the Speaker of the House or the President Pro Tempore of the Senate
  - Dean, College of Health and Public Policy, Delaware State Univ.
  - Senior VP for Government Relations, DE Chamber of Commerce
  - Chair, Dept of Family & Comm Med, Christiana Care Health Services
  - President, Maritime Exchange for the Delaware River and Bay
  - Two others

Maryland Health Care Commission

- Develop State Health Plan/administer Certificate of Need program
- Oversee certain aspects of small group market reforms
- Develop and publish consumer guides for health plans, hospitals, nursing homes and ambulatory surgical centers
- Establish and develop a medical care data base on health care services rendered by health care practitioners
- Establish standards for the operation and licensing of medical care electronic claims clearinghouses
- Determine the cost of mandated health insurance services
- Promote the availability of information to consumers on charges by practitioners and reimbursements from payors
- Oversee and administer the Maryland Trauma Physician Services Fund
- Other policy studies as requested: patient safety, affordability, etc

Maryland Health Care Commission

- 15 members appointed by Gov with advise/consent of Senate
  - Nine must be individuals with no connection to the management or policy of a health care provider or payor
  - Remaining six members:
    - Two physicians
    - Two payors
    - One nursing home administrator
    - One non-physician health care practitioner
- Also geographic representation requirements
- To the extent practicable, assure geographic balance and promote racial, ethnic, and gender diversity in the Commission's membership

Kansas Health Policy Authority - 2005

- Responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies.
- All health insurance purchasing by the State is now combined under KPHA, including publicly funded programs (Medicaid, State Children's Health Insurance Program, and Medikan) and the State Employee Health Benefits Plan.
- Responsible for compiling and distributing uniform health care data in order to provide health care consumers, payers, providers and policy makers with information regarding trends in the use and cost of health care for improved decision making.
- 2007 Legislation: Directed KHPA to develop health reform options in collaboration with Kansas stakeholders.

Kansas Health Policy Authority

- Nine voting health care, business, and community leaders appointed by the Governor and the Legislature
  - President, Chief Executive Officer and General Counsel for Medicalodges, Inc.
  - Associate Professor, Dept of Public Administration, University of Kansas
  - Senior Vice President, Human Resources at EMBARQ Corporation
  - Chairman of the Board, Midway Wholesale of Topeka
  - Professor of Management Practice, Harvard Business School.
  - Retired Co-President and CEO, Center for Health and Wellness
  - Pediatrician
  - CEO of Pratt Regional Medical Center
  - Retired, Midwest Consortium Administrator, Centers for Medicare and Medicaid (CMS), HHS
- Ex-Officio Members
  - Dept of Health & Environment (Sec & Dir of Health); Dept of Social & Rehabilitation Services; Dept of Administration; Dept on Aging; Insurance Department; Department of Education; KHPA Executive Director

Connecticut Office of Health Care Access

- Headed by a Commissioner who is appointed by the Governor

- Mission: To ensure that the citizens of Connecticut have access to a quality health care delivery system:
  - By advising policy makers of health care issues
  - By informing the public and the industry of statewide and national trends
  - By designing and directing health care system development

- **Certificate of Need & Compliance Unit:**

- **Research & Planning Unit:**

Oregon Health Policy Commission - 2003

- Mission: To develop and promote policy recommendations to the Governor, the Legislature, and the Oregon Health Policy and Research (OHPR) that improve the health of all Oregonians by ensuring access to essential health care and support services, increasing quality and improving outcomes for individuals and society, controlling costs, and encouraging healthy lifestyles.

Oregon Health Policy Commission

- Ten voting members appointed by the Governor.
  - Exec VP, Corp Services & Chief Legal Officer,The Regence Group
  - Chair, AterWynne LLP (Strategic Legal Advisors)
  - Director, Integrated Clinical Services, Multnomah County Health Dept
  - Senior Consultant, Watson Wyatt Worldwide
  - President, SEIU Local 49
  - Health Care Consultant
  - Director, Oregon Ctr for Health Professions, Oregon Inst of Technology
  - CEO, The Lussier Center (Management Consulting Services)
  - Chairman, Triquint Semiconductor
  - Vice President and Chief Quality Officer, Samaritan Health Services
- Four legislators (one representing each legislative caucus) serve as non-voting advisory members to the Commission

Lessons Learned in State Reform Efforts

State Coverage Initiatives
Robert Wood Johnson Foundation

Lessons Learned in State Reform Efforts #1

- Successful comprehensive reforms are built on previous efforts, financing mechanisms
- Need ingredients: leadership, opportunity, readiness to act, persistence
- No free solutions
- Successful efforts to enact reforms often need shared financial responsibility
- State expansions in coverage often rely on private insurers to deliver care
- Voluntary strategies will not result in universal coverage - some states are beginning to recognize the need for mandatory participation

Lessons Learned in State Reform Efforts #2

- Hard to get agreement on what is covered (benefit design/affordability)
- Little success so far in addressing underlying cost of health care but a new focus on chronic care management/preventive care holds potential
- Address access, systems improvement, cost containment simultaneously—concern about long-term sustainability of coverage programs and improved population health
- New state reforms can be fairly judged only after several years, allowing a realistic length of time to work through implementation challenges.
- Comprehensive reforms need sequencing
  - Sequential = incremental with a vision

States Can Advance Reform Initiatives But Need Federal Support

- States face growing pressures for reform
  - Uninsurance continues to rise as employer sponsored coverage declines
  - Cost increases threaten state budgets and capacity to sustain Medicaid/SCHIP
- States play critical role in moving the conversations about coverage expansions
  - Testing new ideas (politically and practically)
  - Creating momentum for national policy solution
- States cannot achieve universal coverage without a federal framework and funding
  - Significant variation across states in resources, capacity, and landscape—including uninsured rates, available state funds to invest in coverage, insurance market structures, and other important factors

NCSL Health Committee Roster

Committee Officers & NCSL Staff // Committee Members // Committee Jurisdiction

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Committee Description

This committee has jurisdiction over state and federal health programs, legislation, regulations and policies. The committee educates Congress and federal agencies about state concerns regarding developments in federal health initiatives and programs and grants to states. In addition, it serves as a forum for legislators and legislative staff to learn about and share information regarding health programs and health policy initiatives in other states. Recently, the committee has addressed the following issues:

- Medicare prescription drug coverage
- Medicaid
- Health care cost containment
- Health care access
- Public health and prevention

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Senator Cheryl R. Pflug
Representative Dawn Morrell
Representative Larry Seaquist

West Virginia
Senator Roman W. Prezioso Jr.
Delegate Don C. Perdue
Delegate Barbara Burruss Hatfield

Wisconsin
Senator Timothy W. Carpenter
Senator Jon Erpenbach

Wyoming
Representative Elaine Harvey
Representative Pete Jorgensen
Senator John M. Hastert
Senator Charles K. Scott
John H. Rivera, *Legal Services Division, Legislative Service Office*

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Washington Office: Tel: 202-624-5400 | Fax: 202-737-1069 | 444 North Capitol Street, N.W., Suite 515 | Washington, D.C. 20001

2/11/09 PRESENTA-TION: BRING THE KIDS HOME INITIATIVE

Bringing (Keeping) the Kids Home Update – February 2009

The Trust
The Alaska Mental Health Trust Authority

A collaboration of Department of Health and Social Services, Alaska Mental Health Trust Authority & partner boards, Denali Commission, Rasmuson Foundation, Alaska Native health providers & other service providers, parents, advocacy groups

Exponential Growth In Use of Out-of State Residential Psychiatric Treatment Centers (RPTC)

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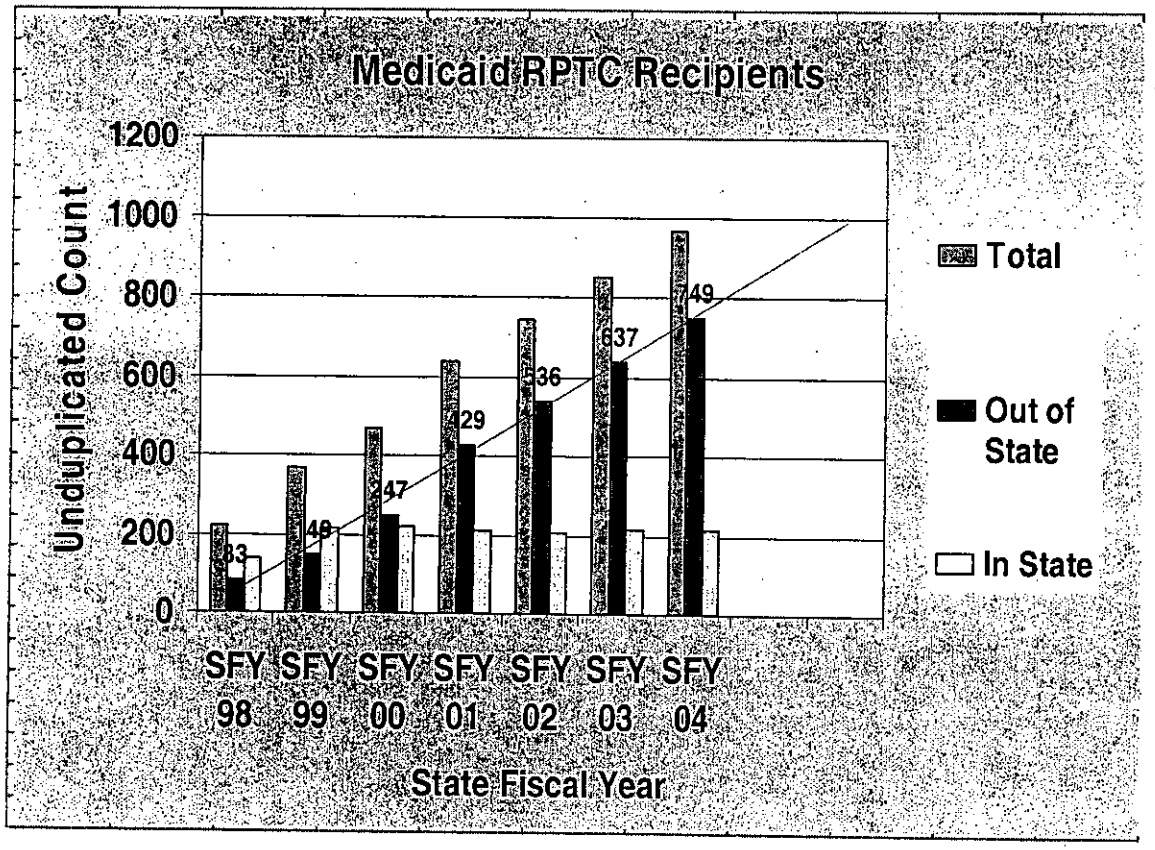

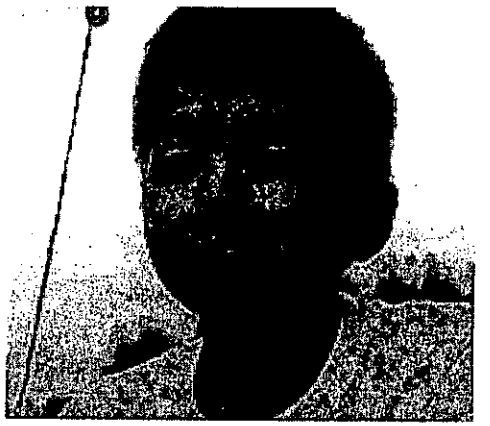

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2246

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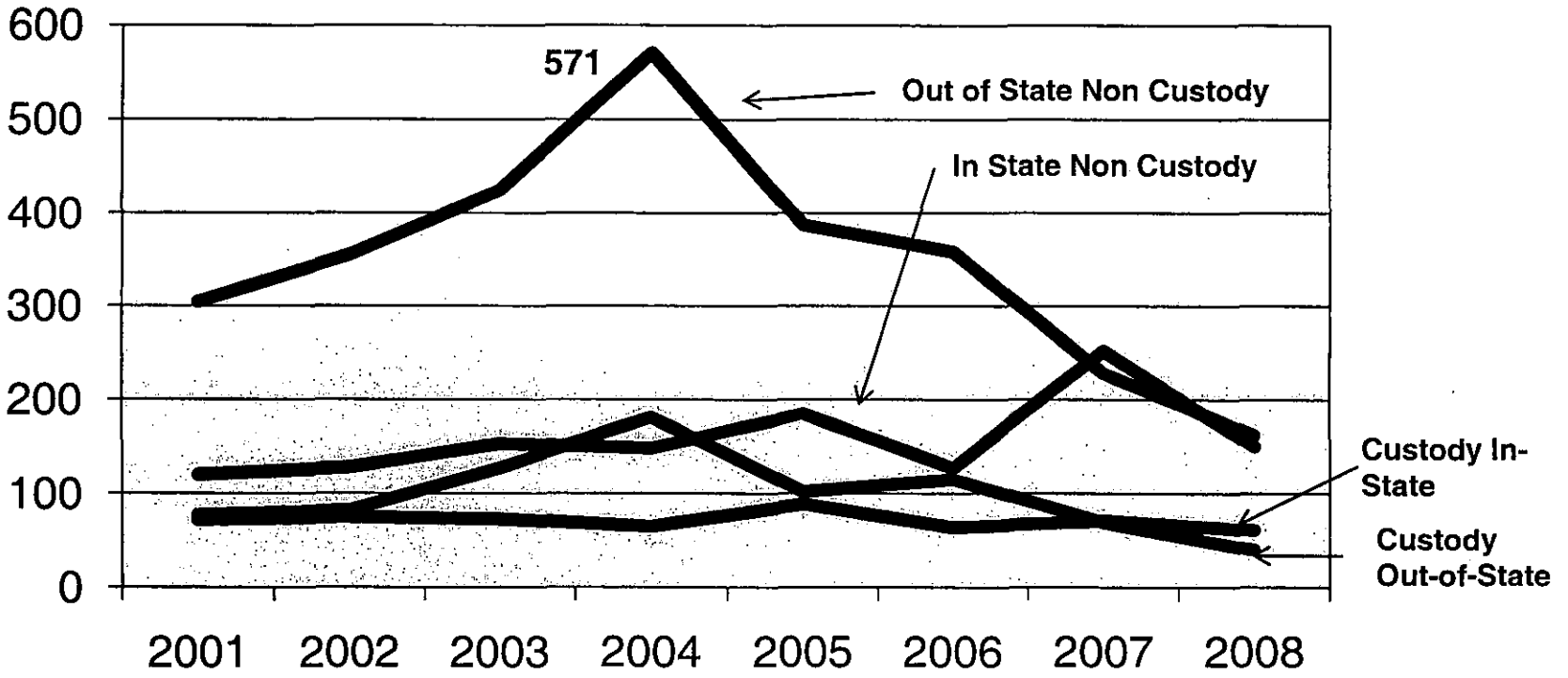
Drop of 73% in out-of-state admissions between FY04 and FY08



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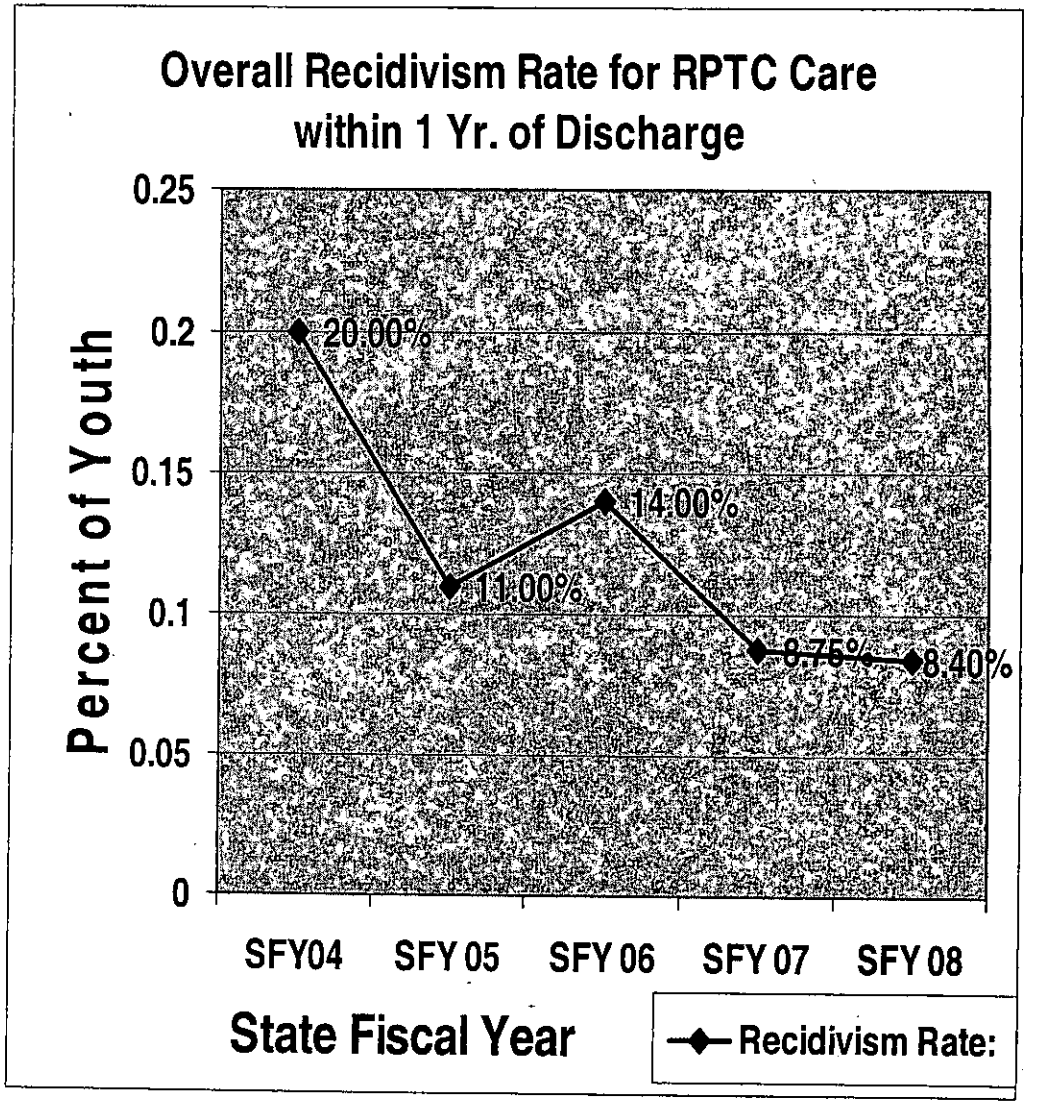

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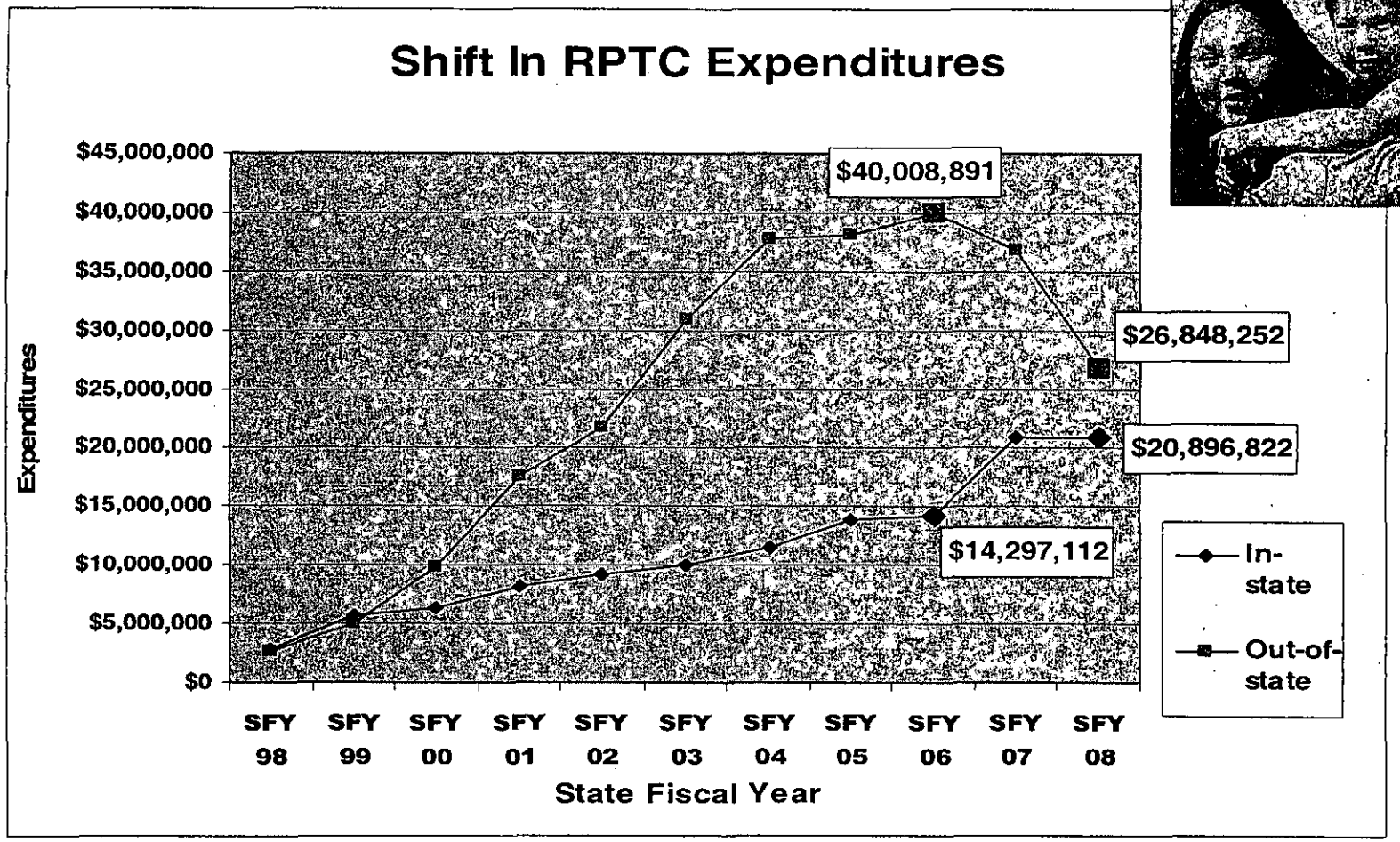

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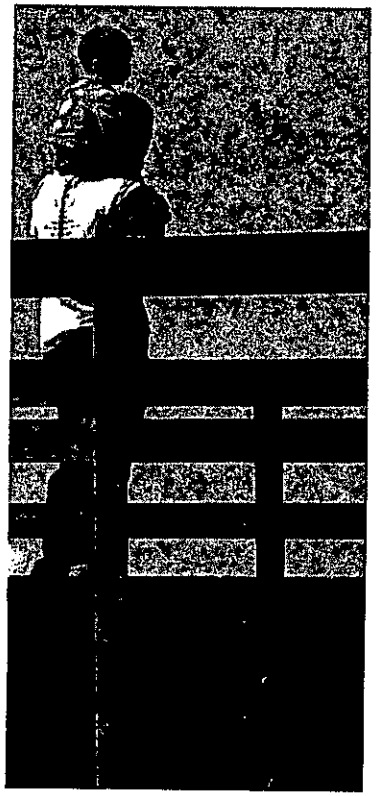
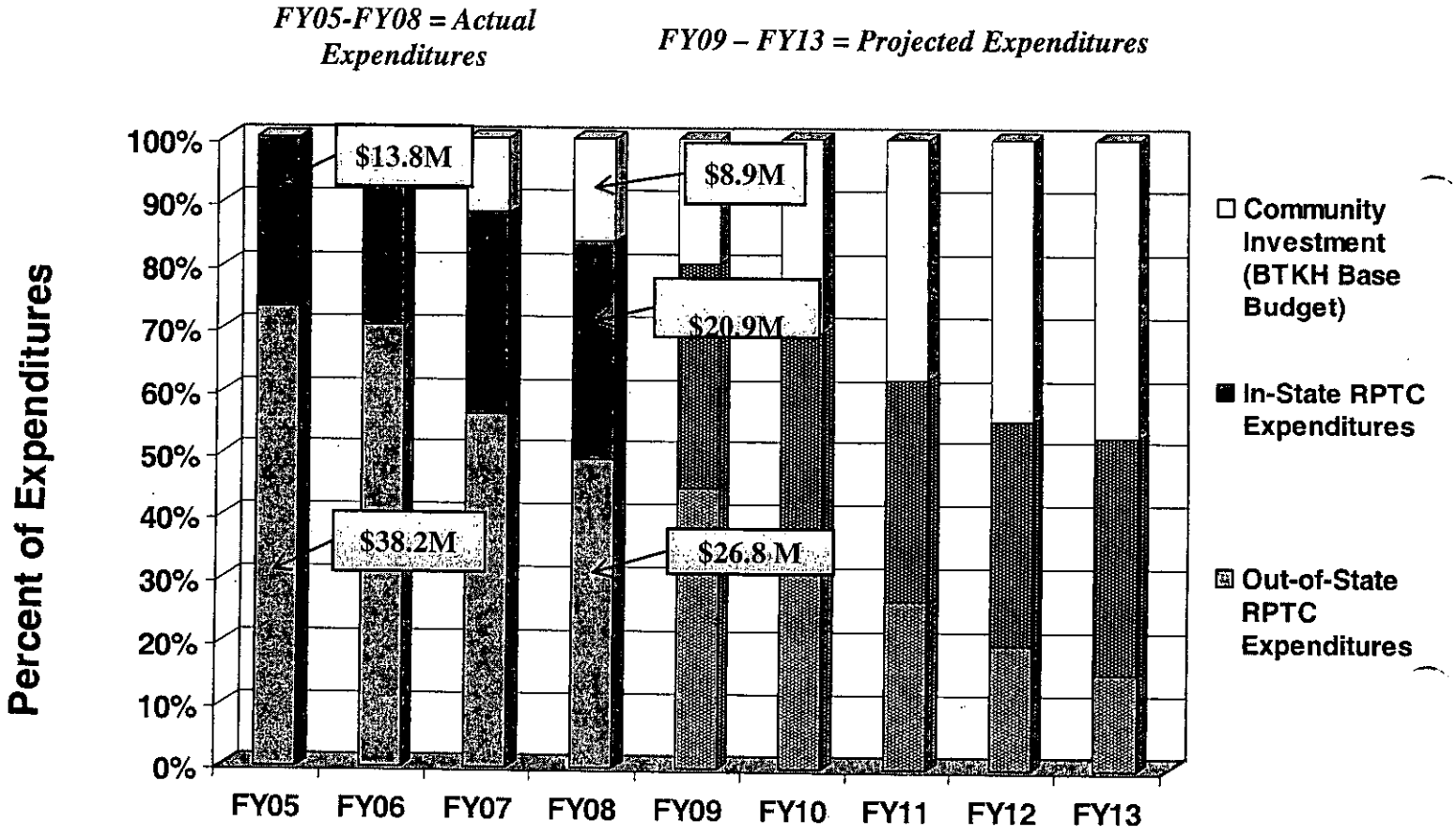
Progress: Projected BTKH Reinvestment





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2250

Ahead in FY 2010: Support for On-going Efforts

Mental Health Trust Recommendations

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Enhance Home, School & Community-based Services			
Outpatient Grants	$250.0	$2,000.0	$2,250.0
Crisis Bed Stabilization	$150.0	$0.0	$150.0
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School-Based Grants	$200.0	$0.0	$200.0
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Individualized Services into Base	$0.0	$800.0	$800.0
Enhance Best Practices			
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Parent & Foster Parent Training	$75.0	$0.0	$75.0

**Includes Federal match not listed separately.*

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Assist in the Transition to Adulthood			
Transitional Aged Youth	$200.0	$300.0	$500.0
BTKH Capital Development *(matches Denali Commission funding)*		$2,316.0	$2,316.0

Group Homes, Transitional-aged Youth & Crisis Stabilization Facilities

*Includes Federal match not listed separately.

2252

Anchorage Community Mental Health Services

SED ROOT CAUSES

• Sexual abuse	20%
• Physical abuse	65%
• Neglect	100%
• Witness to DV	100%
• Family substance abuse	95%
• Complex trauma	100%

Anchorage Community Mental Health Services

Little Tykes Program

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- Implement Evidence Based Practices to improve long-term outcomes:
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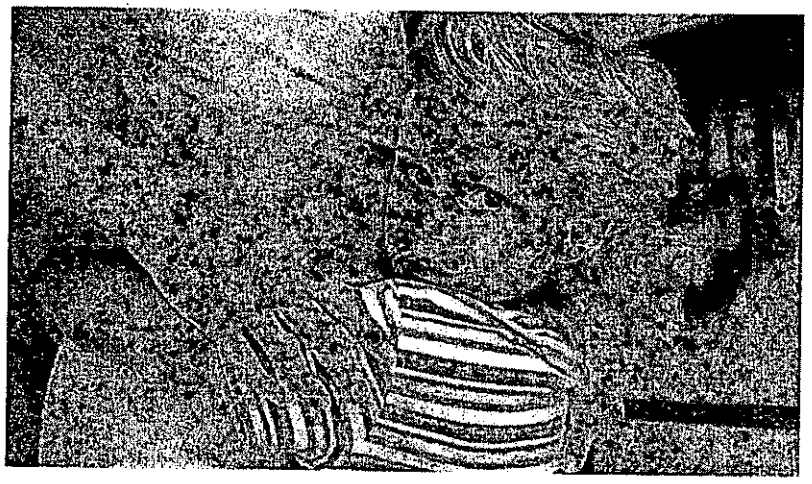

Mat-Su Pilot Project
Integrated Longitudinal Strengths Based Assessment (LSA)
BTKH (310) (A)

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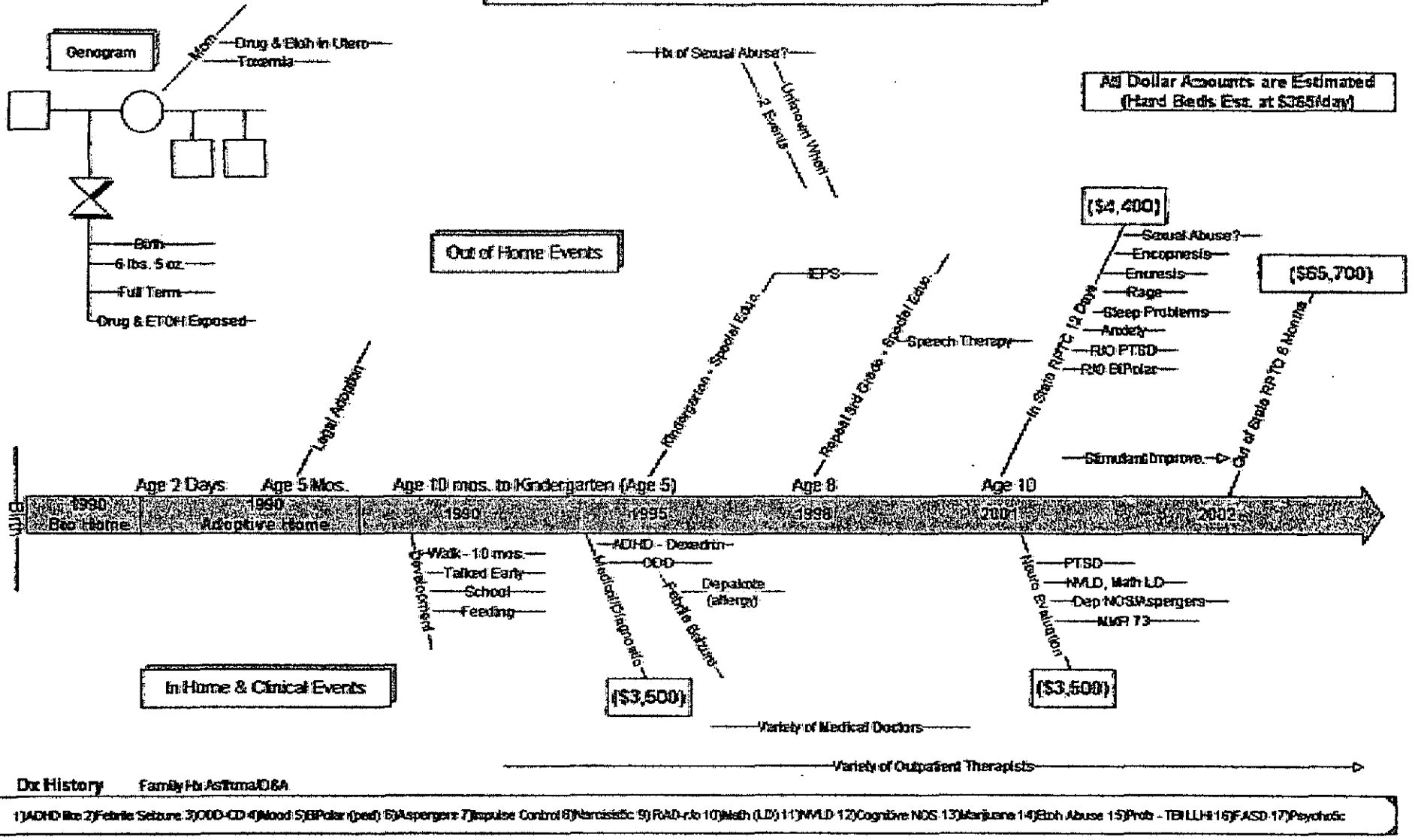

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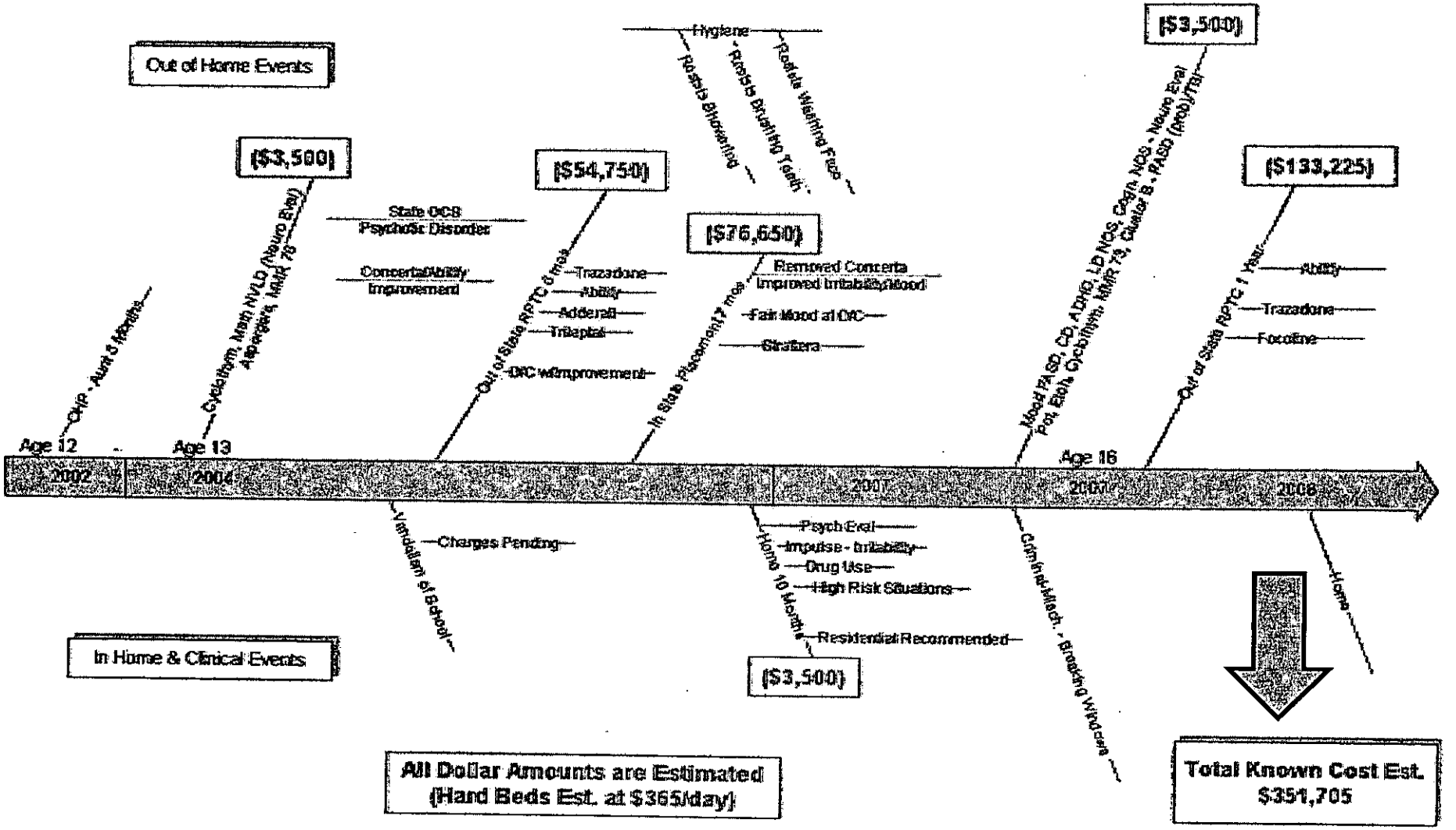
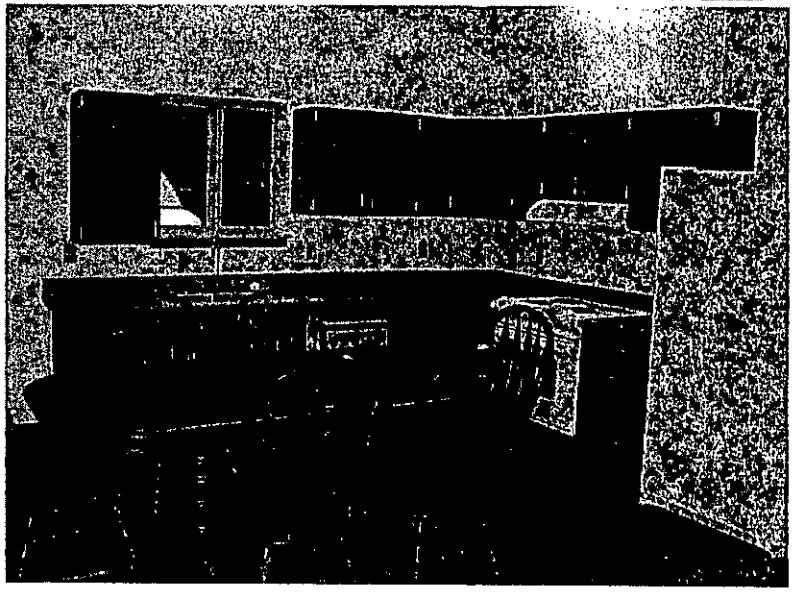


Juneau Youth Services
Transitional Living Program



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- Cornerstone Apartments: 5-bed facility
- Operating Funds for TLP
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2258

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- Data and Outcomes
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  - 9.17 service hours/per client/per month (average)
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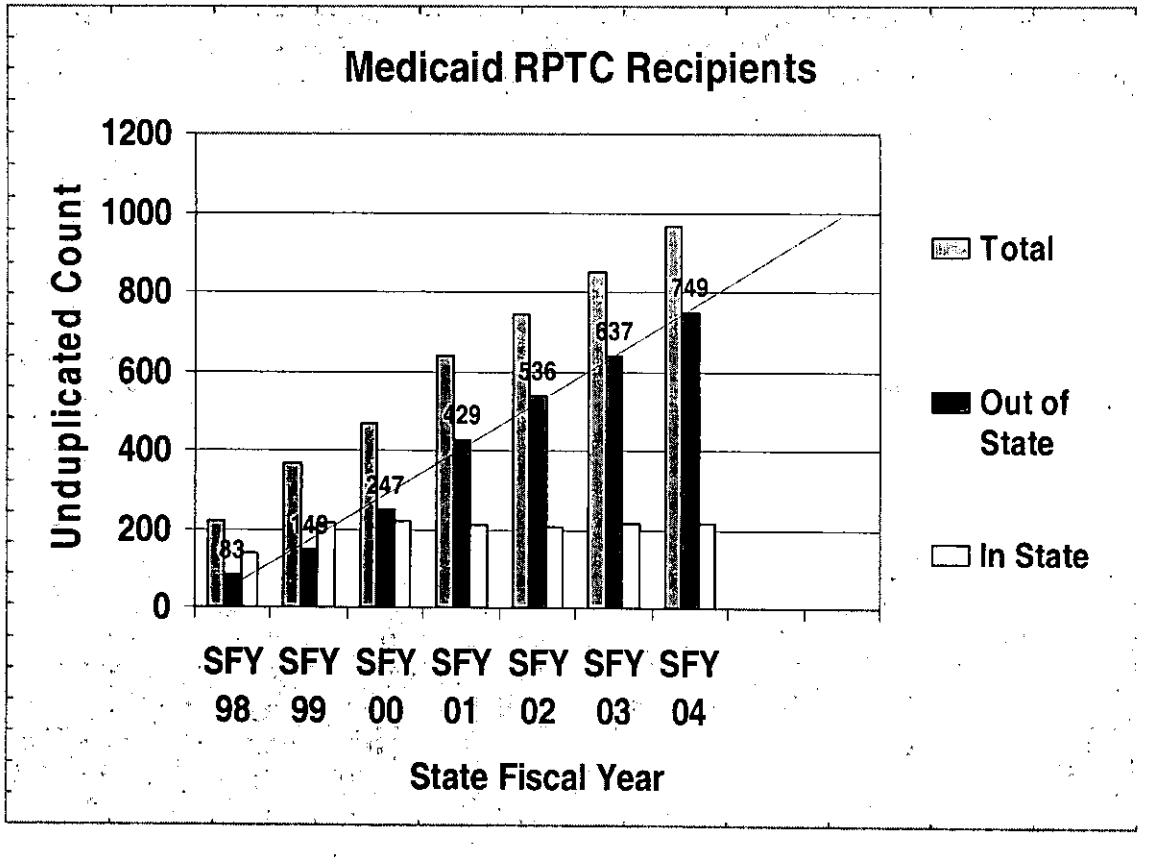

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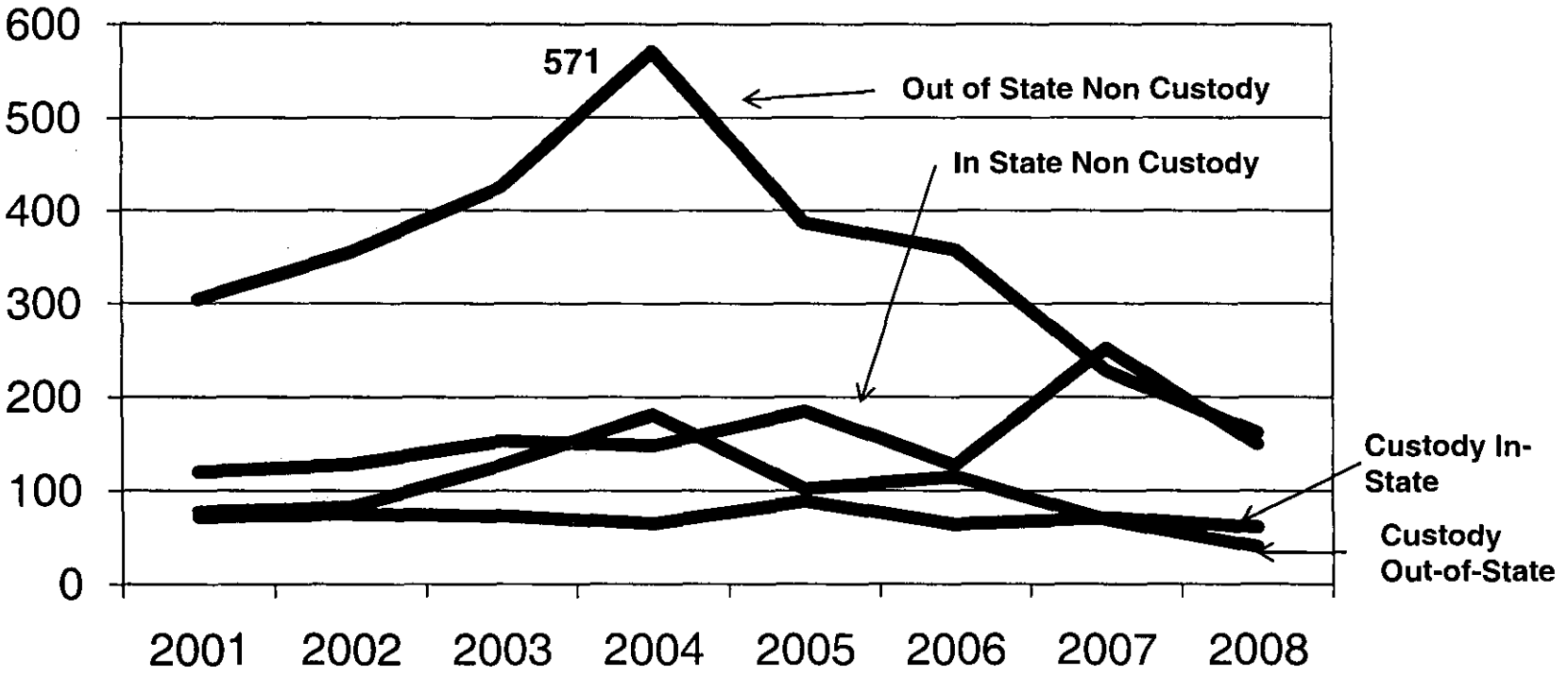

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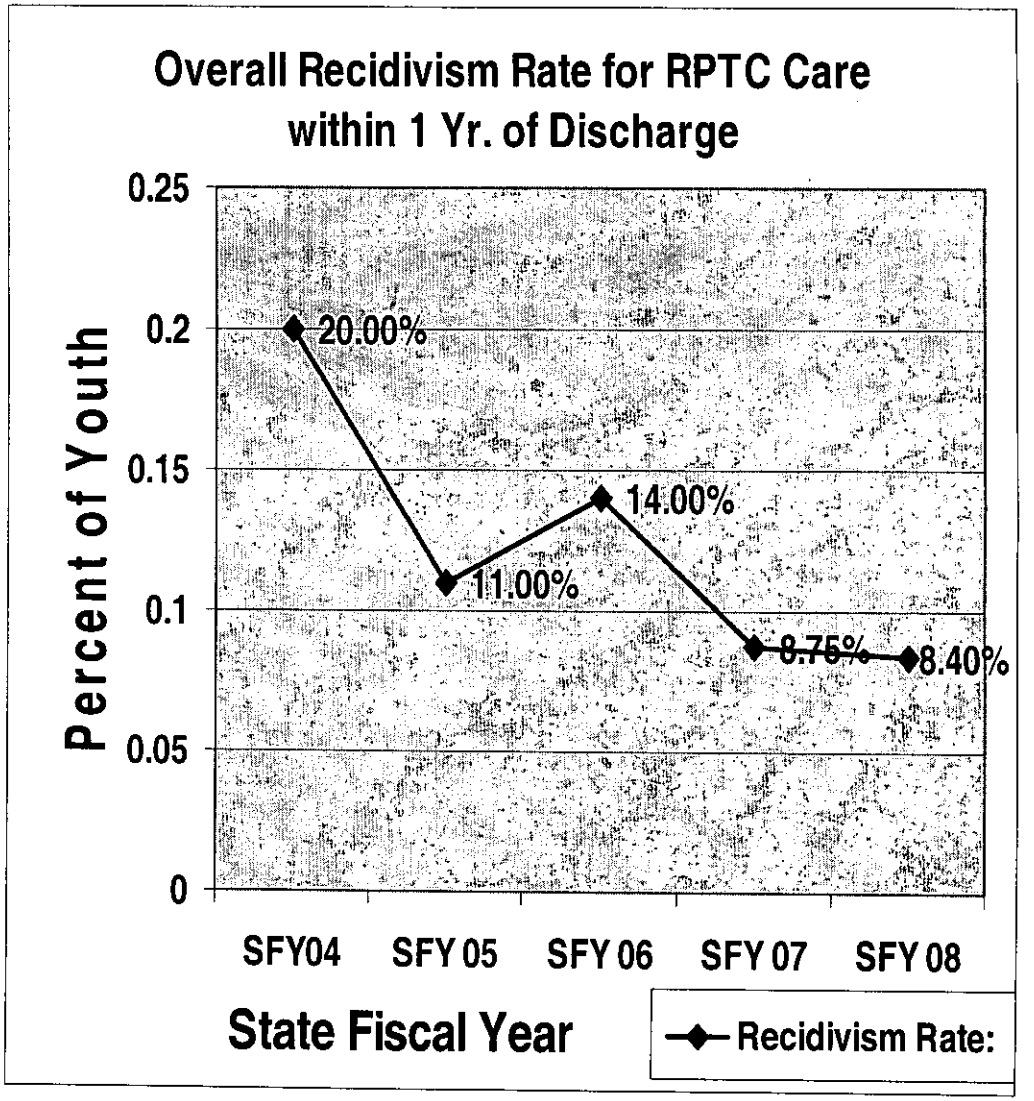

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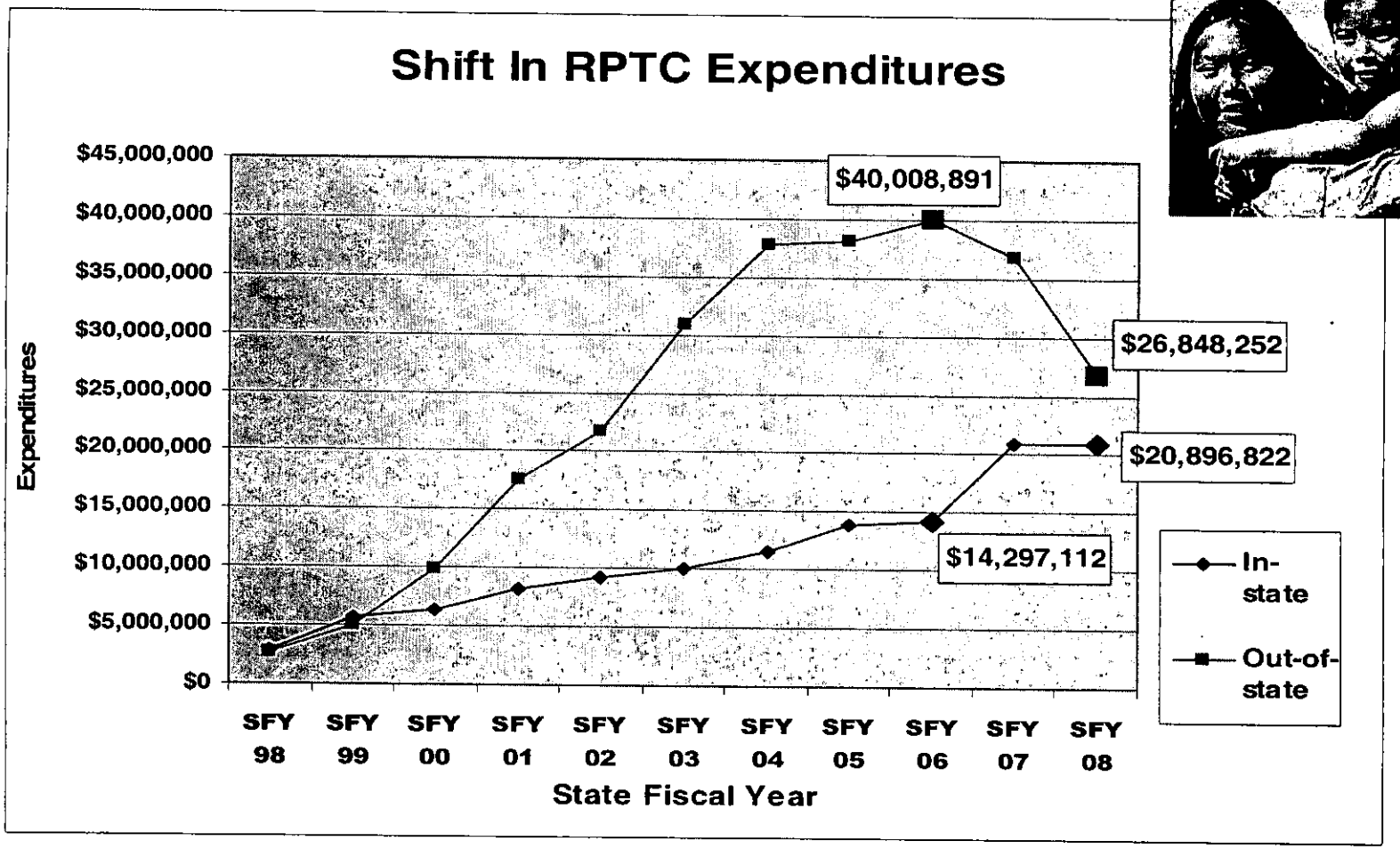

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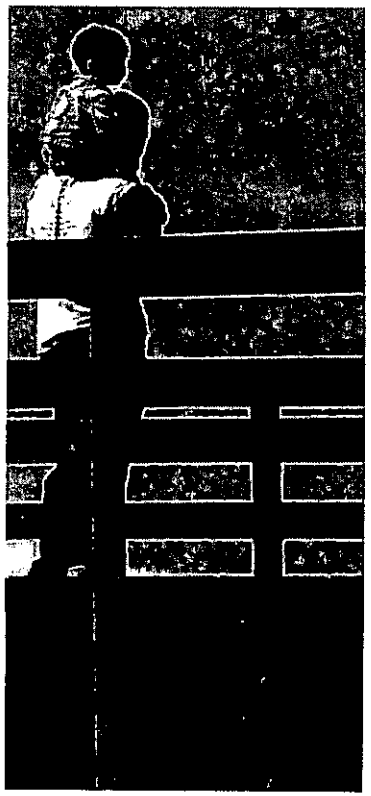

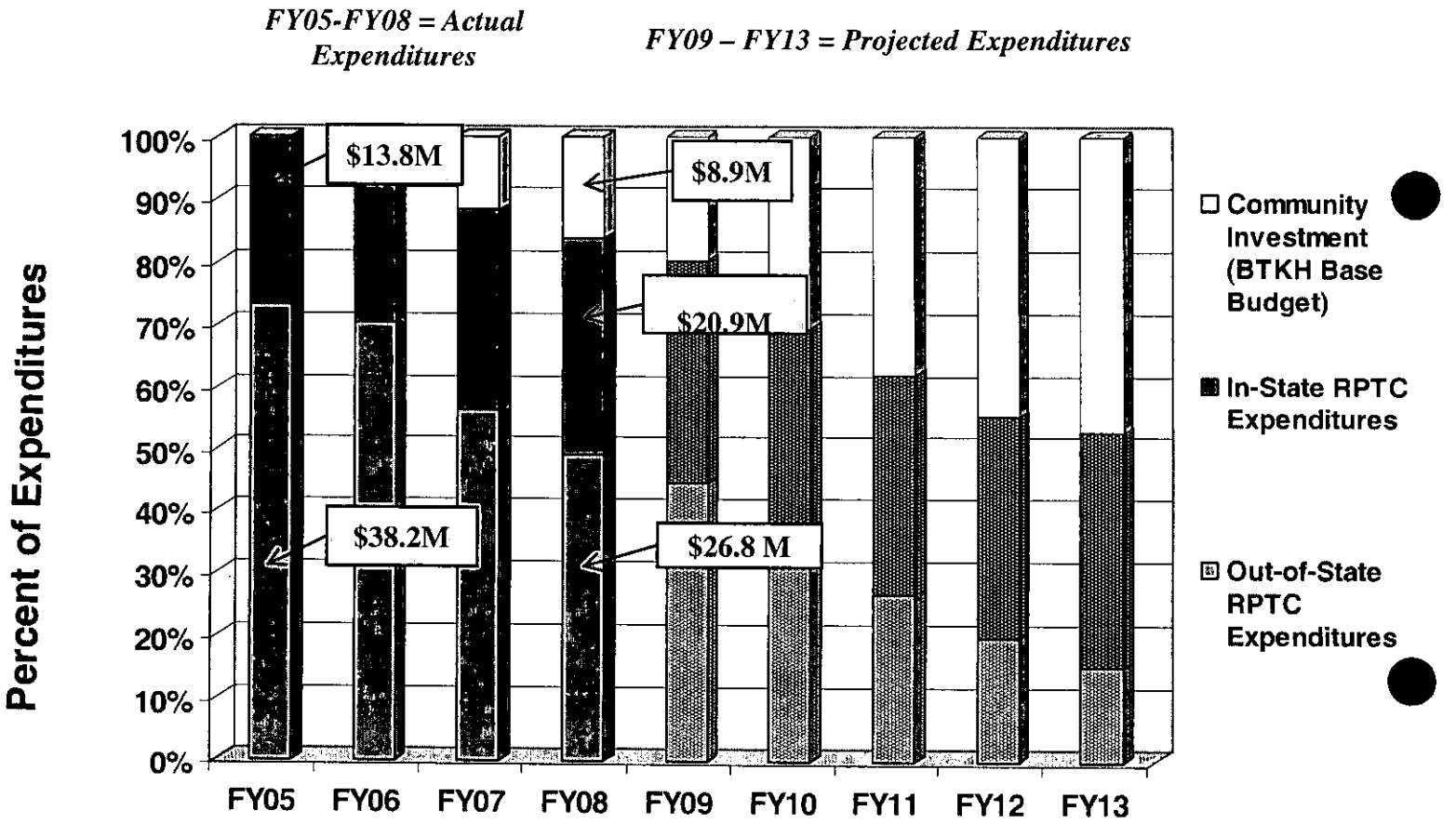

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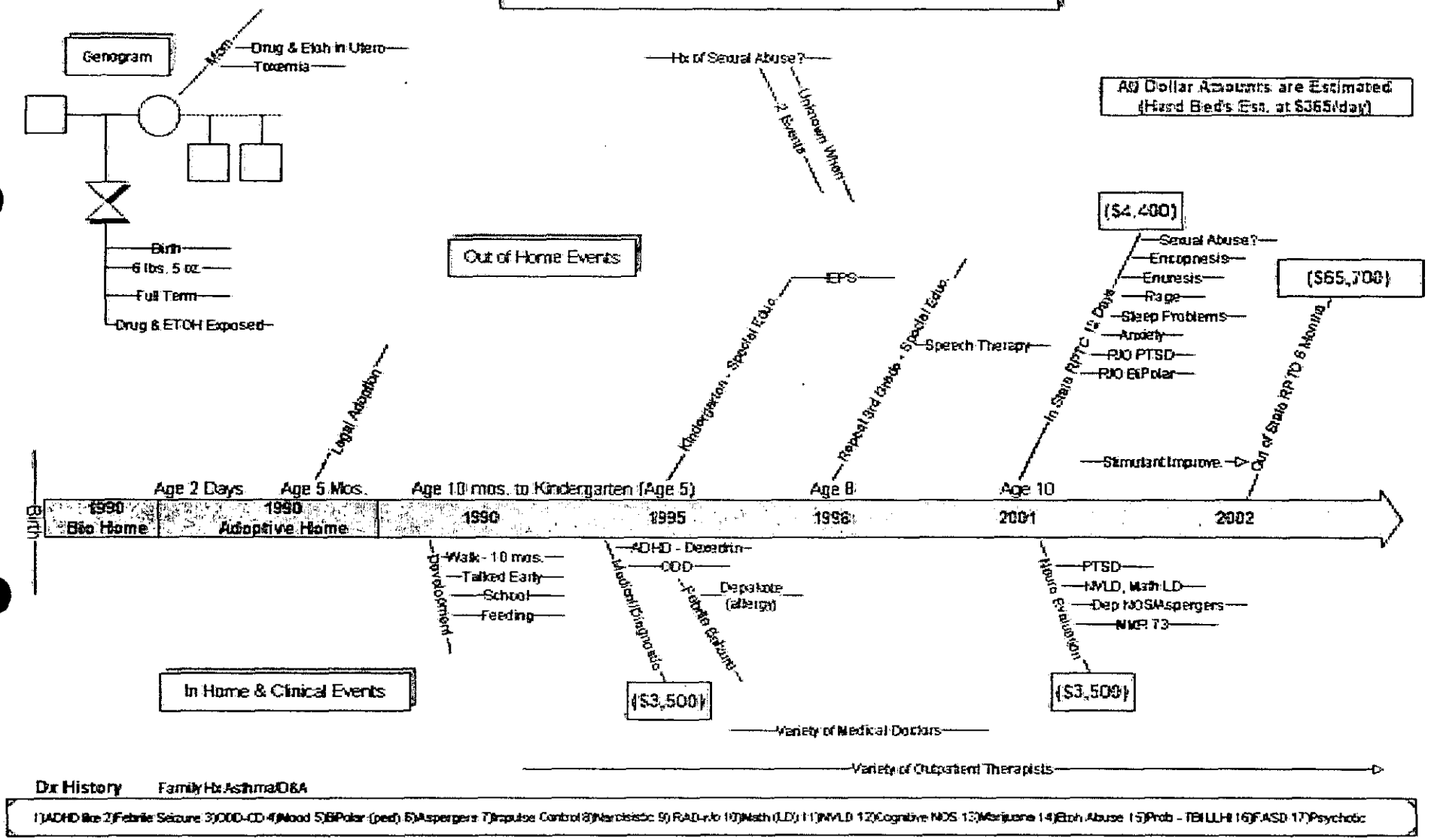

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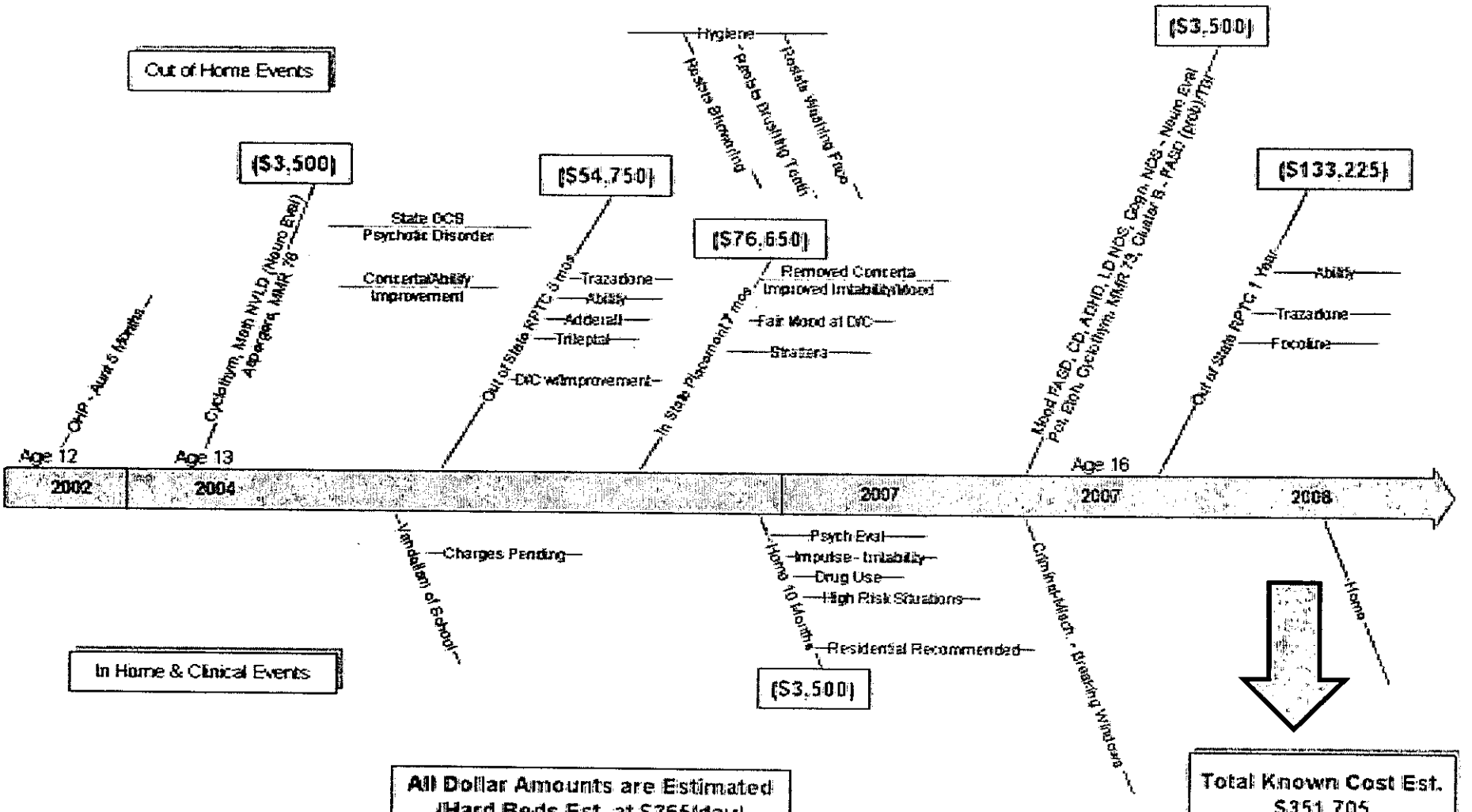

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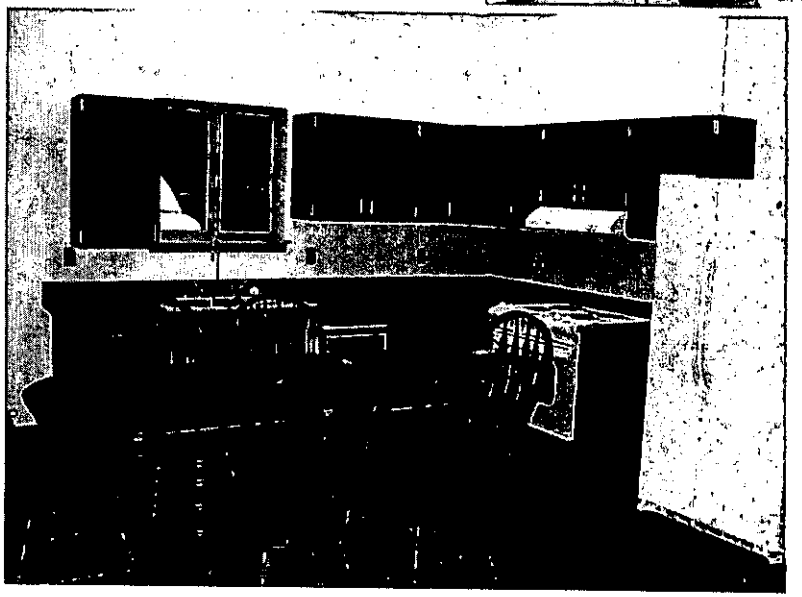

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2276

2/20/09 PRESENTATION: ALASKA TRIBAL HEALTH SYSTEM

Jackson, Patsy A

From: Jackson, Patsy A
Sent: Thursday, February 05, 2009 9:44 AM
To: 'Linda_Zaugg@legis.state.ak.us'
Cc: Davidson, Valerie; Dotomain, Evangelyn (ANHB)
Subject: S HSS - February 20

Linda,

Thank you for your help in working with Senator Davis and the Senate HSS schedule to carve a window of time on February 20. We will provide you with handout materials, and I'd like to give you the names of the people who will present.

Will you identify the presentation topic as an overview of the Alaska Tribal Health System with presentations from the Alaska Native Tribal Health Consortium and the Alaska Native Health Board. Please let me know if you think of anything specific you need or if Senator Davis has anything specific she would like to have prepared for the meeting.

Thanks again.

Pat Jackson
State Liaison for Alaska Native Health
Alaska Native Tribal Health Consortium
pajackson@anthc.org
723-6479 (mobile)

Valerie Davidson
Senior Director
Legal & Intergovernmental Affairs
Alaska Native Tribal Health Consortium
4000 Ambassador Drive
Anchorage, AK 99508
907-729-1908
907-729-1901 fax
vdavidson@anthc.org

Evangelyn "Angel" Dotomain, MBA
President/CEO
Alaska Native Health Board
Phone: 907-562-6006
Facsimile: 907-563-2001
Mobile: 907-232-4293
Direct: 907-868-4848

As of December 5, 2008:
1840 Bragaw Street, Suite 220
Anchorage, AK 99508

2278

Alaska Tribal Health System Sustainability Issues

Presented by
Valerie Davidson, Legal & Intergovernmental Affairs
Alaska Native Tribal Health Consortium
February, 2009

Outline

- Introduction to the Alaska Tribal Health System
- Introduction to the Alaska Native Tribal Health Consortium
- Sustainability issues & Medicaid's role

2

Indian Health Service

- Provides health care in recognition of government to government relationship between Tribes and the U.S. to members of federally recognized Tribes and their descendents
- 3.3 million American Indians/Alaska Natives (AI/AN) in 560 federally recognized Tribes.

3

Alaska Native health history

- ***1900-1970:*** Health care for Alaska Natives was provided by the U.S. government
- ***1970-1998:*** Alaska Natives organized health care organizations under Self-Governance legislation and assumed ownership of health services
  - *Indian Self-Determination and Education Assistance Act* facilitated gradual transfer of health programs from federal to tribal ownership (1976)
  - "*Self-Governance*" legislation provided for perpetual "compact" agreements between U.S. Department of Health & Human Service and tribal programs (1994).
- ***1998-2007-Future:*** All Alaska Native health care is provided by Alaska Native organizations

4

Why Tribal Ownership?

- **Customer-owned health program**
- **Integration of primary care around the family**
- **Local priority setting and budget allocation**
- **Local decision-making & flexibility**
- **Culturally-relevant health programs**

5

Alaska Tribal Health System

- A voluntary affiliation of over 30 Alaskan tribes and tribal organizations providing health services to Alaska Natives/American Indians
- Each tribe or tribal health organization is autonomous and serves a specific geographical area
- Entire Alaska Tribal Health System serves approximately 130,000 Alaska Natives (projected to 160,000 by 2015)

6

Alaska Native Demographics

- Alaska Natives represent 20% of Alaska's population
- Median age is 23.6 years compared to
  - 35.3 years for U.S. All Races and
  - 32.4 years for All Alaskans

7

ATHS Service Population

– Anchorage/Mat-Su valley	40,000	31%
– Rural Southcentral Alaska	12,000	9%
– Arctic Slope (northern coast):	4,300	3%
– Maniilaq (northwest coast):	7,600	6%
– Norton Sound (west coast):	7,400	6%
– Bristol Bay (southwest):	5,300	4%
– Yukon-Kuskokwim (southwest):	24,200	19%
– Southeast Alaska:	16,300	12%
– Interior Alaska:	13,000	10%
TOTAL ALL REGIONS:	130,600	100%

8

Alaska Native Health Status

- Leading Causes of Death:
  - Cancer
  - Heart Disease
  - Unintentional injuries
  - Water transportation/drowning
  - Suicide
  - Alcohol-related
  - Cerebrovascular
  - Chronic Obstructive Lung Disease
  - Influenza and Pneumonia
  - Homicide

9

Alaska Native Health Status

- Leading causes for primary care visits
  - Upper respiratory conditions
  - Accidents and injuries
  - Otitis Media
  - Medical/surgical follow-up
  - Bone and joint disorders
  - Neurosis/other non-psychotic
  - Hypertension
  - Immunization
  - Pre-natal care

10

Alaska Native Health Status

- Leading causes of hospitalization
  - Deliveries
  - Accidents and injuries
  - Pneumonia
  - Pregnancy complications
  - Arthritis
  - Heart Disease
  - Bronchitis/Emphysema
  - Alcohol abuse
  - Cancer

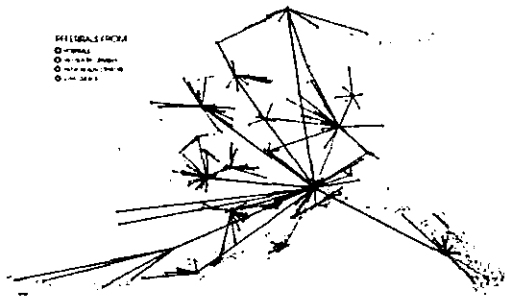
11

Levels of Medical Care Services

- 180 small community primary care centers
- 25 subregional mid-level care centers
- 4 multi-physician health centers
- 6 regional hospitals
- Alaska Native Medical Center tertiary care
- Referrals to private medical providers and other states for complex care

12

Alaska Tribal Health System Referral Patterns



13

Village-Based Medical Services

180 small community health centers

- ~550 Community Health Aides/Practitioners
- ~125 Behavioral Health Aides
- ~20 Dental Health Aides/ 12 Therapists
- ~100 Home health/personal care attendants

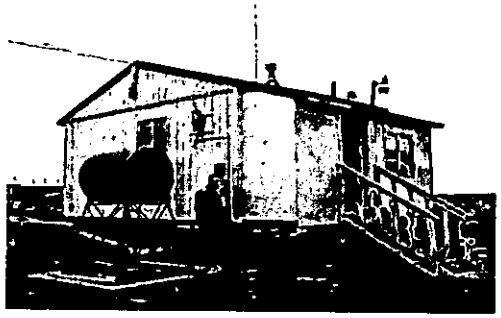
- Average Alaska village: 350 residents

14

Community Health Aide/Practitioners

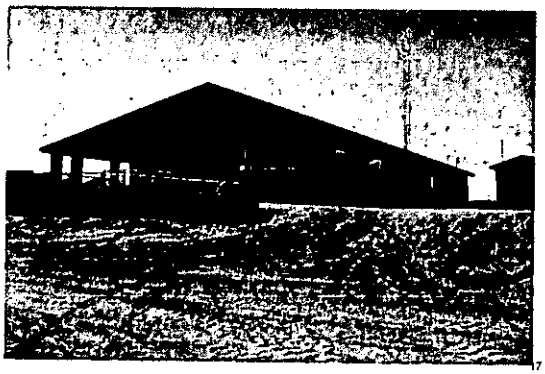
15

Old Newtok Clinic
Yukon-Kuskokwim Delta



16

Kiana Village Clinic- Northwest Alaska



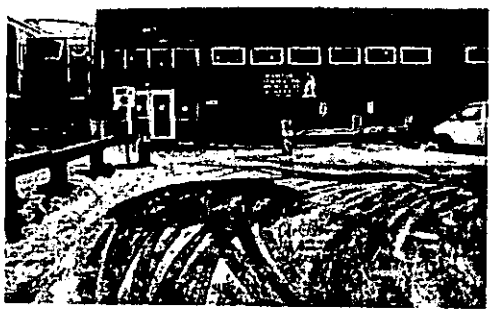
17

Alaska's North and Western Coasts

- Health Systems: Regional health organizations with hospitals serving between 10-50 village clinics
  - Arctic Slope Native Association (6)
  - Maniilaq Association (12)
  - Norton Sound Health Corporation (20)
  - Yukon Kuskokwim Health Corporation (58)
  - Bristol Bay Area Health Corporation (32)

18

Samuel Simmonds Memorial Hospital
Barrow, Alaska



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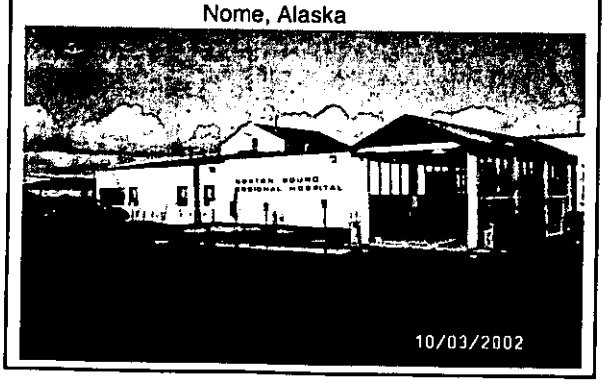
Maniilaq Health Center
Kotzebue, Alaska

20

Norton Sound Regional Hospital
Nome, Alaska



Yukon-Kuskokwim Delta Regional Hospital

Bethel, Alaska

22

Bristol Bay/Kanakanak Hospital

Dillingham, Alaska

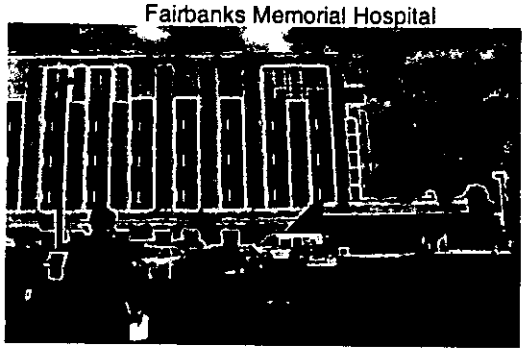
23

Interior Alaska

- Interior region Native health system:
  - 25 village clinics
  - 4 subregional mid-level health centers
  - Physician Health Center in Fairbanks
  - inpatient care purchased from Fairbanks Memorial Hospital

24

Chief Andrew Isaac Health Center and Fairbanks Memorial Hospital



25

Southeast Alaska

- Regional hospital in Sitka : Mt. Edgecumbe
- Physician health centers in Juneau and Ketchikan
- Physician assistants, nurse practitioners, and Community Health Aide/Practitioners in 18 island communities
- Contractual agreements with some community hospitals

26

SEARHC Mt. Edgecumbe Hospital

Sitka, Alaska

27

Metlakatla Health Center

Metlakatla, Southeast Alaska

28

Southcentral Alaska

("Anchorage Service Unit")

- Southcentral Foundation provides
  - direct primary care and community health services in Anchorage, the Matanuska-Susitna Valley, the upper Kuskokwim area, and the Iliamna area
  - primary care support for sixteen (16) Native health organizations in rural Southcentral Alaska

29

Alaska Native Tribal Health Consortium

- Created in 1998 with Congressional authorization
- Provider of statewide health services, supporting all Alaska tribal health organizations and communities
- 1,800 employees
- Provides:
  - Tertiary and specialty medical care,
  - Community health and research,
  - Environmental health & engineering, including water and sanitation facilities construction & management
  - Health information technology services
  - Professional recruitment

30

Alaska Native Medical Center

- Jointly managed by ANTHC (statewide) and Southcentral Foundation (regional)
- Primary hospital services for Alaska Natives from Anchorage and rural Southcentral Alaska
- Tertiary/specialty hospital for all regions

31

Alaska Native Medical Center, Anchorage

32

Alaska Native Medical Center

- 150 beds
- 6,500+ admissions annually
- 1,400+ infants delivered annually
- 385,000 specialty/primary outpatient visits
- 11,000+ surgeries and endoscopies
- 250 medical staff, 700+ nurses
- $250 M operating budget (ANTHC+SCF)

33

Residential Treatment Centers

-Southcentral Foundation (Adolescents/Women)
-Cook Inlet Tribal Council (adults)
-Yukon Kuskokwim Health Corporation
(adolescent inhalant/adults)
-Fairbanks Native Association (adult/adolescent)
-Tanana Chiefs Conference (recovery camp)
-Maniilaq (adult recovery camp)
-SEARHC (youth/adult/women)
-Copper River (family/youth recovery camp)

34

Dental Services

- 14 regional hub dental clinics provide itinerant services to 150 villages
  - 3 to 50 chairs per clinic
- Dentists spend up to 15 weeks a year traveling for village services
- System-wide: 65 dentists/25 vacancies
- ANTHC is training and deploying mid-level Dental Health Aide Therapists

35

Community Health Services

- Medical system is complemented by 'wraparound' community health services programs, provided by tribes and tribal health organizations, and supported by ANTHC:
  - health promotion/disease prevention
  - health research
  - injury prevention
  - food safety monitoring
  - emergency preparedness
  - immunizations

36

Health Facilities

- Annual federal investment in building, renovating, and maintaining Alaska Native health facilities is estimated at $55 million
- ANMC needs a $100M+ expansion
- Barrow and Nome hospitals are ready for replacement at over $100M each
- Nearly 100 primary care clinics have been replaced, another 50+ need replacement
- Long-term care facilities are also needed

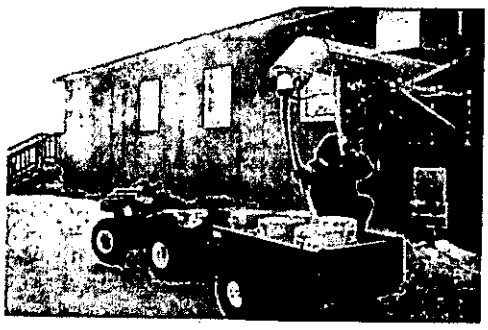
37

Sanitation Facilities Construction

- Statewide funding for all Native community water and sanitation facility projects estimated at $60 million annually from all sources (State, HUD, EPA, Rural Development, Indian Health Service)
- $600 million+ unmet need remains: primarily in 40 western Alaska communities

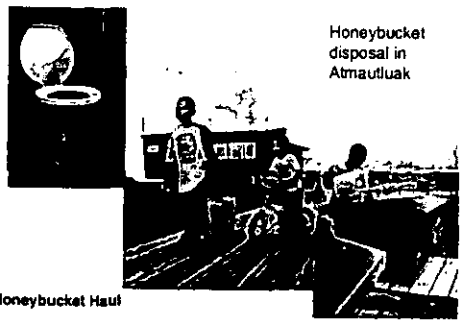
38

Community Watering Points



39

"Honeybucket Haul Systems"



Honeybucket disposal in Atmautluak

Honeybucket Haul

40

Water Service Utilidors

41

Why invest in sanitation?

- Infants in communities without adequate sanitation are:
  - 11 times more likely to be hospitalized for respiratory infections
  - 5 times more likely to be hospitalized for skin infections

42

ATHS Employment & Economic Impact

- Alaska Native tribes and tribal health organizations employ over 7,000 full and part-time staff statewide
- Resources circulate in the state because we are local

43

Some major Alaska Native health initiatives

- *Care coordination* for chronic/high-acuity patients
- *Electronic Health Records* deployment
- Tribal *long-term care*, residential and home-based services development
- *Alternative health resources* enhancement (Medicaid, Medicare, insurance)
- *Wellness/health promotion* effort

44

Sustainability Issues

- The Indian Health Service funds only 51% of the level of funding needed to provide basic health care services.
- IHS funding does not keep pace with basic medical inflation.
- IHS funding is "discretionary" and competes with national parks for funding.

45

Sustainability Issues

- *Severe underfunding of the Indian Health System results in layoffs & reduction in services:*
- Due to the gap between IHS funding and need, health services to AI/ANs are severely rationed.
- Funding levels especially restrict:
  - Adult dental care
  - Non-hospital skilled nursing care
  - Rehabilitation, substance abuse treatment
  - Behavioral health services
  - Psychiatric care

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Authority to Bill

- Due to this disparity, Congress authorized IHS facilities to recover reimbursements from:
  - Medicaid,
  - Medicare, and
  - State Children's Health Insurance Programs (ie. Denali KidCare)

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Partnership with State

- Long Term Care
  - Home & Community Based Services
  - Residential
- Behavioral Health Continuum of Care
- Financial Infrastructure
- Managed Care Feasibility

48

Alaska Benefits

- The Centers for Medicare & Medicaid Services (CMS) provides a Federal Medical Assistance Percentage (FMAP) of 51% to the State of Alaska.
- However, State receives 100% FMAP for AI/AN patients who receive their care in an IHS facility.
  - A 49% savings to the State General Fund when patients use the ATHS.

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Sustainability Issues

- *Facility Demands*
  - *Facility Development Innovations*
    - *Joint Venture*
    - *Small Ambulatory Program*
  - *Facility Operational Needs*
    - *Medical Equipment Replacement*
    - *Facility & Environmental Support*
    - *Maintenance & Improvement*
    - *Village Built Clinic Lease Program*
  - *Other Facility needs*
    - *Long Term Care Facilities*
    - *Residential Alcohol & Substance Abuse Facilities*

50

Sustainability Issues

- *Energy Crisis and its impact on health*
  - *Increase in demand for health services*
  - *Decrease in ATHS ability to provide care*

51

Sustainability Issues: Energy Crisis

- Increase in demand for health services
  - infectious disease due to overcrowded homes (especially in communities without sanitation facilities)
  - behavioral health needs as families begin to experience increased financial pressures
  - Compromised health due to inability to maintain body heat, especially for those with compromised immune systems
  - People who are reliant on durable medical equipment who are not able to pay for increased electrical costs will increase need for emergency care

52

Sustainability Issues: Energy Crisis

- Decrease in ability to provide care
  - Fuel and electricity costs already represented 33% of the cost of clinic operations before the energy crisis
  - Rising fuel and electricity costs combined with chronic underfunding result in exceed the capacity to provide the care
  - Clinics are limiting hours of operation during a time we expect to see an increased demand for health care

53

Sustainability Issues: Energy Crisis

- Need to address sustainability
  - Facility costs for addressing energy needs for:
    - Clinics
    - Hospitals
    - Sanitation Facilities
  - Operating Costs to meet additional burdens on
    - Additional demand for care
    - Transportation costs
    - Increased supply costs
    - Special consideration needs to be made for populations in which there is no other health care provider

54

Questions?

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ANTHC Vision: "Alaska Natives Are the Healthiest People in the World"

2298

Alaska Native Health Board Overview

Evangelyn Dotomain

February 20, 2009

2299

Topics of Discussion

- Overview of ANHB
  - Mission & Operation
  - Statewide Membership
- Economic Impact
- State Priorities
  - Issues
  - Needs
- Questions

Overview of ANHB

- Mission:

  "To promote the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. "
- Founded in 1968
- Tribal Health Advocacy
  - Federal and State Advocacy, BOD Support, Facilitation & Statewide Forum, Tribal Information & Communication

23301

Membership

Alaska Native Tribal Health Consortium • Aleutian Pribilof Islands Association • Arctic Slop Native Association • Bristol Bay Area Health Corporation • Chugachmiut • Copper River Native Association • Council of Athabascan Tribal Governments • Eastern Aleutian Tribes • Karluk IRA Tribal Council • Kenaitze Indian Tribe • Ketchikan Indian Community • Kodiak Area Native Association • Metlakatla Indian Community • Mt. Sanford Tribal Consortium •Native Village of Eklutna • Native Village of Tyonek • Ninilchik Traditional Council • Norton Sound Health Corporation • Seldovia Village Tribe • Southcentral Foundation • South East Alaska Regional Health Consortium • Tanana Chiefs Conference • Valdez Native Tribe • Yukon Kuskokwim Health Corporation

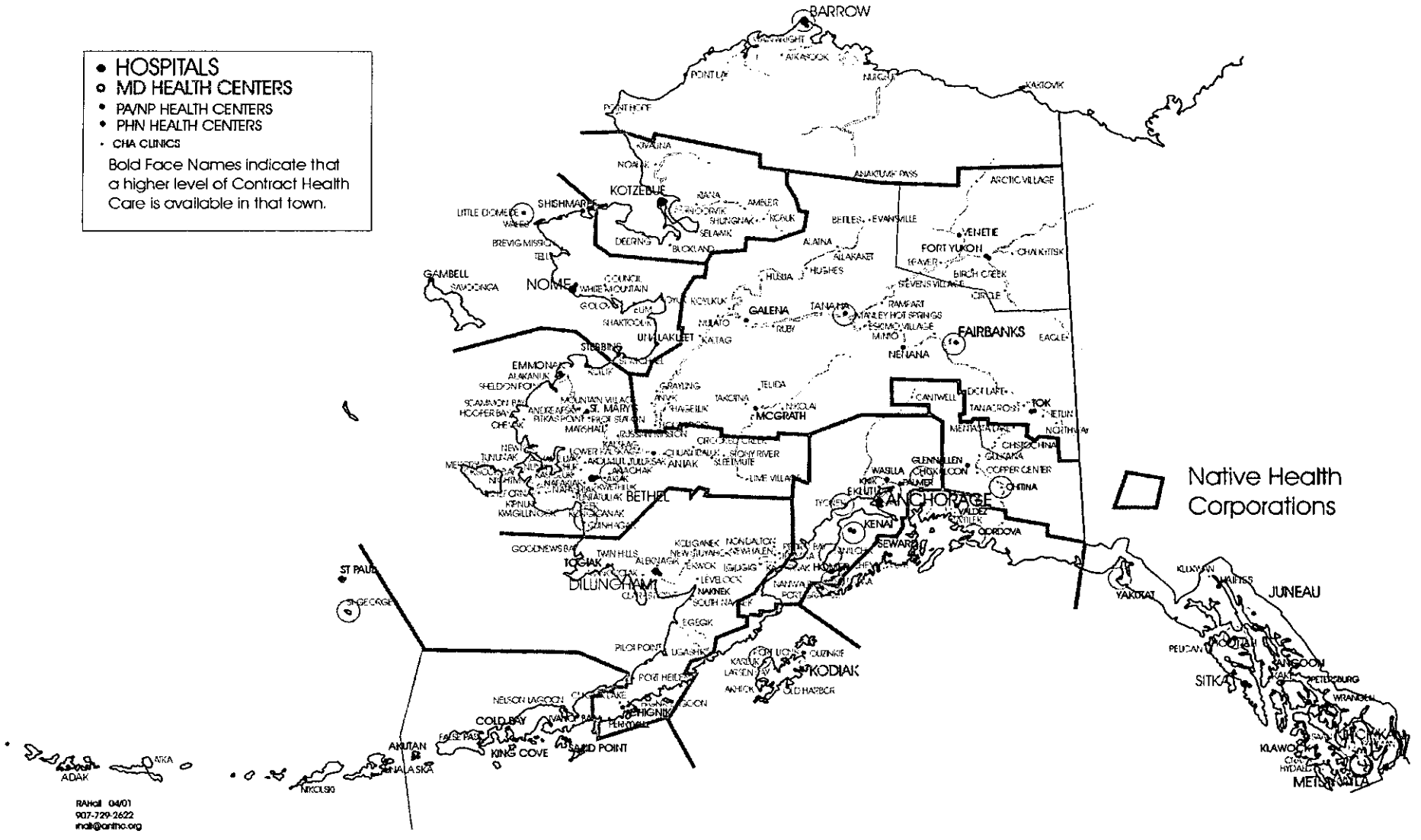
Tribal Health Among Alaska's 100 Largest Employers

	Employees	Ranking
Alaska Native Tribal Health Consortium/ Alaska Native Medical Center	**1855**	**11**
Yukon Kuskokwin Health Corporation	*1292*	*15*
Southcentral Foundation	**1250**	**16**
SE Alaska Regional Health Consortium	*826*	*28*
Maniilaq Association	**555**	**44**
Tanana Chiefs Conference	*485*	*56*
Norton Sound Health Corporation	**478**	**59**
Bristol Bay Area Health Corporation	*355*	*70*

2007 Alaska Economic Trends

THE ALASKA NATIVE HEALTH CARE SYSTEM

Location Names and Service Level



RAHall 04/01
907-729-2622
rhall@anthc.org

Tribal Health Overview

- Tribal health care has improved health for Alaska Natives
- Disease rate have dropped dramatically due to:
  - Improved access to health care
  - Increase in basic public health measures
    - Childhood and Other Vaccines
    - Sanitation and Water Facilities
- However, there are challenges
  - Chronic under-funding
  - Staffing shortages
  - Increasing health care costs
  - Growing Alaska Native population
- Coupled with inadequate funding for Indian Health Service (IHS) for many years
  - Increases have not kept up with yearly inflation rates or medical cost inflation

A Perfect Storm

- Socio-economic Status
  - Remote Communities with little economic base
  - High unemployment rates
  - Low income levels
- Health Care Issues: A Perfect Storm
  - Travel farther than others to receive health care services
  - With money they don't have
  - Usually much sicker and with more medical issues than the average person by the time they receive care at a health facility
  - Fewer medical resources available
  - Higher costs than other facilities in the United States

2306

State Priorities

- Energy Solutions for Health Care
- Medicaid
- Behavioral Health
- Water & Sanitation
- Electronic Health Records
- Ensuring Safe Communities

2307

Energy Solutions for Health Care

- Power Cost Equalization
  - Fully fund for FY10 Operating Budget
  - Expansion of Regulation to include
    - Clinics
    - Non-Profits
- Additional Energy Assistance

Medicaid

- ANHB encourages the State of Alaska to continue to invest in demonstration projects to test innovative approaches through the ATHS
- Any proposed changes to current Medicaid policy should:
  - Enhance or maintain access to Medicaid by vulnerable residents
  - Expand or maintain types of services currently covered by Medicaid
  - Ensure payment rates cover the entire cost of providing the service
  - Improve health, save lives, and reduce emergency health care costs

Behavioral Health

- Support behavioral health grants and programs by utilizing the tribal consultation methodology to direct funding in the most effective manner
- Continue financial support for the Alaska Tribal-State Forums on domestic violence, child abuse, child neglect and sexual assault
- Additional funding to establish housing and treatment options for severely and chronically mentally ill
- Support and funding for the Rural Psychiatric Treatment Center (RPTC) programs
- Strongly supports Suicide Prevention programs which are culturally appropriate and impactful

2310

Water & Sanitation

- Village Safe Water Program support to design and construct water and sanitation facilities in rural Alaska
- Operations & Maintenance Subsidy
  - $15 million investment to support water and sewer operations and maintenance for one year would help protect public health, the major capital investment in this infrastructure, and help extend the life of water and sewer systems

Electronic Health Records

- State appropriations to support the Alaska eHealth Network focusing on the deployment of electronic health records and a system for private, secure exchange of health information between medical providers, their patients, and the payers
- Support for electronic health records to allow for greater continuity of care, less medical and pharmacy errors, and greater efficiency

Ensuring Safe Communities

- Substantial and ongoing increases in funding for VPSO program
  - Greater need for first responders
  - Shortage causes CHA/Ps to take on much of this work
  - But the partnership is essential to both to reduce burnout and provide needed service

Additional: Workforce Development

- High vacancy rates:

Occupational Groups	Statewide Estimates			
	Positions	Vacancies	Vacancy Rate	*Tribal Vacancy*
All Occupations	34738	3529	**10.2%**	***16.5%***
Physicians	1931	226	**11.7%**	***27.1%***
Professional Nurses	7139	696	**9.8%**	***15.5%***
CNA/LPN/PCA/HHA	1762	111	**6.3%**	***14.3%***
Dentist/Pharmacists/ Therapists	2281	404	**17.7%**	***42.9%***
Behavioral Health	7450	1033	**13.9%**	***14.5%***

- Support for loan repayment and incentive programs
- Increased outreach and workforce development opportunities

Alaska Native Health Board
State Legislative Priorities
Fiscal Year 2010

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ALASKA TRIBAL HEALTH SYSTEM

The health status of American Indians and Alaska Natives (AI/ANs) is much poorer than that of the average American. Many live in remote communities with little economic base, high unemployment rates and low income levels. These conditions result in a "perfect storm" of health care obstacles: AI/ANs in Alaska travel farther than others to receive health care services with money they don't have, and are much sicker, with more medical issues, than the average person by the time they receive care at a health facility that has fewer resources and higher costs than other facilities in the United States.

Funding for health has led to improved Alaska Native health status
Despite these obstacles the Alaska Tribal Health System (ATHS) has worked to improve health for Alaska Natives. Rates for diseases, such as tuberculosis, have dropped dramatically with improved access to health care and basic public health measures, like childhood vaccinations and installing water and sewer systems in rural Alaska. Between 1950 and 1997, Alaska Native life expectancy rose from 46 years to 68 years of age (ISER, Status of Alaska Natives Report, 2004).

Still, Alaska Natives continue to suffer from significantly higher rates of suicide, violent injury, and unintentional injury than the general population and face unprecedented rates of cancer, obesity, and diabetes. The ATHS provides a broad range of services, consistently improving health care delivery. However, chronic under-funding, increasing health care costs, and a growing Alaska Native population are hampering much needed progress.

Funding has not kept pace with need, inflation
The Indian Health Service (IHS) has not received adequate funding for many years. Modest increases have not kept up with inflation, increasing medical costs, or the ever expanding funding gap.

Overview of the Alaska Tribal Health System
ATHS is a multifaceted, interdependent healthcare system with sophisticated patterns of referral developed over 40 years by Alaska's 231 federally recognized Tribes. The ATHS strives to provide better health care to our people, half of whom live in remote communities across 586,412 square miles of largely road-less land. Alaska's Tribes and Tribal organizations manage more than 99 percent of IHS programs under the Indian Self-Determination and Education Assistance Act and, since 1994, the Alaska Tribal Health Compact, allowing federal programs to be redesigned to meet the needs in Alaska.

The Alaska Native Health Board (ANHB) is the statewide voice of Alaska Native health advocacy, consistently emphasizing the importance of self-determination in healthcare services and encouraging wellness in Native communities through policy change. The ANHB continues a 40 year commitment to ensuring healthier Alaskan Natives. ANHB encourages our federal and state policymakers to join us in finding solutions and funding to help us save lives, improve Alaska Native health, and use resources more efficiently and effectively.

The Alaska Native Health Board (ANHB) represents 24 tribal health organizations serving approximately 130,000 Alaska Native and American Indian individuals. These priorities reflect the current state needs of these members and will be the focus of ANHB state advocacy for Fiscal Year 2010.

PRIORITY ONE: ENERGY SOLUTIONS FOR HEALTH CARE

ANHB urges the Legislature to continue the Power Cost Equalization (PCE) benefit at 100% for FY09 and to fully fund PCE in the Administration's FY10 operating budget. The PCE should be expanded via regulation in three crucial ways for it to be truly effective in rural Alaska:

- Include Clinics, regardless of funding source
- Include non-profits
- Include fuel/heating oil

PRIORITY TWO: MEDICAID SUPPORT AND FUNDING

The federal government covers 100% of Medicaid payments for Alaska Native Medicaid beneficiaries if they receive care from the Alaska Tribal Health System (ATHS). This provides a unique opportunity for the State of Alaska to improve the health of Alaska Natives and save money by:

- Continuing to invest in demonstration projects to test innovative approaches through the ATHS.

PRIORITY THREE: BEHAVIORAL HEALTH SUPPORT & FUNDING

ANHB invites the State Legislature to support the Governor's request for $19.1 million in behavioral health grants. The increased funding level will help address significant unmet needs by:

- Enabling DHSS grant funded programs for domestic violence, mental health, suicide prevention, and substance abuse services to operate in rural Alaska,
- Train providers, community based counselors and behavioral health aides.

DOMESTIC VIOLENCE, CHILD NEGLECT & ABUSE

Continued financial support for Alaska Tribal-State Forums on domestic violence, child abuse, child neglect and sexual assault (DV/CA/CN/SA), as well as increased funding for programs and shelters in Alaska Native communities.

SEVERELY AND CHRONICALLY MENTALLY ILL – HOUSING

ANHB urges support for additional funding to establish housing and treatment options for the severely and chronically mentally ill.

BRING THE KIDS HOME

ANHB encourages continued support and funding for the Rural Psychiatric Treatment Center (RPTC) programs. RPTC programs are needed to ensure children are able to obtain treatment as close to home as possible and provide in-state options for care.

PRIORITY FOUR: WATER AND SANITATION SUPPORT & FUNDING

VILLAGE SAFE WATER PROGRAM

ANHB requests support for $22.9 million for the State's Village Safe Water (VSW) program to design and construct water and server facilities in rural Alaska.

OPERATIONS & MAINTENANCE SUBSIDY

An investment of $15 million for water and sewer operation and maintenance for one year would help protect public health, the capital investment in the infrastructure and help extend the life of water and sewer systems.

PRIORITY FIVE: ELECTRONIC HEALTH RECORDS SUPPORT & FUNDING

ANHB recommends a state appropriation of $6.5 million to support the Alaska eHealth Network focusing on the deployment of electronic health records (EHR) and a system for private, secure exchange of health information (HIE) between medical providers, their patients, and the payers.

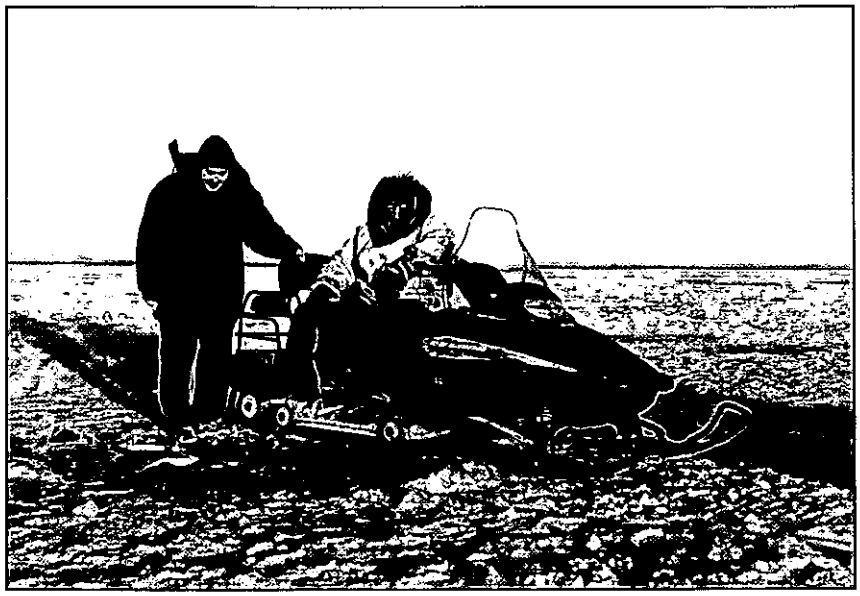
ELECTRONIC HEALTH RECORDS RPMS

The Alaska Tribes propose that all E-health initiatives allocate a percentage of funds to support the Indian Health Service Resource and Patient Management System (RPMS) public domain system.

PRIORITY SIX: ENSURING SAFE COMMUNITIES

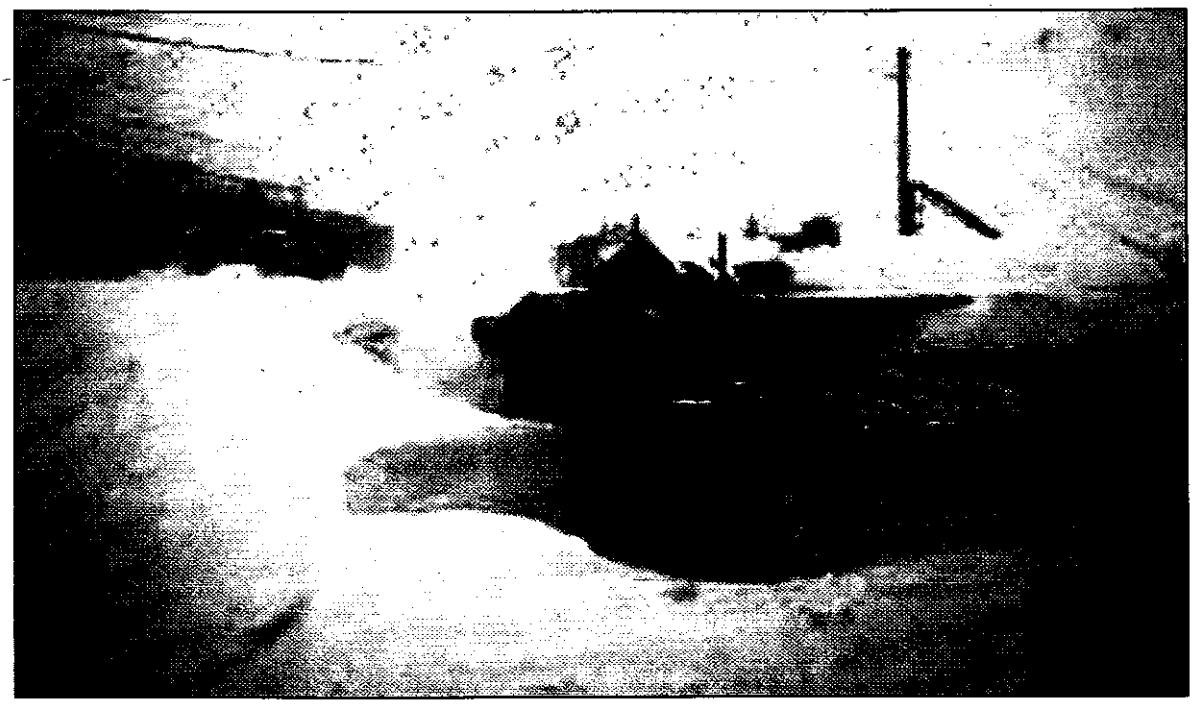
ANHB recommends substantial and ongoing increases in funding for the Village Public Safety Officer program *(VPSO)*. In December 2005, there were only 48 VPSOs across the entire state. At least 147 were needed. As a result of the shortage, victims of violent crimes in rural Alaska communities often wait days before a State Trooper can respond.

Priority One: Energy Solutions for Health Care Across Alaska



Rural Alaska has been battling the Energy Crisis for years, but the burden of the crisis has become so severe that Alaskans are being forced to choose between heating their home or hunting for food for their families. In a time of surplus, no one should have to make this choice. It is time to be inclusive of those in the hardest position and be innovative in leading future alternative energy solutions.

Higher utility and operational costs are negatively impacting health care delivery throughout Alaska, especially in Rural Alaska.



Alaska Native Health Board (ANHB) urges the Legislature to continue the Power Cost Equalization (PCE) benefit at 100% for FY09 and to fully fund PCE in the Administration's FY10 operating budget.

The goal of the PCE program is to provide economic assistance to customers in rural areas of Alaska where the kilowatt/hour charge for electricity can be 3 to 5 times higher than the charge in more urban areas of the state. PCE only pays a portion of approximately 30% of all KWh's sold by the participating utilities. PCE helps small rural areas maintain the availability of communications and the operation of basic infrastructure and systems, including water and sewer, incinerators, heat and light. In order for a clinic to qualify for PCE:

- Must be designated as a Community facility
- Clinics that are designated as government facilities do not qualify for PCE

The PCE should be expanded via regulation in three crucial ways for it to be truly effective in rural Alaska:

- **Include Clinics, regardless of funding source**
- **Include non-profits**
- **Include fuel/heating oil**

Priority Two: Medicaid Support and Funding

The federal government covers 100% of Medicaid payments for Alaska Native Medicaid beneficiaries if they receive care from the Alaska Tribal Health System (ATHS). **This provides a unique opportunity for the State of Alaska to improve the health of Alaska Natives and save money by:**

- **Fully funding and supporting Medicaid, and**
- **Continuing to invest in demonstration projects to test innovative approaches through the ATHS.**

While Alaska Natives are 19% of the state's population, in State FY 2005:

- Natives were 38.8% of the Medicaid-eligible population,
- Of these, almost 70% were children, and
- Of all Medicaid eligible Natives, 88.1% used some form of Medicaid services. (*FY 2005 Tribal Medicaid Activity, State of Alaska DHSS*)

Medicaid is important to Alaska Natives because of the high unemployment and poverty rates in our communities. Like all low/no-income families and children, Alaska Natives who qualify for Medicaid are at higher risk of diseases, injury, and premature death. Ensuring Medicaid covers basic health care for Alaska's most vulnerable residents will decrease costs associated with emergency room visits, increased disease, more complex care, and higher death rates for these Alaskans.

Priority Two: Medicaid Support and Funding

Any proposed changes to current Medicaid policy should:

- **Enhance or maintain access to Medicaid by vulnerable residents**
- **Expand or maintain types of services currently covered by Medicaid**
- **Ensure payment rates cover the entire cost of providing the service**
- **Improve health, save lives and reduce emergency health care costs**

Medicaid helps Alaskans avoid huge social and economic costs otherwise borne by the State and its residents. The State of Alaska will realize substantial cost-savings by continuing to collaborate with the Alaska Tribal Health System.

Priority Three: Behavioral Health Support and Funding

Many Alaska Natives still do not have access to behavioral health services despite the clear need. An integrated health system requires availability of qualified and trained behavioral health providers in every community. The full establishment of this vision is only possible with State financing which supports the concept of services in the right place and at the right time to prevent escalation of the need for more intensive and costly services. To assist in meeting this vision, the following program support and funding is needed.

ANHB invites the State Legislature to support the Governor's request for $19.1 million in behavioral health grants and provide support for behavioral health programs and utilizing the tribal consultation methodology to direct the funding in the most effective manner.

The increased funding level will help address significant unmet needs by:

- Enabling DHSS grant funded programs for domestic violence, mental health, suicide prevention, and substance abuse to operate in rural Alaska,
- Support substance abuse and mental health services, and
- Train providers, community based counselors and behavioral health aides.

Many other health challenges facing Alaska Natives are tied to behavioral health conditions; chief among these is substance abuse. The combination of substance abuse and mental illness is associated with much higher rates of multiple diseases and early death:

- 1 in 11 Alaska Native deaths is alcohol-induced
- Alcohol was the 4th leading cause of death from 1993 to 2002 (*Alaska Bureau of Vital Statistics*)
- Alcohol contributed to 85% of reported domestic violence cases and 80% of reported sexual assault cases between 2000-2003 (*ISER, Status of Alaska Native Report, 2004*)
- Suicide among Alaska Natives remained steadily at 2 times the non-Native rate from 1992 to 2000 (*Alaska Bureau of Vital Statistics*).

DOMESTIC VIOLENCE, CHILD NEGLECT & ABUSE
Continued financial support for Alaska Tribal-State Forums on domestic violence, child abuse, child neglect and sexual assault (DV/CA/CN/SA), as well as increased funding for programs and shelters in Alaska Native communities are direly needed.

Additional support is needed because:

- For the past 27 years, Alaska has ranked nationally in the top five for DV/CA/CN/SA
- American Indian/Alaska Native (AI/AN) people are victimized 3-4 times more frequently than other Alaskans
- Alaska's child sexual assault rate is 6 times the national average
- 75% of AI/AN women are physically and/or sexually assaulted during their lifetime
- In 2005, 62.5% of female homicide victims murdered by men were AI/AN

SEVERELY AND CHRONICALLY MENTALLY ILL– HOUSING

ANHB urges support for additional funding to establish housing and treatment options for the severely and chronically mentally ill. Among AI/AN people with mental illness, the morbidity rates for various mental illnesses are astronomically higher (alcoholism=770% higher; suicide=190% higher) than those of their non-Native peers. (*National Alliance on Mental Illness 2003 Strategic Plan*)

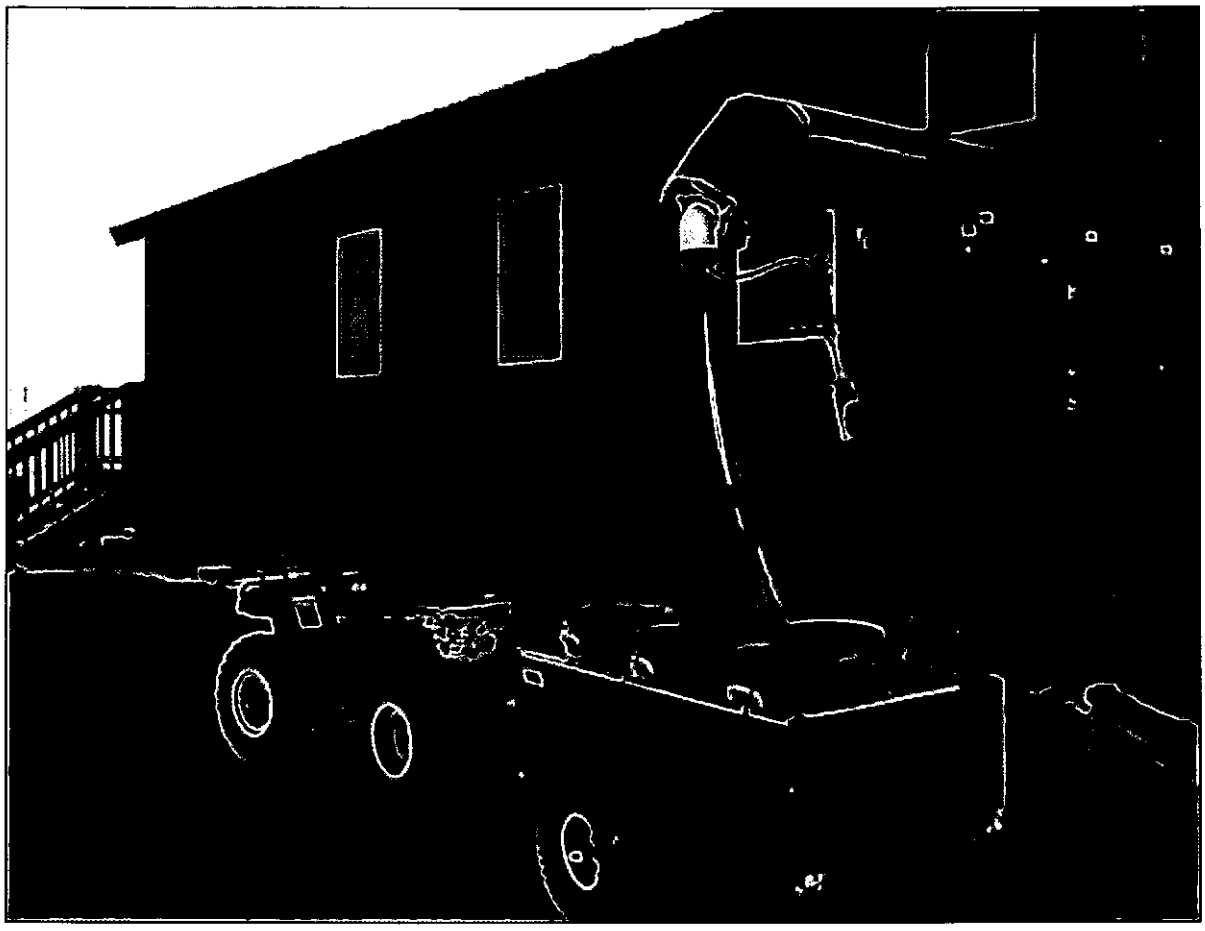
- 33.5% of 21,037 Alaska's State Mental Health Authority clients for 2006 were AI/AN people; this figure represents 6.6 % of the total AI/AN in Alaska, more than double the rate for all Alaskans, and three times the rate for all Americans. (*US HHS Center for Mental Health Services 2006 State Report for Alaska*)
- 36 % of homeless Alaskans are Alaska Native people (who comprise 19 % of the state's total population).
- 4,700 Alaskans are released from institutional care (prisons, state hospitals) to homelessness; 35% of Alaska prison inmates surveyed said they had no place to reside upon release and would enter a homeless shelter or live on the streets.

BRING THE KIDS HOME: Number of Alaska Native children in out-of-state RPTC

ANHB encourages continued support and funding for the Rural Psychiatric Treatment Center (RPTC) programs. RPTC programs are needed to ensure children can obtain treatment close to home and provide in-state options for care.

On May 5, 2008, there were 281 children in out-of-state care. Of these, 33% were Alaska Native youth. All six state regions had Alaska Native youth in out-of state care. The largest proportion of these youth were from the Anchorage region (40%), followed by the Northern region (26%), the Southeast region (11%), both the Mat-Su and Southwest regions (8% each), and finally the Kenai Peninsula region (4%). Home regions were not recorded in slightly over 3% of the Alaska Native youth in out-of-state care.

Priority Four: Water and Sanitation Support and Funding



VILLAGE SAFE WATER (VSW) PROGRAM

There is an urgent and continuing need for safe running water and wastewater systems in many rural communities in our state.

- More than 6,000 homes in rural Alaska are without safe drinking water
- Nearly 14,000 homes require upgrades or improvements to their water, sewer, or solid waste systems to meet minimum sanitation standards
- Leveraging state dollars brings 3 times as many federal dollars to provide safe drinking water and sewage systems to rural households in Alaska

The VSW Act has been momentous to the construction of sanitation systems. In 2005, the Department of Environmental Conservation, VSW received $74 million in federal funding for design and construction of sanitation projects. This funding requires a state match at the rate of $1 for every $3 in federal funding and in FY08 State funding required amounted to just over $18 million.

ANHB requests support for $22.9 million for the State's Village Safe Water (VSW) program to design and construct water and server facilities in rural Alaska.

OPERATIONS & MAINTENANCE SUBSIDY

Having adequate financial resources for water and sewer O&M is necessary for protecting public health as well as the $2.5 billion capital investment in the water and sewer infrastructure.

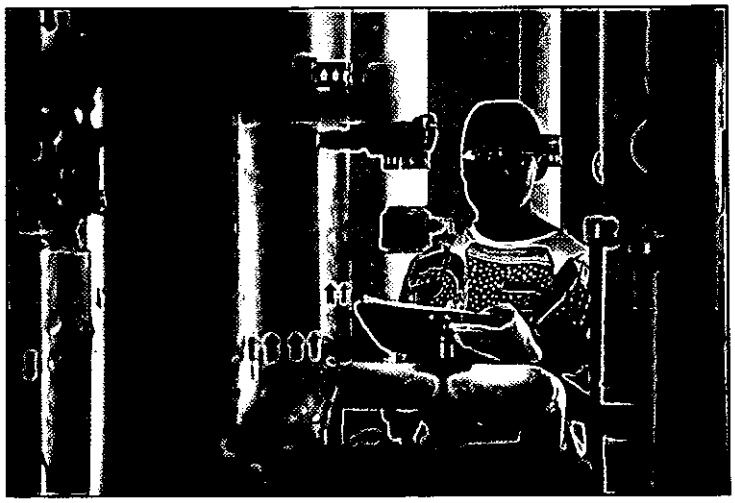
High operational costs due to exorbitant fuel and energy costs, may result in rural water systems being shut down during the winter months. A large percentage of rural residents have limited seasonal incomes that prevent many rural water utilities from generating the revenue necessary to operate effectively without an outside subsidy. Water utility operations have historically been underfunded, resulting in decreased operational life of infrastructure and unreliable water service in many rural villages.

Ineffective or non-existent attention to the O&M of water and sewer systems is a major, long standing threat to the health and economic well being of Alaska Native people.

- Health benefits are generally not seen until people use 8 to 14 gallons of water per day per person.
- Rural residents who travel to haul their water are reported to use as little as 1.8 gallons per day, while the average American uses 80 to 100 gallons per day.

ANHB looks forward to the day when we can report to the Legislature that all the households in rural Alaska have adequate water and sewage systems.

An investment of $15 million for water and sewer operation and maintenance for one year would help protect public health, the capital investment in the infrastructure and help extend the life of water and sewer systems.



Priority Five: Electronic Health Records Support and Funding

ANHB recommends a state appropriation of $6.5 million to support the Alaska eHealth Network focusing on the deployment of electronic health records (EHR) and a system for private, secure exchange of health information (HIE) between medical providers, their patients, and the payers. State assistance will help to ensure that EHR and HIE become part of the strategy for health care reform in Alaska. The EHR Network is a vital step in making health information exchanges a reality in Alaska. Studies from other states show real cost savings for purchasers, providers, and other health care entities, and improved quality of health care.

EHR/HIE deployment brings multiple benefits for Alaskans:

- State matching funds will attract larger federal grants for EHR
- Timely access to secure, clear, appropriate information leading to decreased medical errors and quick response to epidemics and bioterrorism
- Better health care for patients, especially in emergencies, through access to more complete medical history, test results, current medications, allergies, etc.
- Recruitment of new medical providers to Alaska through access to advanced medical support systems

Despite soaring health care costs and concerns about improving the quality of care, health information is maintained and transmitted in much the same way that it has for over 50 years resulting in duplication, waste, and health risks. The technology exists today to create electronic health records that are safe, secure, and provide immediate, meaningful access to personal health care information.

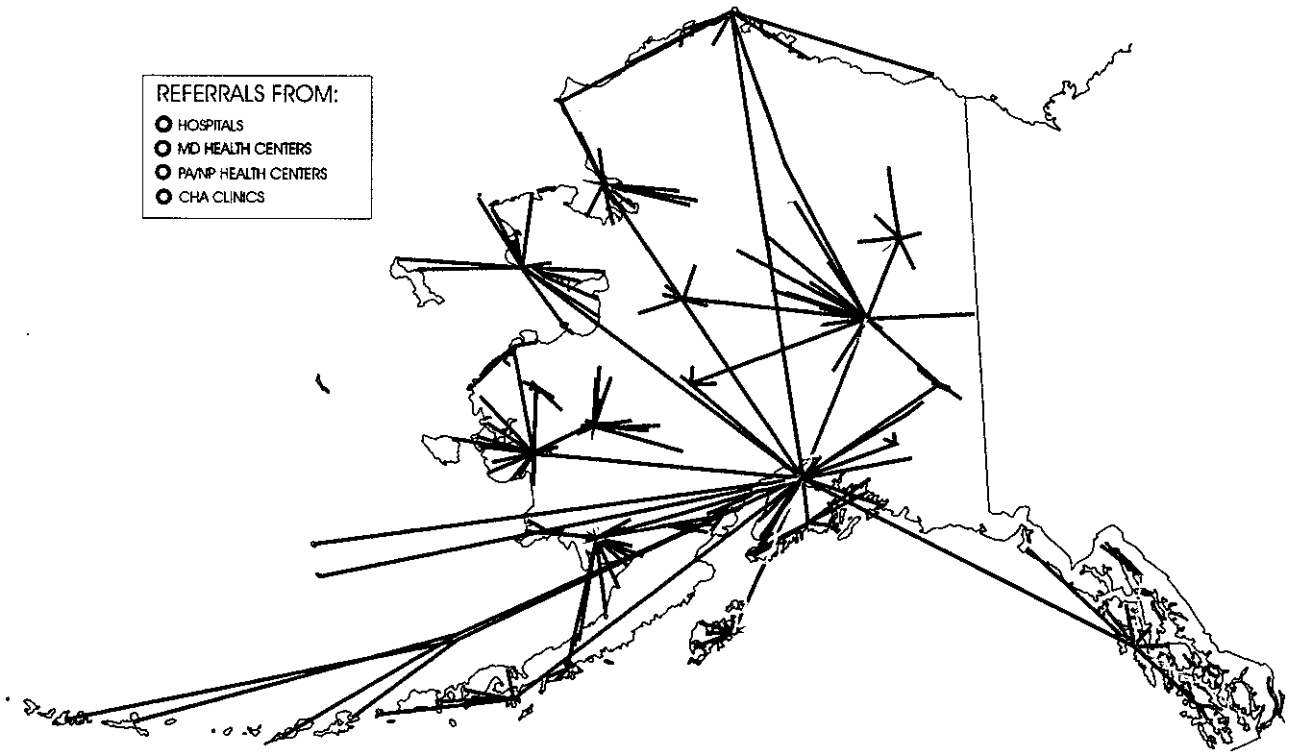
The Alaska Tribes propose that all E-health initiatives allocate a percentage of funds to support the Indian Health Service Resource and Patient Management System (RPMS) public domain system.

RPMS is the Indian Health Service IT-solution for all Tribal Health Organizations participating in the GPRA Tribal reporting project. The flexible hardware configures over 50 software applications and combines appropriate network communication components to provide a comprehensive clinical, financial, and administrative solution. ANTHC provides technical support for the Tribal RPMS Users in Alaska. This support includes installation of new and updated software for new and current sites, training on the applications, and tech support for users.

As a whole IHS does not receive adequate funds to support RPMS nationally and has indicated that they may be forced to implement fees in the future for Tribes wishing to fully use the system.

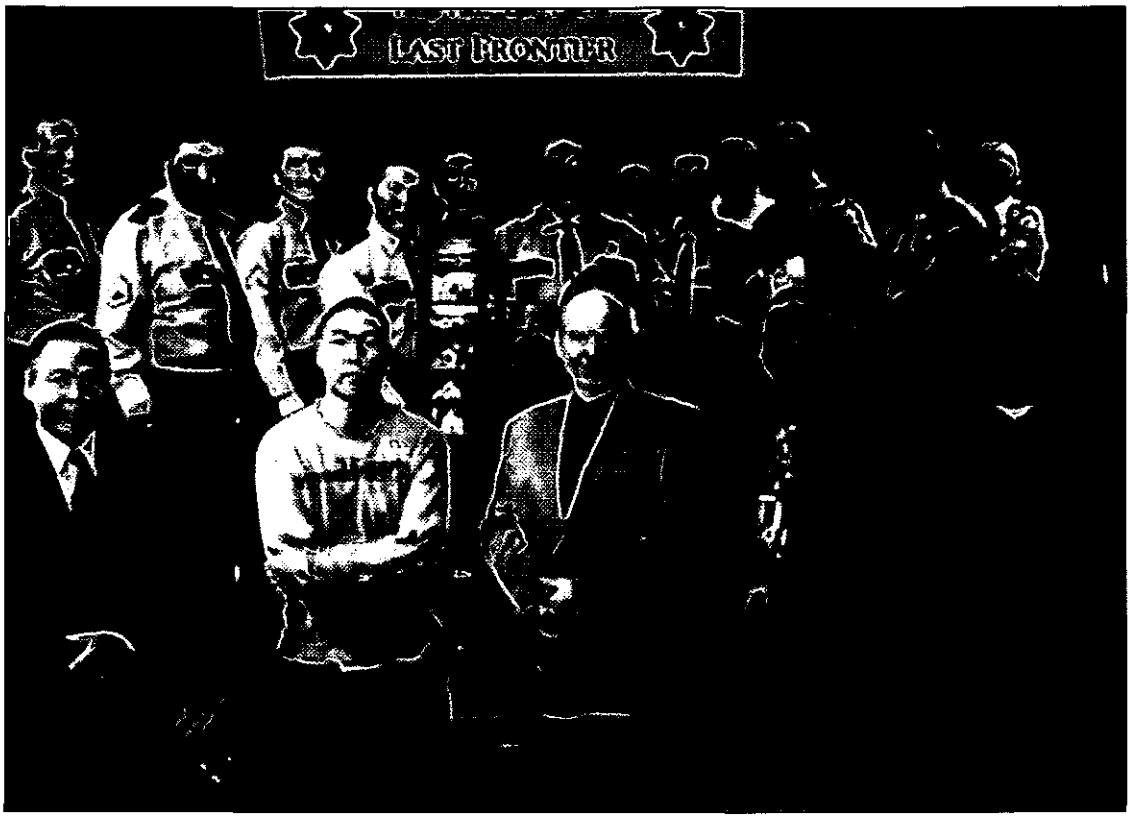
THE ALASKA NATIVE HEALTH CARE SYSTEM

Typical Referral Patterns



Map provided by
Alaska Native Tribal Health Consortium
Division of Information Technology
www.anthc.org

Priority Six: Ensuring Safe Communities



"The Village Public Safety Officer Program was designed to train and employ individuals residing in the village as first responders to public safety emergencies such as search and rescue, fire protection, emergency medical assistance, crime prevention and basic law enforcement. The presence of these officers has had a significant impact on improving the quality of life in the participating villages."

ANHB recommends substantial and ongoing increases in funding for the Village Public Safety Officer program.

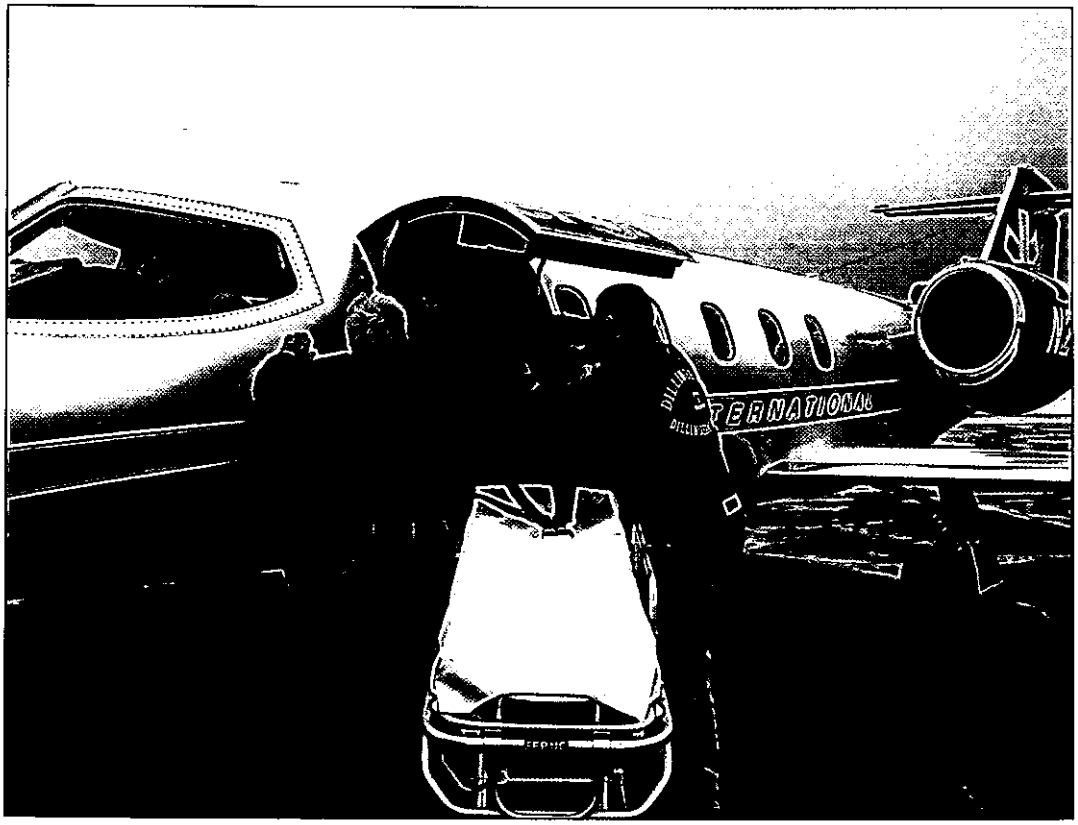
With rising costs of energy moving families into smaller homes and causing greater questions about how families will pay energy bills, is it expected that greater need for first responders to increased domestic violence calls, suicide attempts, violent crimes, and other emergent issues.

Unfortunately, there is a dire shortage of VPSO officers in rural Alaska, despite the original intent of the program. In December 2005, there were only 48 VPSOs across the entire state. At least 147 were needed. As a result of the shortage, victims of violent crimes in rural Alaska communities often wait days before a State Trooper can respond.

In addition, when there is no VPSO in a rural community, Community Health Aides from the local clinic are often called in to be the first responder. During these times, Community Health Aides are not available to provide health care. Also, it is very difficult for proper, high quality health care to be administered amidst crime or in unsafe environments.

Community Health Aides and Community Health Practitioners have been providing primary health care in rural Alaska villages as the first link in the Alaska Tribal Health System.

During major emergencies or epidemics, coordinated responses between VPSO, Volunteer Firemen, Health Aides, and Emergency Medical Services are necessary to the safe provision of health care. However, with a shortage of VPSOs, it can be difficult to provide a unified response.



The Alaska Native Health Board, Alaska Tribal Health System, and our state and federal partners working together to provide the highest quality health care and promote Alaska Native wellness in all aspects of Native life.

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Acknowledged Photographers: Brian Adams, Craig Haver, Clark Mishler, Ray Soloman, and Jan Welt.

Alaska Native Tribal Health Consortium
2008 Annual Report

Celebrating Our 10th Anniversary 1998-2008

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and President of the Board - 2

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Introduction

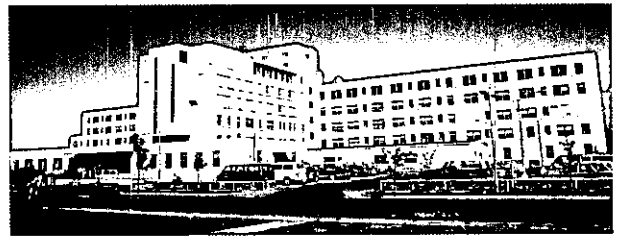
The leaders of the Alaska Native Tribal Health Consortium have a vision: *Alaska Natives are the healthiest people in the world.* To achieve that vision, we work with our customers, members of the Alaska Tribal Health System, and non-Native agencies that share common objectives. We work toward a unified health system to achieve the highest quality services. These efforts continue a journey to wellness that began many years ago.

In the 1800s, infectious diseases such as influenza, smallpox, and tuberculosis (TB) caused deadly epidemics among Alaska Natives. As late as 1950, Alaska Natives had a life expectancy of 47 years, compared to 66 years for non-Natives.

As new remedies became available, that extreme gap between Alaska Native and non-Native life expectancy narrowed, but it didn't close. In 1998, life expectancy was 69 years for Alaska Natives, versus 76 years for non-Natives. Alaska Natives now experience high rates of death from cancer, heart disease, and unintentional injuries. Infectious diseases continue to affect Native people too.

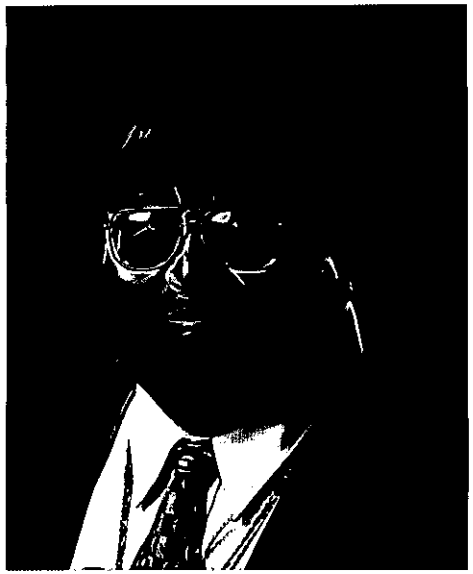
The photographs and timeline in this annual report show some of the steps the Alaska Native Tribal Health Consortium has taken to improve the health status of Alaska Natives since it began operations in 1998. The report outlines the Consortium's achievements during Fiscal Year 2008 (October 1, 2007 to September 30, 2008 or FY08). It shares our hopes for the future.

To help achieve our vision, we ask our employees to provide the highest quality health services, a level of service that makes Alaska Natives proud. We encourage Alaska Natives to make healthy choices and to help keep our families and communities strong. To stay healthy, be informed about health. Be physically active and eat nutritious foods. Be well.



In parts of Alaska in the 1940s, as many as 90 percent of Alaska Natives test positive for tuberculosis (TB). To fight the TB pandemic, the Indian Health Service opens the Anchorage Medical Center of the Alaska Native Service in downtown Anchorage. Commonly called ANS, it serves as a sanitarium until new medications make TB rare, then becomes a medical center offering acute and specialty, as well as outpatient care. *Photos courtesy of University of Alaska Anchorage Archives and Anchorage Museum of History and Art.*

CHAIRMAN OF THE BOARD
AND PRESIDENT



LINCOLN A. BEAN, SR.

Dear friends,

The Alaska Native Tribal Health Consortium is unique. We are the largest, most comprehensive tribal health organization in the nation. Tribal members are our customers and own and manage the company. Moreover, we serve our customers, all across Alaska, throughout their lives.

In the ten years since tribes assumed management of statewide tribal health services in Alaska, tribal health leaders have taken the company in new directions, tailored to tribal needs. In those ten years, the Consortium has taken great, unprecedented, strides to improve the health status of Alaska Native people.

- The percentage of rural Alaska Native homes with water and sewer systems rose from 63 to 76 percent, an increase of 13 percent.
- In 1998, the Alaska Native Medical Center (ANMC) provided medical care for about 100,000 outpatient visits. In FY08, ANMC provided care for more than 400,000 outpatient visits.
- The Consortium has expanded programs to educate and train Alaska Natives in health professions, and has conducted research on many of the priority causes of disease among Alaska Native people.
- Our technological advances have enabled us to improve our level of customer service, and have attracted national awards and international attention for innovation.

In addition, traditional cultures have a strong role in shaping the organization to provide culturally appropriate services.

These feats are the result of the hard work and determination of our partners, stakeholders, and employees. I appreciate your continued support and look forward to a bright future. It is a great honor to serve as Board Chairman and President of the Consortium. *Gunalcheesh* (thank you in Tlingit) for the opportunity.

Lincoln A. Bean, Sr.

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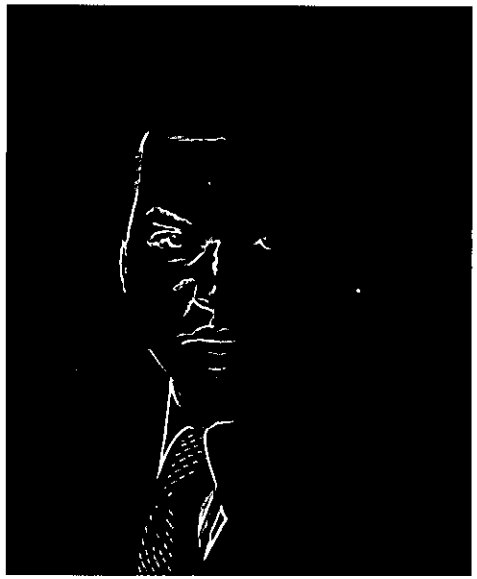
Don Kashevaroff

CHIEF EXECUTIVE OFFICER



Greetings,

As you may know, I served on the Consortium's Board of Directors for ten years, before becoming the Consortium's Chief Executive Officer in June 2008. To better serve our customers, the Board has overseen many changes and alterations in direction, priorities, and programs.

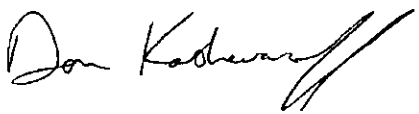
One thing that hasn't changed is that federal funding to meet the health needs of Alaska Native people has been limited. Now we face even greater budgetary challenges. We expect the buying power of public funding to continue to decline due to inflation. In addition, experts predict that the Alaska Native population will keep growing. There is strong demand for ANTHC services and we expect that to continue to grow.

Fortunately, in addition to the funding we receive from the Indian Health Service, we are able to seek funding from other federal agencies. Under tribal management, the Alaska Native Medical Center is able to seek reimbursement from programs such as Medicare and Medicaid, and from private insurance.

In the coming year, the Consortium will more actively reach out to customers who have these forms of insurance. This will bring added dollars into the Alaska Tribal Health System, which helps improve the quality of health services for all Alaska Natives. We also continue to set targets and work toward long-term financial goals. As always, we remain committed to delivering unsurpassed value to every customer.

As you read this annual report, you will see highlights of FY08, and a timeline and photographs outlining achievements from our first ten years. However, our goal is not to stop with these accomplishments. We plan to keep moving forward and working with our people toward a healthier life.

Please let me know how we are doing and how we can improve services across Alaska – many of our achievements have been the result of your comments and suggestions. Thank you for your support.



Don Kashevaroff

ANTHC DIVISIONS

Working as One Family, *Alaska Native Tribal Health Consortium employees cultivate relations that promote trust and value for all parties, or "win-win" relationships. We are building operational excellence – to work faster, better, and at lower costs without compromising the quality of health services we provide. We continue to work to offer exceptional quality services leading to the best outcomes. Our employees strive to be our customers' first choice by exceeding customer expectations in a culturally respectful and positive manner.*

Alaska Native Medical Center

The Alaska Native Medical Center (ANMC)* is part of a network of health care providers located in small village clinics, health centers, and regional hospitals. With other network members, ANMC provides services to patients, and works with their families to help create a warm, healing environment.

ANMC has achieved Magnet Status for nursing excellence, a level of recognition given to only about one percent of all the hospitals in the nation. ANMC is also Alaska's only Level II Trauma Center, the highest level possible in Alaska. It operates full outpatient services and a multi-disciplinary trauma center.

ANMC is a 150-bed inpatient facility and trauma center. The hospital offers a full range of medical services including, for example, board-certified specialists in heart disease, cancer, and in intensive care for babies. ANMC employs close to 250 physicians and midlevel practitioners and more than 525 nurses.

* Together Alaska Native Tribal Health Consortium and Southcentral Foundation jointly own and manage the Alaska Native Medical Center (ANMC) under the terms of Public Law 105-83. These parent organizations have established a Joint Operating Board to ensure unified operations of ANMC.

Alaska Native Medical Center opens on Tudor Road in Anchorage in 1997.

A new era of statewide management of tribal health services begins on June 1, 1998 when the Alaska Area Native Health Service signs a contract transferring statewide services to the Alaska Native Tribal Health Consortium. Pictured here at the signing, seated, from left: Lincoln Bean, SouthEast Alaska Regional Health Consortium; Chris Mandregan, Director, Alaska Area Native Health Service; Alaska Native Tribal Health Consortium Board Chairman Larry Ivanoff, of Norton Sound Health Corporation (NSHC); ANTHC Board Secretary H. Sally Smith, of Bristol Bay Area Health Corporation. Standing, from left to right: Paul Manumik, Yukon-Kuskokwim Health Corporation (YKHC); Ben Atoruk, Manilaq; Evelyn Beeter, Mt. Sanford Tribal Consortium; Connie Chya, Kodiak Area Native Association; Katherine Grosdidier, Southcentral Foundation; Mike Zacharof, Aleutian/Pribilof Islands Association; Henry Hunter, Sr., YKHC; Pat Aamodt, Arctic Slope Native Association; Anne Walker, Chugachmiut; Terrance Booth, Metlakatla Indian Community; and Carolyn Crowder, NSHC.

December 1997 - The US Congress creates the Alaska Native Tribal Health Consortium under Appropriations Legislation, Section 325 (Public Law 105-83).

1998

February 1998 – newly formed Alaska Native Tribal Health Consortium hires its first employee, Chief Executive Officer Paul Sherry.

ANTHC Division of Environmental Health and Engineering works to provide services to some of the 62.8 percent of homes throughout rural Alaska lacking water and sewer service.

Tribal status allows Consortium to collect reimbursements from Medicaid, Medicare, and other insurance payers, which ANTHC uses to expand and improve services for customers.

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Division of Environmental Health and Engineering

The Division of Environmental Health and Engineering (DEHE) works to protect the health of Alaska Natives. To stay healthy, it is critical people have safe drinking water, adequate waste disposal facilities, and health care facilities that are properly operated and maintained.

DEHE provides assistance to Alaska Native tribal governments, tribal health organizations, and municipalities across Alaska. It fulfills its role – lasting solutions to promote healthy communities – by providing facility construction and engineering, environmental health support, and tribal utility support. DEHE provides technical support, utility operations, and public works job training to tribal utilities. It assists with utility operations by handling billing and collections.

Division of Community Health Services

The Division of Community Health Services (DCHS) also seeks to elevate the health status of Alaska Native communities. It works directly with many tribal health organizations and with Alaska Native communities to improve the health of Alaska Native families. As just a few examples, DCHS provides these services through:

- Training
- Research
- Health status monitoring
- Promotion of family wellness

DCHS staff develop comprehensive regional and community-based solutions for priority health problems. DCHS provides technical assistance to communities and tribal health programs, and develops partnerships with other agencies for these purposes.

Inventory of sanitization deficiencies in Alaska identifies more than 33,000 types of sanitation assistance needed in Alaska Native homes, with an estimated cost of about $850 million. The only alternative for many villagers is to collect waste in "honey buckets," which they haul to an open lagoon to empty.

July 1999 – Alaska Native Medical Center earns certification as Alaska's only Level II Trauma Center, the highest rating available in Alaska for emergency treatment providers.

October 1999 – Launches statewide telehealth project Alaska Federal Health Care Access Network (AFHCAN), which will allow clinicians statewide to share data for diagnosis and treatment.

1999

January 1999 – Recruits Alaska Natives for engineering externships, with assignments in Bethel, Sitka, and Dillingham.

Working With Our People

One of the Consortium's strategic objectives is to be responsive to our customers' needs, and to provide best-in-class customer service. One way to do this is to increase our ability to support professional development of Native health service providers. This will promote Native employment and foster customer service that is culturally relevant and respectful of Alaska Native cultures.

In FY08, ANTHC created a protocol for assessing community excellence in environmental health. This helps communities decide where to focus limited time and resources to achieve the greatest health benefits.

We conducted research on diseases that are a priority for Alaska Native people and used research results to create better standards of care. Topics included hepatitis, suicide, and helicobacter pylori (a carcinogen and risk factor for gastric cancer).

Nearly 200 Alaska Native Medical Center patients and ANTHC employees enrolled in the Consortium's tobacco cessation (quitting) services. This helps address Alaska Native tobacco use rates that are more than twice the national average.

To increase the ability to provide treatment for nicotine dependence, and to develop or improve on-site programs, ANTHC provided technical assistance to 10 Alaska health care organizations and held its annual tobacco treatment specialist training.

ANTHC worked to ensure agencies address health issues when evaluating and permitting large development projects. We developed a health impact assessment for the proposed expansion of the Red Dog Mine and for oil and gas leasing in the Chukchi and Beaufort seas.

Division of Environmental Health and Engineering works on design and construction of sanitation facilities in more than 70 communities. In 2002, 6,000 homes were still without running water and sewer services.

ANTHC Division of Community Health Services implements a maternal and newborn monitoring program to follow low levels of industrial pollutants now appearing in marine subsistence species.

ANTHC launches a statewide personal health and wellness campaign entitled *Inform and Inspire*, including radio, TV, and print advertising in Alaska. Our message: *Alaska Natives Making Healthy Choices.*

2000

May 2000 - Completes an Alaska Native Health Campus site and facility plan outlining changes needed to accommodate growth, including changes to day surgery, dental operating room, Quyana House, and the laboratory.

Summer 2000 – Begins an internship program to encourage Alaska Native and American Indian high school, under-graduate and graduate students to enter health fields.

November 2000 – Dr. Richard Mandsager retires after nearly 15 years as Alaska Native Medical Center Administrator.

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ANTHC coordinated efforts to increase colorectal screening. About 60 percent of colorectal cancer cases would be prevented if those above the age of 50 were screened.

ANTHC banned soda pop sales at all of its facilities. This action supports the health of our customers, employees and visitors, and provides role models of people making healthy choices.

Following the emergence of a few cases of serious, sometimes fatal, vaccine-preventable diseases such as Haemophilus influenzae (Hib) and pneumococcal meningitis, ANTHC began an educational campaign about the importance of receiving vaccinations on schedule.

ANTHC created two Anchorage outreach programs, PROMISE, and Mpowerment, to help reduce the impact of HIV and sexually transmitted disease. We also offered training on HIV and infants, and HIV and dentistry.

ANTHC coordinated several training sessions and statewide meetings. These included workshops on end-of-life decisions, population projections, statistics, and data analysis. We offered mentoring on scientific research techniques.

The Consortium, in partnership with the State of Alaska, held a statewide Maternal and Child Health and Immunization Conference, with two dozen speakers and 30 sessions. Participants included health providers such as midwives, nurses, physicians, and Community Health Aide/Practitioners.

ANTHC held focus groups for parents, interviewed youth, and developed an educational campaign about a vaccine that prevents a virus linked to 70 percent of cervical cancer cases. The prestigious *International Journal of Circumpolar Health* accepted a manuscript on the Consortium's Human Papilloma Virus Parent Focus Group Study.

ANTHC created a suicide prevention video, and began work on a video about historical trauma and its effects on mental and spiritual health.

Staff spoke in international, national, and statewide forums about their research on priority diseases affecting Alaska Natives, a reflection of the significance of their work. These talks included presentations on the Hepatitis B vaccination at the World Health Organization, and on traditional food safety to an Australian conference.

ANTHC helps raise the number of Indian Health Service scholarships from an average of less than a dozen per year to a record 32.

ANTHC assists tribes in administering injury prevention projects involving smoke detector installation, car seats, and float coats.

Completes several hospital remodeling projects, including the day-surgery area, the addition of an operating room, and renovation of the laboratory, and expanded guest areas in Quyana House.

2001

Begins development of a Dental Health Aide program to increase dental care services in rural villages.

March 2001 – ANTHC launches a *Stop the Pop* campaign using letters to schools and stores, support of legislation, and advertising to reduce soda pop consumption and sales in schools.

Constructs $48 million in sanitation facility projects in Alaska Native communities, improving sanitation service to 2,552 homes, 359 of them for the first time.

The Consortium creates the Office of Alaska Native Health Research to study priority issues of Alaska Native health and to train Alaska Native health researchers.

Working With Our Partners

Many federal, state, nonprofit, and private organizations support our vision and share funding, time, and other resources to work toward common outcomes. Working with our customers and partners, the Consortium is in a unique position to continue our leadership role in the national Indian health system and in health services statewide. In FY08, ANTHC worked with its partners on a wide range of projects.

Anticipating the effects of high-energy costs on village utility systems, ANTHC has taken steps to help reduce those impacts. We worked with the State Remote Maintenance Works Program, and the State Department of Commerce and Economic Development to help reduce or eliminate fuel shortages and emergencies.

With the Denali Commission and the people we serve, we helped build six clinics and designed nine clinics in FY08.

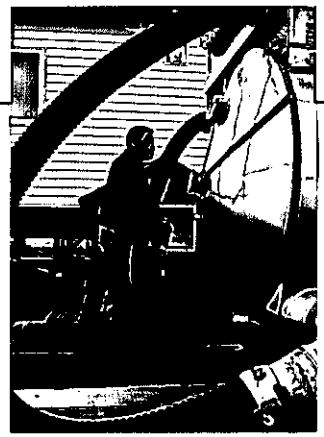
The Consortium co-hosted an international conference on sexually transmitted disease among Alaska Natives and Inuit, First Nations, and Métis of Canada.

With the State of Alaska, ANTHC assisted 100 villages in developing community and clinic disaster plans to reduce rates of preventable injury and disease.

With funding from the Federal Communications Commission, we began work on an "Alaska e-Health Network," an electronic health records system that would allow secure exchange of patient information among Alaska health care providers. This would prevent potential errors and repeated tests, and increase efficiency.

ANTHC raises $4 million in grants to provide training for village-based dental health aides, counseling, and home health care for elders. Dental Health Aide Therapists travel to New Zealand for the best and most cost-effective program training available.

A research project tests the effects of a pneumococcal vaccine that fights serious blood infections, meningitis, and pneumonia.



The ANTHC Division of Environmental Health and Engineering (DEHE) creates the Statewide Utility Association to help member communities connect with resources and create an exchange of knowledge.

DEHE creates the Alaska Utility Supply Center, with a parts warehouse that buys supplies in volume at lower cost and stocks and ships supplies for rural water and sewer systems.

2002

AFHCAN telemedicine project completes goal of providing telemedicine carts to 235 Alaska health care sites.

Division of Environmental Health and Engineering and the Yukon-Kuskokwim Health Corporation create the Regional Utility Cooperative to help reduce outages, improve water quality, lower costs, and provide training.

2340

ANTHC hosted a three-day national Indian Health Service Nursing Leadership Conference with more than 200 participants from across the United States.

With State of Alaska funding, and working with two other tribal health organizations, ANTHC began work to plan and develop new long-term care facilities. ANTHC also completed a feasibility report about long-term care services.

Five staff took part in the Governor's climate change sub-cabinet created to build scientific knowledge, develop policies to protect and prepare for impacts, and assess opportunities to reduce greenhouse gas emissions to decrease the amounts contributing to climate change.

With the Alaska Food Bank, we launched a food distribution program in thirteen villages, with plans to expand it to others.

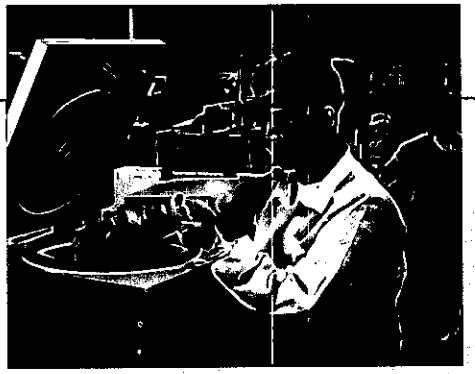
The Consortium sold telehealth technology, now available in any language, to buyers who wish to expand access to health care for people in remote areas. Sales included the first of 15 telehealth cart deployments to Greenland.

The Consortium created the nation's first Dental Health Aide Therapist training facility in partnership with the W.K. Kellogg Foundation, the Rasmuson Foundation, Bethel Community Services Foundation, and academic partner University of Washington.

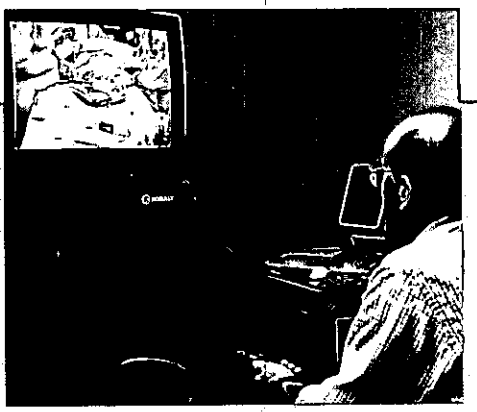
Ten students are in training at two sites, one in Anchorage and the other in Bethel at the Yuut Elitnaurviat (people's learning center) Dental Training Clinic. The first US-trained students will graduate in December 2008.

The success of this program is the result of a huge collaborative effort among tribal health organizations, funding partners, and academic institutions – all working to improve oral health among Alaska Natives.

Alaska Native Medical Center achieves prestigious *Magnet Status* for nursing excellence, an honor achieved by only 1 percent of all US hospitals.



College of American Pathologists reviews Alaska Native Medical Center laboratories and honors it for being in the top 3 percent of laboratories nationally.



Telemedicine helps save the life of a woman who is hemorrhaging and could not be transported to an operating room because heavy fog prohibited air travel. In this photo, Dr. Daniel Szekely uses video teleconferencing to help guide the actual surgery in Kotzebue.

2003

Teleradiology project begins installing equipment in villages, linking health care providers with teleradiology specialists both in and outside Alaska, and reducing time for diagnosis and treatment.

Telemedicine system AFHCAN receives the *Grace Hopper Award for Innovation in Technology.*

Division of Environmental Health and Engineering receives the U.S. Academy of Environmental Engineers Grand Prize in Operations and Management for its work with the Village of Savoonga's water and sewer project.

A Unified Health System

The Consortium is part of the Alaska Tribal Health System, a group of tribal health organizations that work together to promote Native self-determination and health. We work to organize our services so they are in line with services of other Alaska Tribal Health System members. We also work to ensure our internal operations are integrated and aligned with our mission.

ANTHC works with others to ensure patients move smoothly from one location or level of care to another. People representing clinical, patient, and logistical perspectives are considering options on how to redesign processes and develop procedures for use throughout the Alaska Tribal Health System. ANTHC is working to facilitate improvements in areas such as discharge planning, patient referrals, and patient travel.

ANTHC staff met with people from other tribal facilities and formed a laboratory quality assurance committee to ensure accurate and timely laboratory test results for all Alaska Natives.

ANTHC continues to support operation and management of rural water and sewer systems through the Statewide Utility Association. The Association includes the Alaska Utility Supply Center, a parts warehouse that buys and ships supplies, and provides billing and collections services. It also includes an eight-village Regional Utility Cooperative, created with the Yukon-Kuskokwim Health Corporation to help reduce outages, improve water quality, lower costs, and provide training.

Division of Community Health Services staff provide personal care attendant and certified nursing assistant training to 60 students in Bethel and Nome.

Alaska Native Medical Center purchases a 16 slice, high-speed Computer Tomography (CT) Scanner, providing state-of-the-art diagnostic data.

November 2004 - New ANTHC office building opens.

2004

March 2004 – ANTHC is one of thirty tribal partners who sign Memoranda of Agreement to pursue common interests as members of the Alaska Tribal Health System.

The Division of Community Health Services Hepatitis Program establishes a molecular biology diagnostics laboratory. Typically found only in research centers, this is the nation's first housed in a tribal facility.

ANTHC Division of Environmental Health and Engineering starts a construction skills training program that teaches life-long skills and provides Alaska Natives opportunities for advancement.

Internship program provides ten Native undergraduate and graduate students the opportunity to work with Division of Environmental Health and Engineering staff.

2342

ANTHC provided technical assistance to water, wastewater, and solid waste system operators and managers, and project support for sanitation facility construction.

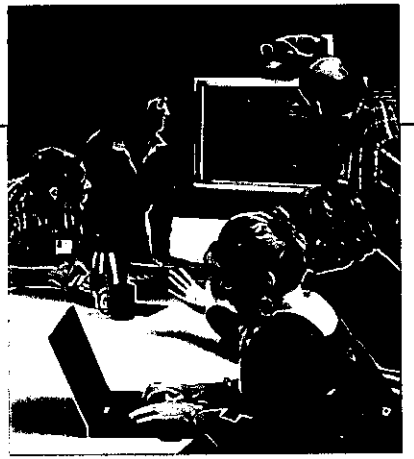
ANTHC coordinated training for utility operators, managers, and local residents, including opportunities in construction trades and operation of water treatment plants.

ANTHC met with tribal health care directors to develop recommendations to the State of Alaska on long-term care, behavioral health, and other aspects of Medicaid reform.

The Consortium saved about $14 million (between 2001 and 2007) by using telehealth in the care of more than 27,000 patients. In one in five of these cases, telehealth helped prevent patient travel, eliminating the inconvenience of being away from family and community. In 7 percent of the cases, telemedicine helped determine that the patient did need to travel and see a specialist. This promotes early diagnosis, when treatment is likely to be of greater benefit.

ANTHC is conducting a 27-year follow-up of children to study the duration of the Hepatitis A vaccine. We are working with 1,350 chronic Hepatitis B carriers to determine risk factors for serious liver disease and liver cancer.

The Consortium expanded a video-teleconference (VTC) system to all Alaska tribal clinics and tribal health care partners. This connects families with their relatives at Quyana House (temporary housing at ANMC for outpatients and escorts). It allows people to connect into meetings and training without having to travel.



ANTHC launches Rural Alaska Village E-Health Network (RAVEN) videoconference project, allowing people in clinics across Alaska to "meet" via videoconferencing

Division of Community Health Services provides basic Health Aide training for 60 students.

ANTHC selects first 15 employees for two-year on-the-job Leadership Excellence through Achievement and Determination, or LEAD, training, which includes a college scholarship.

2005

Division of Community Health Services increases enrollment to 2,586 in a study of the effects on health of diet, physical activity, lifestyle, and cultural activities. The Education and Research Towards Health (EARTH) study involves Alaska Native and American Indian people in Alaska, the Navajo reservation, and North and South Dakota.

Health Information Technology supports more than 10,000 telemedicine encounters, 20,000 telepharmacy encounters, 40,000 teleradiology encounters, and 1 million patient care encounters.

Division of Community Health Services develops training and certification standards for Behavioral Health Aides.

Highest Quality Health Care

The Consortium has created systems to deliver services of ever-improving value to its customers. We strive to boost our overall capability, effectiveness, and productivity. The Consortium works to constantly improve services to become more flexible and responsive to customer needs.

The Alaska Native Tribal Health Consortium extensively remodeled the Alaska Native Medical Center laboratory to improve efficiency, safety, and patient care. ANTHC added computerized systems to the hospital laboratory for processing and testing. This helps produce test results on an efficient, consistent basis.

The changes to the hospital's laboratory improve test turnaround time. This increases safety and reduces the need to send tests to other labs, leading to time and cost savings.

Operation of a new sleep lab was begun to help identify medical problems that can interfere with sleep. Research shows lack of sleep contributes to heart disease and high blood pressure, depression, and impaired immune systems.

The Consortium had construction crews in 32 communities throughout the state to provide safe and reliable in-home water supply and wastewater disposal.

The Consortium's Division of Environmental Health and Engineering completed construction designs despite a 30 percent engineering vacancy rate. Through nation-wide recruiting, DEHE was able to reduce professional level staffing vacancies overall from 35 percent to about 10 percent.

The Division of Community Health Services processes 292 Community Health Aide/Practitioner (CHAP) and Dental Health Aide certification applications for the CHAP Certification Board.

To promote health among employees and customers, ANTHC establishes tobacco-free workplace.

Division of Environmental Health and Engineering improves water and sanitation services in 1,012 homes and works on active projects in 160 communities throughout Alaska.

2006

Alaska Native immunization rates increase to more than 90 percent statewide.

April 2006 – ANTHC publishes the Fourth Edition of the *Alaska Community Health Aide/Practitioner Manual*, as well as a *Comprehensive Cancer Plan for the Alaska Tribal Health System.*

The Consortium's Regional Supply Service Center distributes $5.9 million worth of medical supplies and pharmaceuticals to 95 tribal health facilities.

2344

The following numbers of students received training to work in communities across Alaska:

- 17 students in commercial driver's license (CDL) and heavy equipment operation
- 42 students in carpentry and plumbing
- 98 students in advanced water treatment
- 189 students in water plant operations including basic certification
- The Consortium coordinated Community Health Aide/Practitioner (CHAP) training in multiple learning environments: Nine basic sessions, one clinical update, and one distance session. As a result, 76 students completed CHAP training. Working for tribes and tribal health organizations, CHAPs provide medical care in villages and communities across Alaska.

During FY08, engineering staff completed preparations to expand three important Alaska Native Medical Center service areas:

- A $950,000 construction project to add two new operating rooms
- Remodel and expand oncology
- Build a new neurosurgery clinic

The Consortium held a fundraising Raven's Ball for our *Healthy Alaska Natives Foundation*, which has identified five initiatives: cancer care improvement, elder care support, healthy village environments, wellness and prevention, and Alaska Native health professions scholarship support.

ANTHC launches Camp Coho, a pilot program to help children cope with the loss of loved ones due to cancer.

Consortium completes a groundbreaking study that shows that children in communities where most homes have pressurized, in-home water service have far fewer respiratory disease requiring hospitalization and skin infections.

ANMC receives first of two *Hospital Quality Achievement* awards from Mountain Pacific, a Quality Improvement Organization designated by the US Centers for Medicare and Medicaid Services.

2007

The ANTHC Injury Prevention Program completes the nation's first research project on safer firearm storage practices, installing gun storage cases in 300 homes in six Western Alaska villages to reduce firearm injuries.

ANTHC launches the Healthy Alaska Natives Foundation, which identifies five initiatives to sustain and inspire a healthy Alaska Native community: cancer care improvement; wellness and prevention; healthy village environments; scholarship fund; and elder care support.

The State of Alaska selects the Consortium's Regional Service Supply Center as the agency to deploy National Strategic Stockpile emergency medical supplies in major emergencies.

Future Directions

In Fiscal Year 2009, a new revenue development team will develop collaborative relations with Congress, the Alaska Legislature, federal and state agencies, and private funders to increase revenues to ANTHC.

ANTHC will increase its efforts to prevent employee injuries and to reduce time lost due to injuries, which will increase employee satisfaction through lower rates of injury. It will also allow ANTHC to manage costs and realize savings from reduced premiums for Workers Compensation Insurance.

ANTHC is working to build leadership from within and to transform our workplace culture through leadership training. We are creating a program to build the leadership skills of 200 managers and 700 healthcare providers. We will work to develop employees who are positive and engaged, and who align their efforts with ANTHC mission and values.

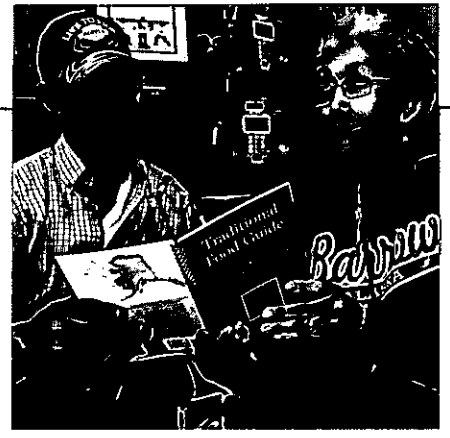
Employees who take pride and are happy in their work contribute to customer satisfaction, and we are working to improve internal communications and teamwork. We will continue to strive to hire the best employees, and nurture and develop their talents.

ANTHC is building systems to help the organization "work smarter." We have created a fund to promote and fund innovation within the company. Increased use of technology has already changed the way we do business. We will continue to look for solutions that reduce costs and maintain or improve quality.

The nation is grappling with declining numbers of health care providers, which is even more of a problem in Alaska. We will continue to work to attract, hire, and retain a host of trained professionals such as doctors, nurses, engineers, dentists, computer technicians, biomedical professionals, respiratory therapists, behavioral health specialists, and trainers. We will continue to sponsor students interested in health careers through internships, externships, and scholarships.

ANTHC begins work on the Alaska e-Health Network, an electronic health records system that provides confidential, secure access to medical records, reduces potential errors and repeated tests, and increases efficiency.

Remodels and adds computerized systems to the Alaska Native Medical Center laboratory to improve efficiency, safety, and patient care.



To support cancer patients and health care providers, the Alaska Native Tribal Health Consortium publishes the *Traditional Food Guide for Alaska Native Cancer Survivors* in April 2008. To order copies of the guide, visit anthc.org on the Internet, or call (907) 729-4491.

2008

June 2008 - Paul Sherry retires as CEO and the Board of Directors hires Don Kashevaroff to fill the CEO position.

Timeline Photographers: Brian Conner, Allen Cousens, Evangeline Dotomain, Kraig Haver, Clark James Mishler, Jan Pennington and Raymond Solomon.

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Board of Directors

The Alaska Native Tribal Health Consortium is grateful to the representatives of the tribal health organizations who served on the Consortium Board of Directors during our first ten years of operations.

Aleutian/Pribilof Islands Association
Mike Zacharof, 1998 – current

Arctic Slope Native Association
Eben Hopson, 1998 – 2005
Herman Kignak, 2005 – 2006
Bernice Kaigelak, 2006 – current

Bristol Bay Area Health Corporation
H. Sally Smith, 1998 – current

Chugachmiut
Esther Ronne, 1998 – 1999
Robert Henrichs, 1999 – current

Copper River Native Association
Eileen Ewan, 1998 – 2004
Julie Bator, 2004
Veronica Nicholas, 2005 – 2006
Charlene Nollner, 2006 – current

Kodiak Area Native Association
Denise May, 1998 – 1999
Rita Stevens, 1999 – 2006
Andy Teuber, 2006 – current

Manilaq Association
Ben Atoruk, 1998
Ruth Moto, 1998 – 2000
Jake Wells, 2000 – 2001
Percy Ballot, 2001 and 2004
Dennis Tiepleman, 2002
Guy Adams, 2002 – 2003
Christina Westlake, 2003 and 2005
Fredericka Schaeffer, 2006 – current

Metlakatla Indian Community
Terrance Booth, 1998 – 2000
Frieda R. Damus, 2000 – 2004
Linda Clement, 2004 – current

Norton Sound Health Corporation
Larry Ivanoff, 1998 – 1999
Emily Hughes, 2000 – current

Southcentral Foundation
Katherine Gottlieb, 1998 – 2008
Charles Clement, 2008 – current

Southeast Alaska Regional Health Consortium
Lincoln A. Bean, Sr., 1998 – current

Tanana Chiefs Conference
Will Mayo, 1998 – 1999
Andrew Jimmie, 1999 – current

Unaffiliated Tribes
Don Kashevaroff, 1998 – 2008
Gary Harrison, 2008 – current
Paul Theodore, 1998
Evelyn Beeter, 1998 – current

Yukon-Kuskokwim Health Corporation
Henry Hunter, 1998 – 1999
Michael Hunt, 1999 – 2000
Earl Hoelscher, 2000
Fritz George, 2001 – 2003
Bill Kristovich, 2003 – 2004
Ray Alstrom, 2004 – current

Financial Summary

2008 Revenue (in millions)

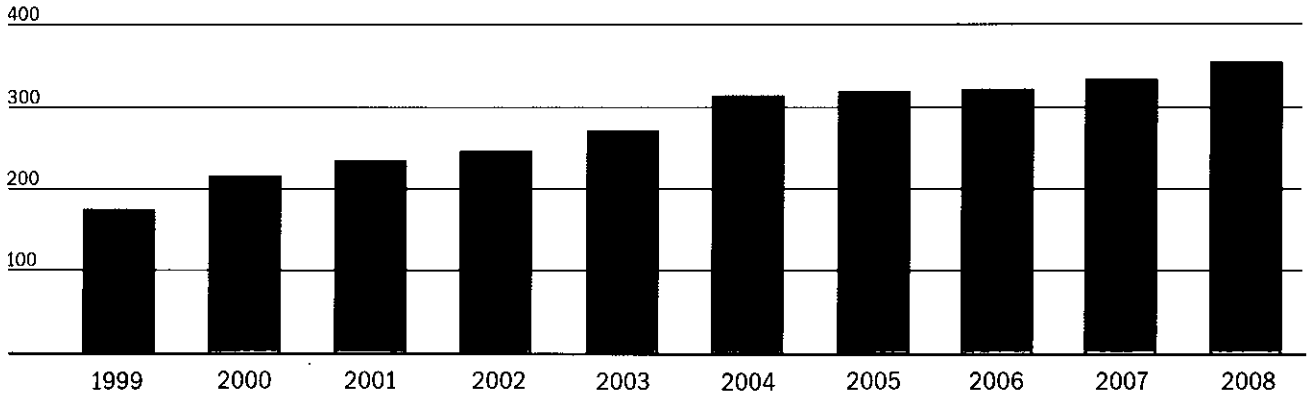
1. Indian Health Service Compact	118
2. Grants Activity	21
3. Medicare, Medicaid, Private Insurance	117
4. Sanitation and Facility Projects	63
5. Statewide Warehouse	19
6. Interest	-3
7. Other	8
Total	343

2008 Expenditures (in millions)

1. Alaska Native Medical Center	201
2. Sanitation and Facility Projects	63
3. Regional Service Supply Center/other	20
4. Grant Activity	21
5. Community Health Services	10
6. Environmental Health and Engineering	7
7. Administration	17
8. Pass-through awards	8
Total	347

This Financial Summary is preliminary as of 10/31/08 and is subject to a formal audit for FY 2008.

Total Revenues 1999-2008 (in millions)



The Alaska Native Tribal Health Consortium was formed in December 1997 to manage statewide health services for Alaska Natives, and began operations in 1998. All Alaska Natives, through their tribal governments and through their regional nonprofit organizations, own the Consortium. It is one of 23 co-signers of the Alaska Tribal Health Compact, a self-governance agreement with the Indian Health Service. In FY08, the Consortium employed 1,855 people, and had an operating budget of $380 million. It is based on the Alaska Native Health Campus near Tudor Road in Anchorage, Alaska.

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Vision

Alaska Natives are the healthiest people in the world

Mission

Providing the highest quality health services in partnership with our people and the Alaska Tribal Health System

Values

Achieving excellence
Native self-determination
Treat with respect and integrity
Health and wellness
Compassion

Alaska Native Tribal Health Consortium
4000 Ambassador Drive
Anchorage, AK 99508
(907) 729-1900 Fax: (907) 729-1901
Website: www.anthc.org

Alaska Native Medical Center
4315 Diplomacy Drive
Anchorage, AK 99508
(907) 563-2662
Fax: (907) 729-1984

Division of Environmental Health and Engineering
1901 Bragaw St., Suite 200
Anchorage, AK 99508
(800) 560-8637
(907) 729-3600
Fax: (907) 729-4090

Division of Community Health Services
4000 Ambassador Drive
Anchorage, AK 99508
(907) 729-3648
Fax: (907) 729-3652

2350

2/25/09 PRESENTA-TION: KEY CAMPAIGN

KEY COALITION OF ALASKA
PRESENTS TO THE
JOINT LEGISLATIVE HEARING

FEBRUARY 25, 2009

NAME	COMMUNITY
1. Emily Ennis	Fairbanks
2. Fred Villa	Fairbanks
3. Kama Gregory	Anchorage
4. Dayna McGuire	Anchorage
5. Ric Nelson	Anchorage
6. Jim Beck	Anchorage/Palmer
7. Shawn Woodard	Fairbanks
8. Janet Maddox	Fairbanks
9. Michaella Maddox	Fairbanks
10. Steve Lesko	Anchorage

2352

What is the Key Coalition?

The Key Coalition is a statewide coalition of supporters, friends and advocates for Alaskans and for their families who experience developmental disabilities.

Key Coalition basic beliefs:

- Community is truly a place for everyone.
- Individuals who experience a disability have a right and a need to live in community.
- Children must have the opportunity to live with natural families. Adults must have supports to exercise maximum independence in community.
- Government has a primary responsibility to provide realistic, non-intrusive, non-segregating, community supports for **ALL** of its citizens.

The **Key Coalition** advocates for equal opportunity, accessibility, and inclusive communities for all Alaskans who experience disabilities. We share the same dream – of a day when no Alaskan has to wait for critical supports, and, a day when our community programs are restored to reasonable health:

Programmatically and Fiscally!

COMMUNITY
And That's what it's all about!

Community services are the most cost-effective way of providing supports

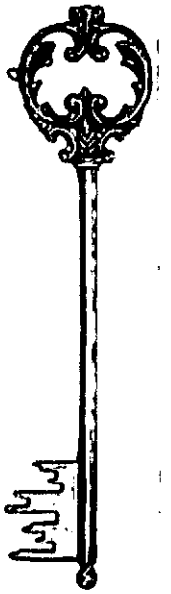
COMMUNITY SERVICES ARE THE KEY FOR INDIVIDUALS WHO EXPERIENCE A DEVELOPMENTAL DISABILITY

Community services support thousands of Alaskans in hundreds of communities throughout our state

Residential Supports
Accessible Housing
Individual Leases/Home Ownership
Low Interest Loans

Employment Supports
Subsistence Activities
Community Jobs
Job Training
Microenterprise

Home Modifications
Ramps/Accessibility
Accessible Bathrooms
Stair Climbers



Family Support Projects
Family Support Program
Short Term Assistance
Crisis Intervention

In-Home Supports
Respite
Personal Care Attendants
Chore Services
Specialized Equipment

TEFRA
Children Staying at Home
Health & Therapeutic Supports

Community services help children remain at home and adults to exercise independence

Please, Support the Key Campaign!

Community services contribute back to the economy

Our Top Priorities

Priority 1: Wait List Elimination

Why? 845 Alaskans still remain on a Wait List in 2009. Cost effective community supports provide for local jobs; keep individuals in their communities and with their families; increase productivity and independence; prevent costly institutionalization of human being.

Priority 2: An Annual Statutory Process to Govern and Adjust Rates for Community Services

Why? After five years of a rate freeze, community programs are no longer able to recruit and retain adequate staff; to meet the escalating costs of gas, heating, insurance; to maintain staff benefits. An equal rate process is essential to assure the heath of our community programs similar to that afforded hospitals and nursing homes.

Priority 3: Enhancement of Infant Learning Program

Why? Early intervention is efficient offering a critical window of opportunity for influencing positive outcomes. Early intervention works, increasing the likelihood of greater individual income and reducing societal costs. Infant Learning strengthens family as parents learn how to provide individualized interventions that help their children in critical areas of development. It is cost effective.

Priority 4: Formation of a Crisis Response Team

Why? In concert with the "Bring the Kids Home" initiative, the establishment of such a Team will: keep many children from costly, removed out-of-state residential placements; assist parents in maintaining kids at home; develop in-state capacity and trained staff; and re-establish our safety net for community supports.

Priority 5: Increase Living Wages: Direct Service Professionals

Why? High vacancy rates, the inability to recruit & retain; low wages; decreased benefits; five plus years of a rate freeze have all contributed to a workforce crisis in our community programs. Quality of care, health and safety are of paramount concerns. As in 24 other states, implement wage pass-throughs for our critical staff.

In addition, the Key Campaign supports:

- Continuation of the Adult Dental Program
- Raising income guidelines for Denali KidCare
- Funding for the Autism Initiative
- Transition funding for the Rural Transition Project

For 22 years, the **Key Coalition** has united people from across Alaska to wage our **Key Campaign**. We have brought together consumers, families and service providers to advocate for those who still wait for services.

In the beginning we were a mere handful of advocates, but we've grown every year. Today we are considered a small army rising across the face of Alaska. With chapters in rural and urban Alaska, we will continue to travel to Juneau for as long as it takes- for as long as people are forced to wait; for as long as our critical community programs are denied access to a fair, reasonable, and annual process of rate adjustment; for as long as the bureaucracy tolerates the disintegration of our families and the denial of the right to community for all Alaskans. Until that day---

Tell our elected officials that you believe in the dream of the Key Campaign – that **COMMUNITY** is for everyone and that the time to end the waiting and to restore our community programs is now!!!

Please join us at the Capitol Steps Rally
February 25, 2009

12:00 NOON

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Key XXII Campaign 2009

"Shoring the Foundation..."

Key Coalition of Alaska
Key XXII
20 09
Strength
"Shoring the Foundation..."
Unity, Advocacy, Community

February 24 and 25, 2009
Juneau, Alaska

Community is the Key

For Alaskans who experience developmental disabilities

2354

3/20/09 FOSTER CARE LEGISLA-TIVE SUMMIT

Lynda Zaugg

From: Apache [apache@wwwjnu02.legis.state.ak.us]
Sent: Thursday, March 12, 2009 12:07 PM
To: LIO Juneau; Peg Warren; Lynda Zaugg
Subject: Teleconference Order Form

Meeting: new

Sponsor and/or Committee Name: Sen H&SS

Date of Teleconference: 3/20/09

Start Time: 1:15

End Time: 3:15

Chairing Site: Juneau Capitol Building

Juneau Room: #205

Testimony: yes

Testimony Time Limit: no time limit

Executive Session: no

Contact Person: Lynda Zaugg

Telephone Number: 907-465-4906

Email Address: lynda_zaugg@legis.state.ak.us

LIO Sites:

anchorage
fairbanks

Other sites may add: yes

Offnet Name(s):

Subject of meeting and/or Bills on Agenda:

Foster Care Legislative Summit
BPH

Foster Care Legislative Summit
Today's Obstacles To Success, Tomorrow's Solutions
March 20, 2009
1:15PM – 3:15 PM
Senate Health and Social Services Committee

OPENING REMARKS
1:15 – 1:20PM

Senator Bettye Davis & Representative Les Gara:

- Introduce Co-Sponsor Legislators & Panel Members
- Forum Goals, Where We Are Today, Problems and Presenter Solution Ideas
- **Questions and discussion will be held at the end of the panel presentations**

FACING FOSTER CARE IN ALASKA: "REAL LIFE POLICY"
1:20 – 1:40

Amanda Metivier, FFCA:

- FFCA Policy Agenda.

RESEARCH DATA AND ALUMNI PERSPECTIVES
1:40 – 2:00

Amanda Metivier
Peter Pecora, Casey Family Programs
FFCA Youth & Alumni Panel (Kaylee Day, Shilo Valle, Anthony (Tony) Barril, Telora Thompson)

- Alaska Alumni Study highlights – homelessness rates
- Post-Foster Care Independent Living Challenges: Hurdles Foster Youth and Alumni Face After Care
- Available Federal Funding after age 21

EDUCATION AND FOSTER CARE
2:00 – 2:20

Barb Dexter, Anchorage School District
Beth Snyder, Anchorage School District

- McKinney Vento

CHILD AND FAMILY SERVICE REVIEWS: PROBLEMS AND SOLUTIONS FOR ALASKA
2:20 – 2:45

John Henderson, U.S. Dept. of Health and Human Services, Children's Bureau *(via phone)*
Tammy Sandoval, Director, Alaska Office of Children's Services (OCS):

- Alaska's Preliminary CFSR Results from September 2008
- Child and family outcomes needing attention most urgently
- Frequency of social worker visits
- Federal Review results
- Performance Improvement Plan – planning and development

CLOSING REMARKS
2:45 – 3:15

Senator Bettye Davis & Representative Les Gara
- Status of current legislation
- Questions & Discussion

PIP = Performance improvement plan
C/E Review - complete set for ~~Sept~~ first part of July
(fines # under Fed Law)

Facing Foster Care in Alaska

Policy Agenda 2008

In May of 2008, the youth and alumni of Facing Foster Care in Alaska, (FFCA) came together from across the state and gathered in Anchorage to share their ideas and experiences about life in Alaska's foster care system. During their gathering youth/alumni brainstormed ideas on what they thought would be most beneficial to them and others in foster care in Alaska. As a result of these ideas, the members of FFCA voted to create this policy agenda.

Tuition Waivers for ALL foster youth in the state of Alaska

The University of Alaska Anchorage currently offers 10 Presidential Tuition Waivers a year to foster youth who are eligible for the OCS Independent Living Program. A young person must have been in foster care on or after their 16th birthday for six consecutive months in order to be eligible for the waiver program. Since these waivers are competing, not every young person in Alaska who applies will receive one. Youth who are placed in a guardianship, adopted, or reunified before age 16 are not eligible to apply for the waiver. Many states provide Tuition Waivers or other forms of reimbursement for college expenses to foster youth interested in pursuing post-secondary education. The youth and alumni of FFCA feel that by providing All of Alaska's foster youth with tuition waivers there would be a higher percentage of foster youth attending post-secondary education. Studies show that approximately 17% of young people who exit foster care pursue post-secondary education, and only about 1% graduate from a four year degree or certificate program. FFCA would like to see that All of Alaska's foster youth are provided with tuition waivers to reduce the stress of worrying about college expenses and knowing that they are guaranteed a higher education.

Support to foster youth pursuing post-secondary education

Many of the youth and alumni who attend post-secondary education programs in Alaska have complained about not having any supports to help them achieve their goals. FFCA members would like to see that universities and vocational programs have supports put in place for foster youth transitioning to higher education. FFCA members recommended adult or alumni mentors, a family to spend the holidays with, and someone within the

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university or vocational program to talk with about stressors. If every youth in Alaska's foster care system made a permanent connection with a caring adult during their stay in foster care this would be less of an issue. FFCA members also recommended implementing the, "Circles of Support Program," to ensure youth in care are making permanent connections with caring adults before exiting from care.

More Independent Living Funds going to youth/alumni

The state of Alaska currently gets approximately $500,000 a year (FY2008 $518,814) in Federal Chafee funds to be used for youth in foster care to work toward independent living. There is currently no state match for this money and it is being stretched very thin as the states Independent Living Program grows, and begins to offer more programs and resources to youth in transition. The youth and alumni of FFCA would like to see that more of this money is offered to youth and alumni transitioning from foster care for housing, education, life skills training, and anything that may support them in becoming independent productive members of society. FFCA is also aware that many states provide a match for the Chafee dollars they receive and would like to see that this is made possible by the state of Alaska.

Transitional Living for youth

Alaska currently allows for youth who turn 18 in foster care the option to extend their time in state custody until the age of 20. There many states that allow for youth to extend custody until age 21, or to leave custody and re-enter if they are willing to pursue post-secondary education. According to the Alaskan Alumni Study 38% of Alaska's alumni reported being homeless after exiting foster care. The Covenant House Shelter in Anchorage reports that two-thirds of their current population is comprised of current and former OCS youth. The youth and alumni of FFCA would like to see a stronger focus in the area of transitional housing for youth who exit from the foster care system. FFCA members shared ideas and recommend allowing youth to remain in state custody while living in college dorms, apartments on their own, or other least restrictive environments outside of the traditional family foster home after reaching age 18.

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Independent Housing Program

Some states currently allow for foster youth to live, "on their own," after reaching age 18, but to remain in state custody and receive foster care payments on behalf of themselves until the age of 21. This allows for foster youth to continue services with their social worker as well as other services offered to youth in custody, and learn to successfully transition out of state custody. The youth and alumni of FFCA would like to see a program such as this put into place in Alaska, or for the state to consider more creative placements for young people once they reach 18, but are not ready to exit from foster care.

Medicaid increased to age 21 under the Chafee Independence Act

There are currently 17 states that have chosen to enact the Chaffee option to extend Medicaid to age 21 for former foster youth, Alaska is not one of these states. Currently, youth in Alaska's foster care system can receive Denali Kid Care until age 19 under the 1115 Waiver. After age 19 these young people can apply for adult Medicaid, but this holds them back from obtaining decent paying jobs and forces them to choose to go without medical coverage. Youth in foster care often attend counseling and have other medical needs, but they are forced to cut off many of these services when they leave custody. The youth and alumni of FFCA would like to see that Medicaid is increased for Alaska's foster youth to age 21 under the Chafee Foster Care Independence Act.

Braces covered under Medicaid

Children and youth in Alaska's foster care system often have only their Basic needs met because there is a strong emphasis on safety and permanency. There is little or no value put on whether a young person in custody needs braces, as this is usually a cosmetic procedure that parents would normally pay for. The youth and alumni of FFCA felt very strongly about this issue and believe that braces should be covered under Medicaid or by OCS. FFCA members discussed how braces could support higher self-esteem for a young person in foster care, and would give them one less thing to worry about besides the social pressures they face as a, "foster youth." FFCA is also aware that braces are covered under Medicaid in the state of Texas, so this could be an option for Alaska.

Decreased use of Psychotropic Medication for Alaska's foster youth

Many of Alaska's youth and alumni complain about being prescribed psychotropic medications after entering the foster care system for symptoms of depression, anxiety, trauma, attachment issues, and misbehavior. The youth and alumni of FFCA feel that these are all normal symptoms of child maltreatment and dealing with all that comes out of being placed in foster care. There has been a national focus on the use of psychotropic medications being over-prescribed for children and youth in foster care. FFCA members have also complained about side-effects caused by these medications resulting in a decreased ability to focus on their education as well as function in everyday society. The youth and alumni of FFCA would like to see that the prescription of psychotropic medications for Alaska's foster children and youth is decreased and reviewed more closely.

Definitions (according to FFCA)

Youth- A young person currently in state custody (foster care).

Alumni- A person who has spent any period of time in the foster care system

Facing Foster Care in Alaska (FFCA)

Mission Statement: Our mission is to improve the foster care system through sharing our experiences, supporting and educating youth and social services and implementing positive change in society as a whole.

FFCA is Alaska's only foster care advocacy organization completely run by youth and alumni of the foster care system. Since their inception in 2003, FFCA has been working to improve Alaska's foster care system by sharing their experiences with people who can create positive changes for Alaska's foster youth. FFCA is a statewide organization that provides support to Alaska's foster youth and alumni and, gives them the ability to share their voice and become leaders in their community.

Acknowledgements

This document was drafted using the feedback from the youth and alumni of Facing Foster Care in Alaska (FFCA). Statistics and information provided by Casey Family Programs and the Office of Children's Services as well as, various other child welfare resources. For questions regarding the content of this policy agenda contact: Amanda Metivier *FFCA President* Ametivier@casey.org

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SB 105
HB 126

casey family programs

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Outcomes of Youth in Foster Care and Alumni: How to Maximize Success

Alaska State Legislator Briefing
March 20, 2009

Presenters:
Amanda Metivier and Peter Pecora with a panel of foster care alumni consultants

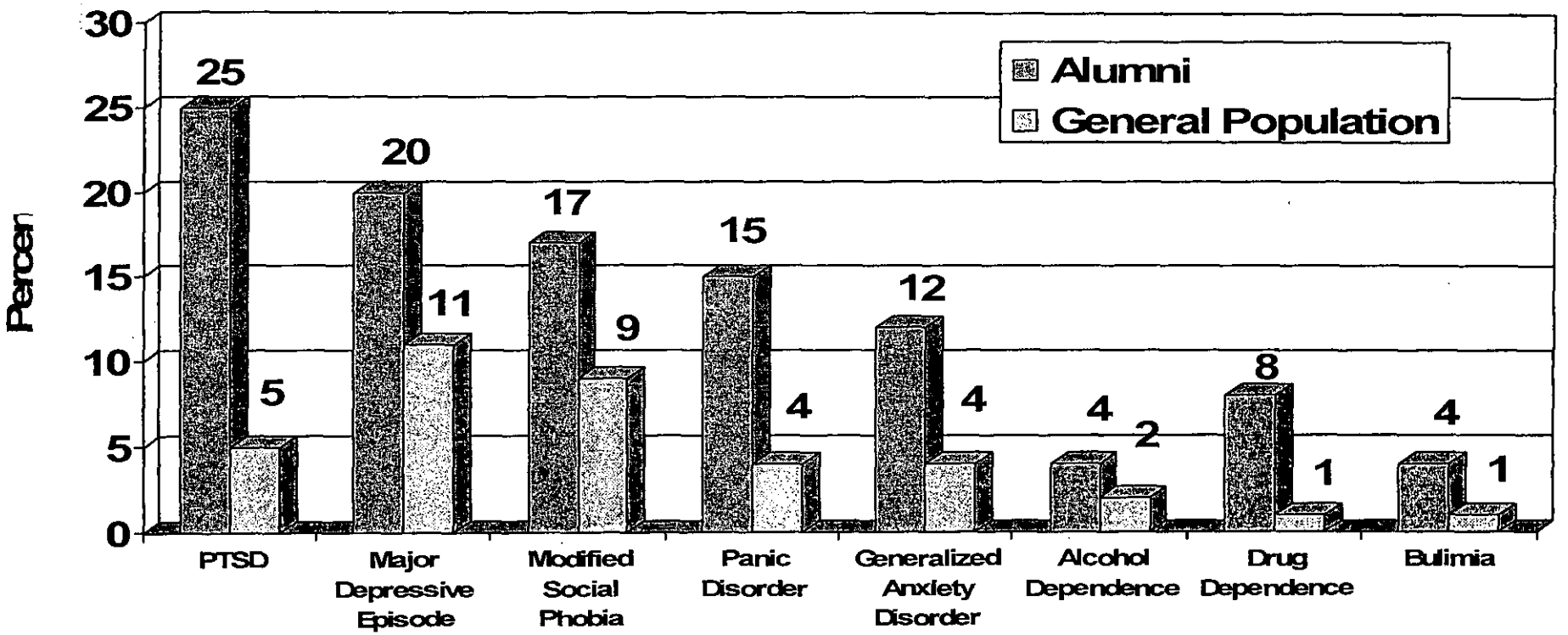
Presentation Overview

Outcome data are interspersed with foster care alumni panel comments and recommendations for:

- Mental Health
- Education
- Employment

Mental Health (NW Study)

Twelve-Month Mental Health Diagnoses Among Foster Care Alumni and the General Population Matched by Age, Race and Gender



Source: Pecora, P. J., Kessler, R. C., Williams, J., Downs, A. C., English, D., & White, J. & O'Brien, K. (Forthcoming). *What works in foster care?* Oxford, England: Oxford University Press.

Midwest Study Diagnoses: Last 12 Months (Illinois, Iowa, Wisconsin)

	Females	Males
At least one CIDI DSM-IV diagnosis	14.2[b]	4.6[b]
Alcohol dependence	3.5	11.6
Drug abuse	1.9	5.8
Drug dependence	1.0	5.1
Generalized anxiety disorder	0	0
PTSD	7.9[d]	3.8[d]

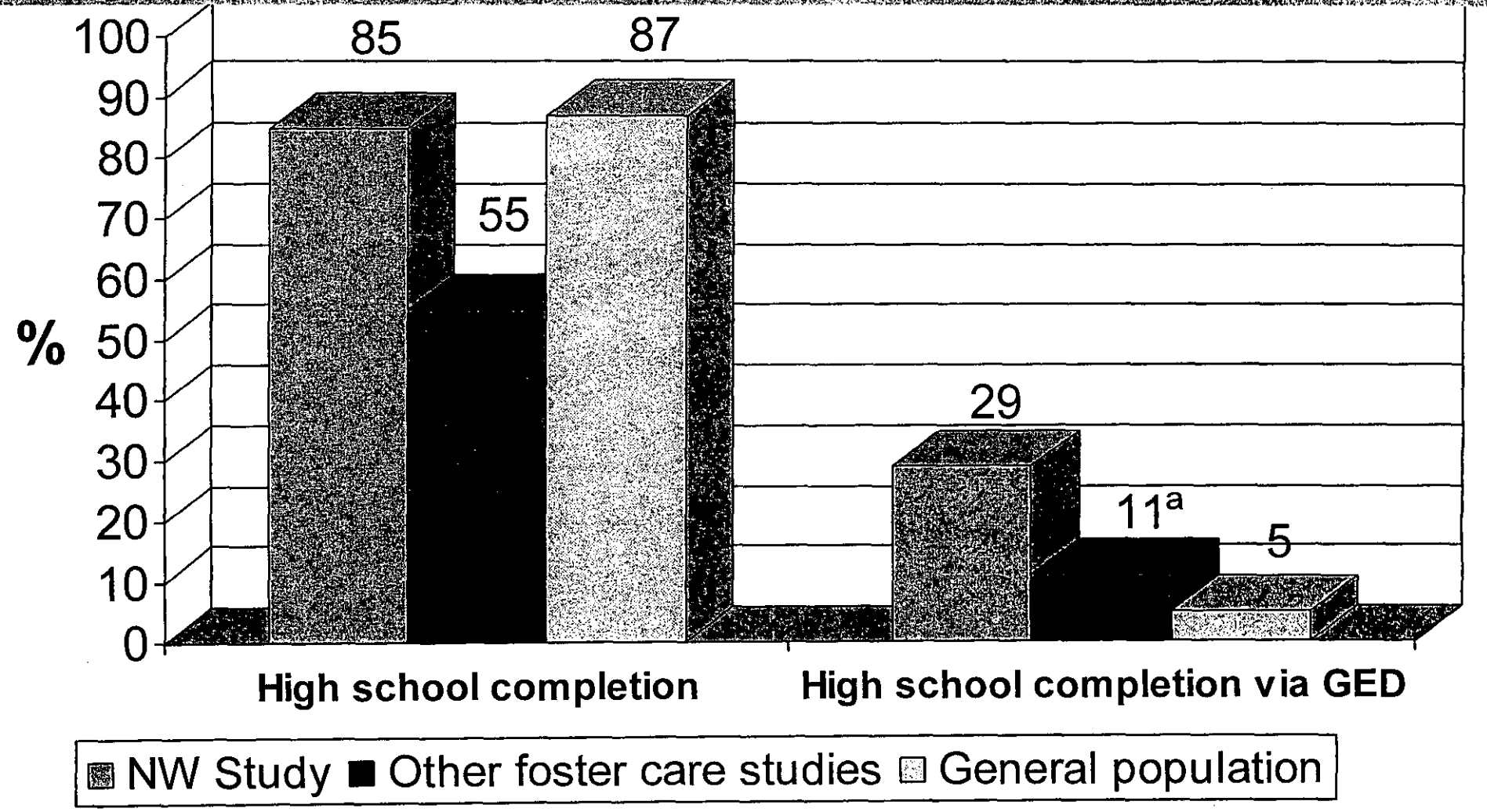
[a] Source: Courtney et al. (2007, p. 46).

Alaska Study Mental Health Findings

- Five times as many alumni scored in a clinical range on the SF-12 scale as the general population (10.3 versus 2.3%)

- 1 in 4 of the alumni had used a hotline, support group, counselor or overnight stay for substance abuse or mental health services in the last year.

Education Outcomes

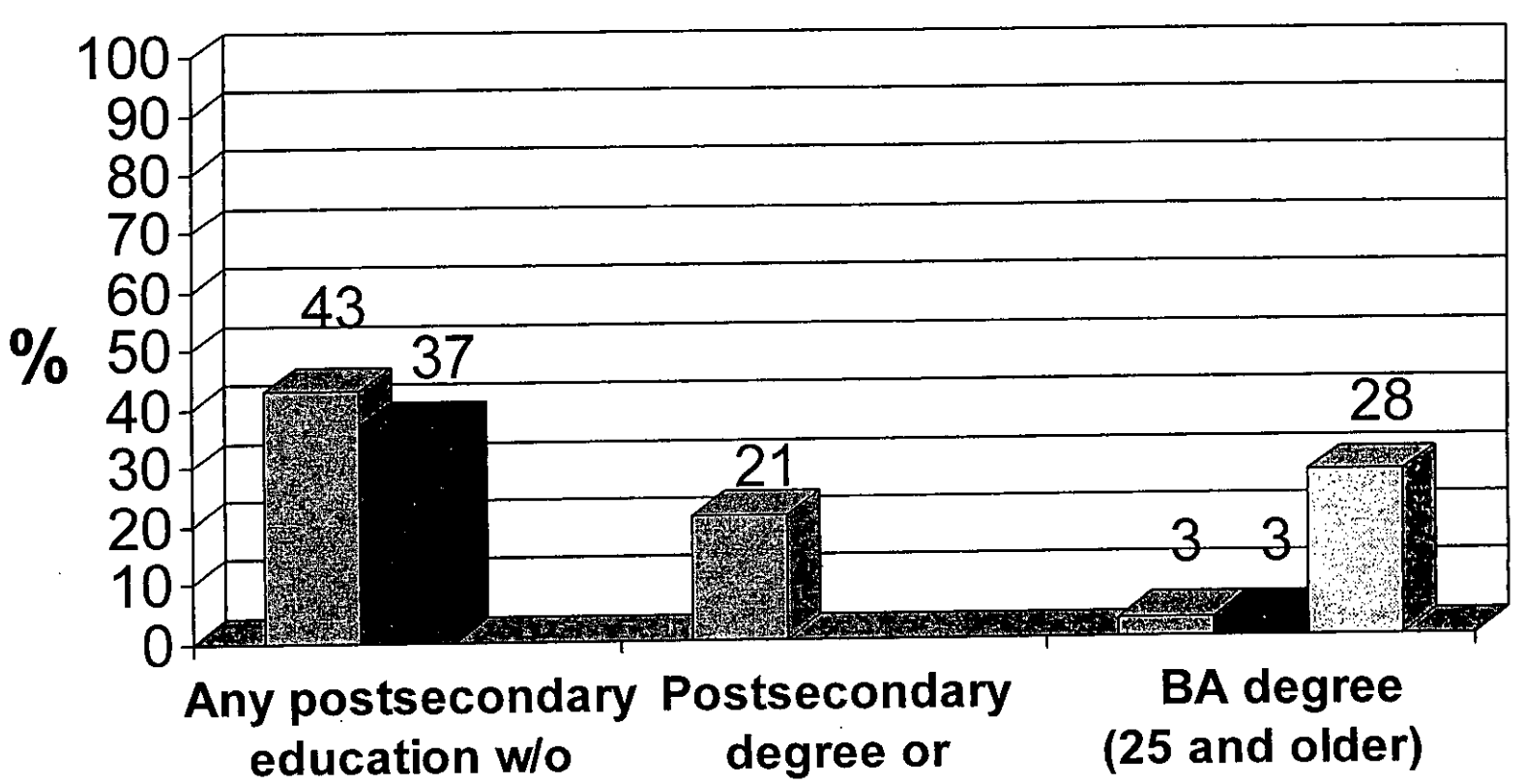


[a] (Mech 2003)

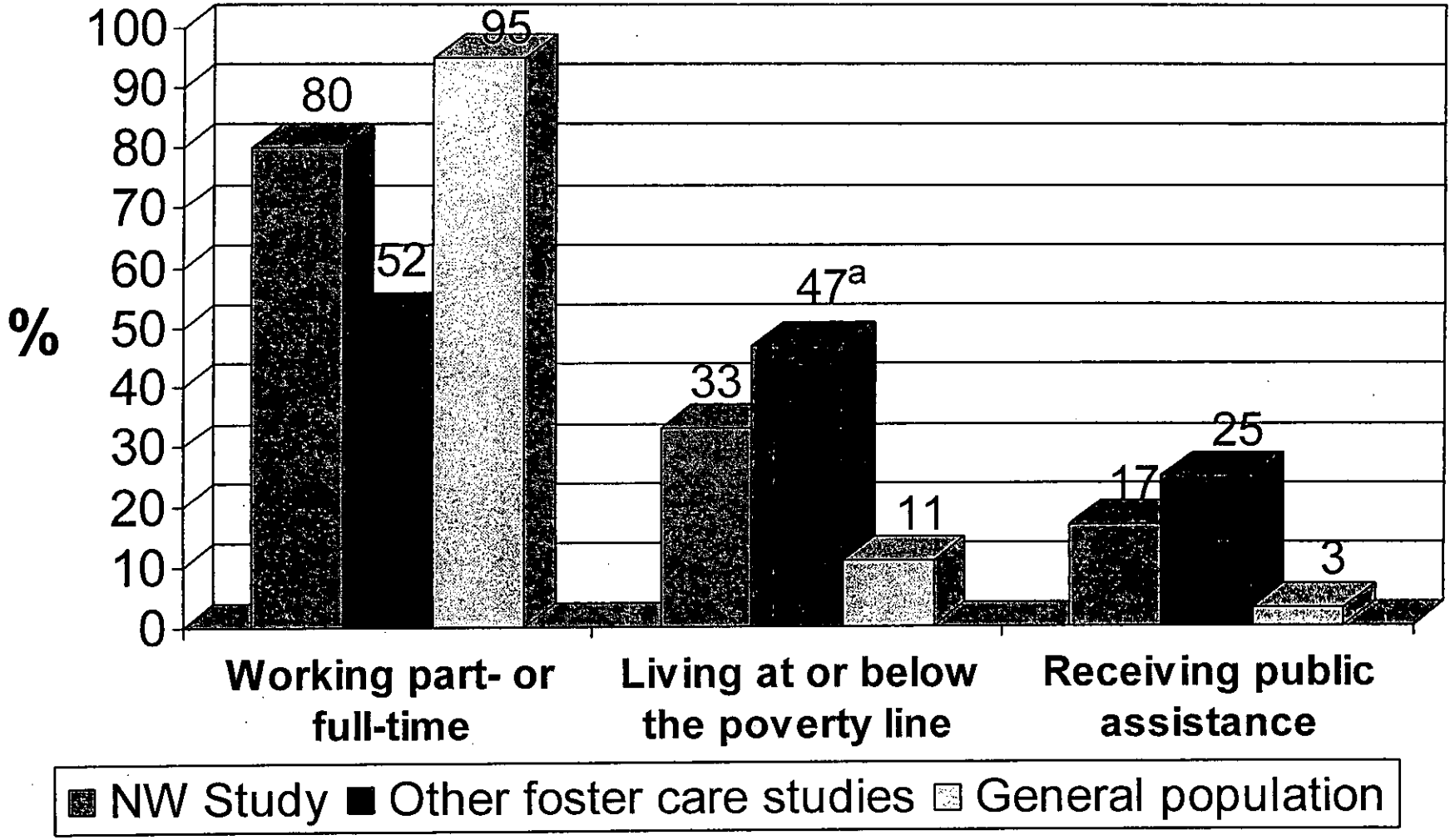
Alaska Education Findings

- In the Alaska study nearly 79% had completed high school by the time of the interview:
- 63.6% with a diploma
- 15.2% had a GED

Outcomes: *Education cont...*



Outcomes: *Employment and Finance*



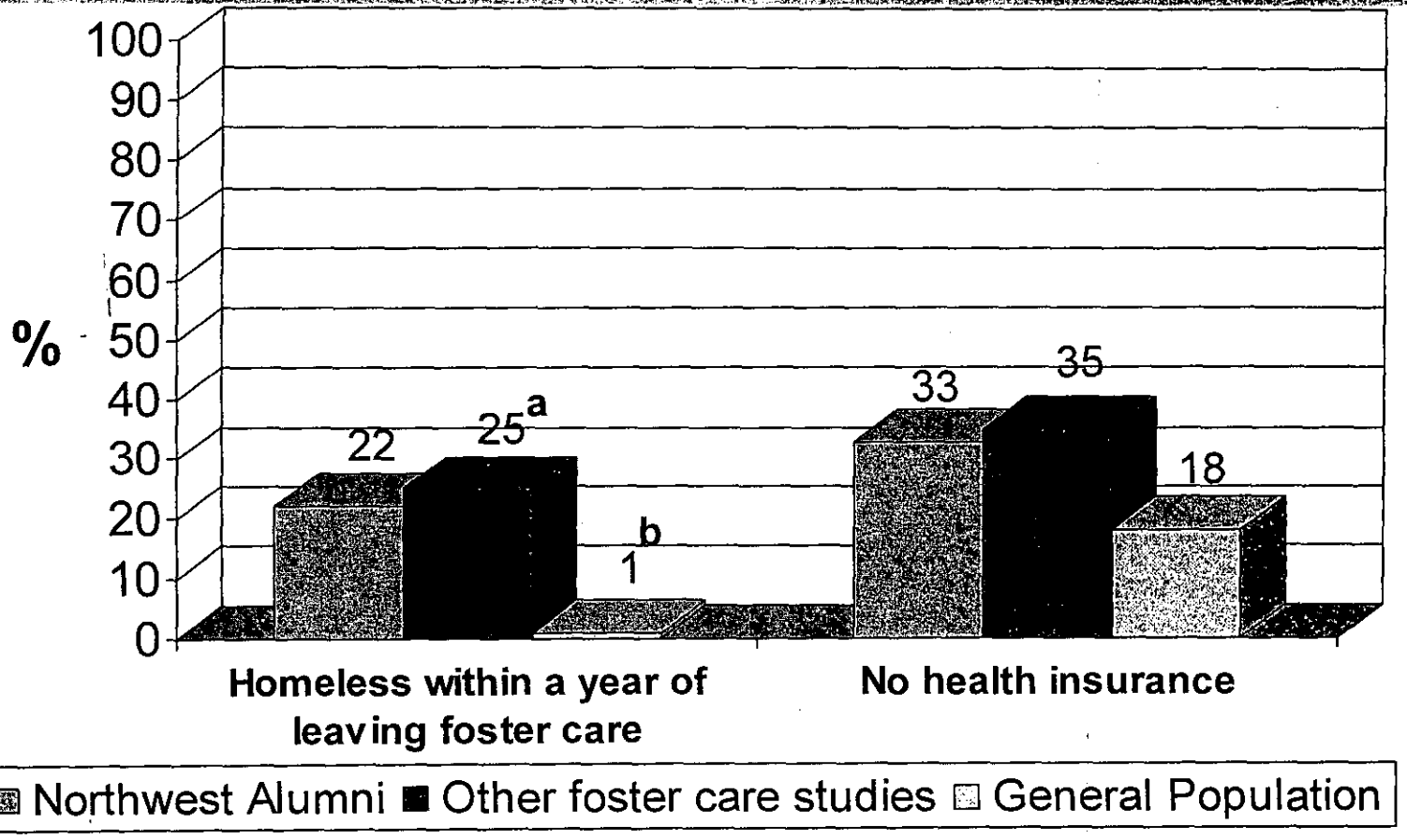
[a] (Brandford & English 2004, Washington State data)

Alaska Alumni Employment

- Alumni unemployment rate: 29.6%
- General population: 7.1%

How can more alumni obtain living wage jobs with health care benefits?

NW Alumni Homelessness and Health Insurance



[a]Homeless at any point since leaving foster care. [b]Homeless at any point in past year.

Outcomes: *The Glass IS half-full!*

- ***Mental Health***
  - 45.6% Have **no** 12-month mental health diagnosis
- ***Education***
  - 85% Completed high school
- ***Employment/Finance***
  - 21.3% Have household income at least three times the poverty level
  - 83.2% Do not currently receive cash public assistance
  - 74.0% Are working now or in school
  - 63.6% Have volunteered in their communities or church

Predictors of Success:
What helps?

1. Stabilize a child's placement experience to build life-long connections with supportive adults and peers.
2. Increase youth access to high quality therapeutic services & support.
3. Targeted educational services.
4. Extracurricular experiences.
5. Life skills development and work experience.

Appendix A: Recommendations
Mental Health

Increase youth and alumni access to evidence-based mental health treatment:

- Provide health insurance coverage through Medicaid,
- Increase availability of group work & evidence-cased treatment approaches (e.g., trauma-focused cognitive therapy).

Minimize placement change:

- Via better child-family matching & more responsive services.
- Association between fewer changes and fewer mental health problems.

Increase education services and experiences:

- Stability and support in the school environment can cause a positive effect on adult mental health

Recommendations: *Education*

- Set high but realistic expectations for youth in care to complete high school via a diploma if at all possible.
- Help young adults enroll in local college-preparatory programs.
  (E.g., GEAR-UP, TRIO, and Upward Bound)
- Ensure staff and youth are aware of good vocational options that pay well.

Recommendations: *Employment & Finances*

Strengthen housing programs:

- To prevent homelessness.
- Increase supervised transitional housing.

Overhaul independent living preparation:

- Evidence shows that alumni vary widely in their level of readiness for emancipation.

Provide youth in transition with concrete resources:

- Begin life skills training at an earlier age.
- Involve youth in real-life work, housing and other situations.

Acknowledgements

This presentation is based on research conducted by:

- Casey Family Programs
- Harvard Medical School
- The Universities of Washington and Michigan
- Oregon Department of Human Services
- Washington Department of Health and Human Services
- The Northwest Alumni Studies team is grateful to and has learned much from the youth, alumni, parents and field staff including:
  - **Project Coordinator:** Kirk O'Brien: kobrien@casey.org
  - **Co-Principal Investigators:** Ronald Kessler, Diana English, James White, Chris Downs

Additional Information

Casey Family Programs: www.casey.org

Search "Northwest Alumni Study"

Contact Information:

Casey Family Programs
1300 Dexter Avenue North, Floor 3
Seattle, Washington 98109-3547

Phone: (206) 270.4936.
Website: www.casey.org
Peter Pecora: ppecora@casey.org

Presenters

Amanda Metivier is an alumni of foster care and, the president of ***Facing Foster Care in Alaska*** (FFCA). Amanda is currently pursuing her BSW at University of Alaska at Anchorage, and works for Casey Family Programs.

Peter Pecora is the Principal Investigator for the Northwest and National Alumni studies, Senior Director of Research Services with Casey Family Programs, and Professor at the School of Social Work, University of Washington.

Frank Amardurix
Admitted D.
4766

Lynda Zaugg

From: Katie Conway
Sent: Wednesday, March 18, 2009 8:08 AM
To: Lynda Zaugg
Subject: FW: Foster care hearing

What do you think of doing a press release or formal, building wide invitation for Friday's foster care event?

Katie Conway
Staff to Representative Les Gara
State Capitol Room 500, Juneau, Alaska 99801
Phone: (907) 465-6591
Fax: (907) 465-3518

From: Rep. Les Gara
Sent: Tuesday, March 17, 2009 6:04 PM
To: Katie Conway
Subject: Foster care hearing

Can you encourage Bettye's office to do a press release, or at least send a notice to all legislators to invite them?

Tx. What day is it?

Representative Les Gara
Alaska State Legislature
716 W. 4th Avenue, Suite 310
Anchorage, Alaska 99501
Phone: 907-269-0106
Fax: 907-269-0109
www.akdemocrats.org

FOSTER CARE SUMMIT MEETS IN JUNEAU FRIDAY

'Today's obstacles to success; tomorrow's solutions

JUNEAU – Sen. Bettye Davis and Rep. Les Gara (both D-Juneau) will host a foster care summit on Friday from 1:15 to 3:15 p.m. in the Senate Health and Social Services Committee room at the State Capitol. The forum will address the state of foster care in Alaska and identify challenges and solutions.

Presenters will include Amanda Metivier, president of Facing Foster Care in Alaska (FFCA); Peter Pecora from Casey Family Programs and representatives from the Anchorage School District the US and Alaska Departments of Health and Human Services and a panel of youth and Alumni from FFCA.

Sen. Davis, who chairs the H&SS Committee, has worked hard to bring this summit to fruition. "This is an important issue in Alaska, and we're trying to inform the public and to get people working together for solutions to the challenges facing these young people. I encourage everyone to attend this summit and help us make Alaska a better place for everybody."

When 38 percent of Alaskans coming out of foster care become homeless, and less than 10 percent end up making it through college, that's a call for action," said Gara who grew up in foster care. "There's a lot we can do to create opportunity for foster youth, and the purpose of the conference is to brainstorm together to find meaningful solutions – now rather than later."

38 percent of foster children go homeless after leaving state custody. Less than 10 percent make it through college. Children bounce between schools as they bounce between families. Policymakers are looking for solutions.

A copy of the agenda is attached for your convenience.

For more information about the summit or foster care please contact Sen. Davis or Rep. Gara.

Sen. Bettye Davis: sen.bettye_davis@legis.state.ak.us , (907) 465-3822
Rep. Les Gara: rep.les_gara@legis.state.ak.us , (907) 465-2647

HB 126: FOSTER CARE/CINA/EDUCATION OF HOMELESS

SPONSOR(S): Representative(s) GARA, Crawford, Kerttula

CURRENT STATUS: (H) HSS

FISCAL NOTE:
1) Zero – ACPE
2) FY10: 204.2 – OCS
3) FY10: 725., FY11 – FY15: 445.2 – OCS
4) FY10: 1,971.4, FY11 – 15: 953.9 – OCS

BILL HISTORY/ACTION:
(H) EDC 2DP: Gardner, Buch; **2NR**: Seaton, Keller

BILL SUMMARY: Continuing the secondary public education of a homeless student; relating to the purpose of certain laws as they relate to children; relating to tuition waivers, loans, and medical assistance for a child placed in out-of-home care by the state; relating to foster care; relating to children in need of aid; relating to foster care transition to independent living; and relating to juvenile programs and institutions."

ISSUES (pros & cons):

TALKING POINTS (if any):

COMMITTEE/DATE: 3/11/2009
Roll: Seaton, Gardner, Buch, Keller
Action: Moved
Next Referral: HSS
Amendments: none
Change in CS: none

Amendments/Changes:

Committee Discussion/Action:
No discussion. Only moved the bill.

Testimony Summary:
No testimony today.

COMMITTEE/DATE: 3/9/2009
Roll: Seaton, Gardner, Buch, Munoz, Keller, Edgmon
Action: Heard and held
Next Referral: HSS
Amendments: 4 adopted
Change in CS:

Amendments/Changes:
1) Adds two provisions to say non-state entities are not required to participate in this program if they do not receive the funds for it.

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2) First two parts make it clear that we are adopting McKinney Vento concept. Clarifying language. Part 3 adopts McKinney Vento, but if federal law changes, we don't have to until we know what it is and if it is beneficial. Part 4 clarifying language on who is covered.
    a. Amendment to Amendment – Deletes page 3 through 4 that increases foster youth age to 21.
3) Deletes "and for providing comparable education" from page 1, line 11.
4) Deletes "adequate" from page 3, line 31.

Committee Discussion/Action:

Testimony Summary:
Theresa Lombardo, Director of the Casey Family Program, supports bill.

Barb Dexter, Anchorage School District Child District Transition, supports the bill. When you allow a child to stay in their school, they do not have that few months of falling behind when transitioning to another school.

COMMITTEE/DATE: 3/2/2009
Roll: Seaton, Gardner, Buch, Wilson, Munoz, Keller, Edgmon
Action: Heard and held
Next Referral: HSS
Amendments: none
Change in CS: none

Amendments/Changes: none

Committee Discussion/Action:
Rep Seaton only opened up public testimony.

Testimony Summary:
Lauren Rice, Director of Advocacy for Covenant House Alaska, testified in support of HB 126. Most foster youth show up at Covenant House with absolutely nothing. They do not have the resources or skills to make the transition into adulthood. We know more today what foster youth need. This data comes back from foster youth. This bill increases the likelihood of their success.

Carol Comeau, Superintendent for Anchorage School District, Supports this bill. Over 2000 students who have been identified in the Anchorage School District. Concerned about it being defined as one school year instead of every year. Concerned about the "academic exception" exemption clause. Needs more definition.

COMMITTEE/DATE: 2/25/2009
Roll: Seaton, Gardner, Buch, Wilson, Munoz, Keller, Edgmon
Action: Heard and held
Next Referral: HSS
Amendments: none
Change in CS:
1) Sections 4, 14, & 16:Adopt statutory definition of 'out of home' care
2) Section 10: Provide immunity for social worker if they fail to complete their monthly visit to the foster youth

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3) Section 13: revised conforming language to allow the age of foster youth to be extended up to 21 year olds.
4) Section 17: Provides transitional housing of up to a year for when foster youth come out of foster care.

Amendments/Changes:

Committee Discussion/Action:
Rep. Gardner stated that in section 1, it states that the student may change schools if it is in their best academic interest. Sometimes, it is in a child's best overall interest to be moved. There are more reasons then academic.

Testimony Summary:
Rep. Gara presented the bill. After coming out of foster care, most foster kids end up homeless at one point in their life. When we move them from school to school to school, studies show that the foster youth will do poorly academically. 65% have been in 3 or more elementary schools. These happen during the middle of the school year. This bill helps foster youth to stay in the same school if they move. It provides transportation funding for them if they end up staying in the same school if they move homes.

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Lynda Zaugg

From: Katie Conway

Sent: Tuesday, February 24, 2009 8:04 PM

To: 'Henderson, John (ACF)'; 'Theresa Tanoury'; 'Amanda Metivier'; 'Sandoval, Tammy K (HSS)'; 'Lesmann, Mike (HSS)'; 'PPecora@casey.org'; 'Dexter_Barb@asdk12.org'; 'Snyder_Beth@asdk12.org'

Cc: 'Laughlin, Wilda J (HSS)'; Lynda Zaugg; David Theriault

Subject: RE: repeat, trimmed down foster care conference in Juneau, March 20th?

Hi folks,

We have a date and a time for the mini-foster care conference! The event will be **March 20th** from **1:15 to 3:15PM** in the Senate HSS committee. It was difficult securing a two hour block of time for this event so it is absolutely critical that we stay within the assigned time and not use more than we have. That being said, I think it's time we set an agenda! Below is a list of presenters and topics we can use as a starting point for that agenda. This list is in no particular order, and the topics are not set in stone. I'm eager to hear your thoughts.

1. John Henderson: Face to face visits and the Federal review
2. Peter Pecora: homelessness study, and available federal funding for care up to age 21
3. Barb/Beth: McKinney Vento in ASD and whether there is still a need for supplemental state funding
4. Amanda Metivier/FFCA: Reasons behind the FFCA policy agenda items this year
5. OCS: Federal Review, role of OCS in transition from foster care (ILP programs), Tammy's discretion.

Thank you!
Katie

Katie Conway
Staff to Representative Les Gara
State Capitol Room 500, Juneau, Alaska 99801
Phone: (907) 465-6591
Fax: (907) 465-3518

From: Katie Conway
Sent: Friday, February 20, 2009 11:25 AM
To: Henderson, John (ACF); Theresa Tanoury; Amanda Metivier; Sandoval, Tammy K (HSS); Lesmann, Mike (HSS); PPecora@casey.org; Dexter_Barb@asdk12.org; Snyder_Beth@asdk12.org
Cc: Laughlin, Wilda J (HSS); David Theriault
Subject: RE: repeat, trimmed down foster care conference in Juneau, March 13th?

Hi again everyone,

As the 13th wasn't available for everyone I'm now checking to see if March 20th works instead.

Thanks!

Katie Conway
Staff to Representative Les Gara
State Capitol Room 500, Juneau, AK 99801
Phone: (907) 465-6591
Fax: (907) 465-3518

From: Henderson, John (ACF) [mailto:john.henderson@acf.hhs.gov]
Sent: Thursday, February 19, 2009 11:58 AM

To: Katie Conway; Theresa Tanoury; Amanda Metivier; Sandoval, Tammy K (HSS); Lesmann, Mike (HSS); PPecora@casey.org; Dexter_Barb@asdk12.org; Snyder_Beth@asdk12.org
Cc: Laughlin, Wilda J (HSS); David Theriault
Subject: RE: repeat, trimmed down foster care conference in Juneau, March 13th?

Katie, Thank you for the invitation and I'd be pleased to participate at least by phone if that would suffice but I'll need to take a closer look at our travel budget to see if I could manage a trip up to Juneau in person.

John Henderson
Child Welfare Regional Program Manager
DHHS/ACF Region X
2201 Sixth Ave., Suite 300, MS 73
Seattle, Washington 98121-1827
ph: 206-615-2482
fx: 206-615-2575

From: Katie Conway [mailto:Katie_Conway@legis.state.ak.us]
Sent: Thursday, February 19, 2009 11:58 AM
To: Theresa Tanoury; Henderson, John (ACF); Amanda Metivier; Sandoval, Tammy K (HSS); Lesmann, Mike (HSS); PPecora@casey.org; Dexter_Barb@asdk12.org; Snyder_Beth@asdk12.org
Cc: Laughlin, Wilda J (HSS); David Theriault
Subject: repeat, trimmed down foster care conference in Juneau, March 13th?

Hi folks,

Last week Representative Gara and Senator Bettye Davis filed comprehensive Foster Care bills relating to education funding, transitional housing, and extending care. This bill is largely the result of the absolutely stellar Foster Care summit this fall in which you were all key contributors. Thank you again! Les and Sen. Davis, co-chair of the Senate Health and Social Services Committee), are now speaking about the possibility of having another Foster Care conference in Juneau during this session. During their brief, preliminary conversation they selected March 13th as a possible date, and the venue would likely be the Senate HSS committee. The idea would be to have similar presentations as during our fall day-long summit but in just two hours. We're hoping you would all be interested and able to participate. The intention with this email is to feel you all out for the possibility of putting this together. Ideally we'd have John Henderson, Peter Pecora, OCS, and FFCA speaking in Juneau, and Barb and Beth by phone from Anchorage (unless you think you could make it here), for a total of five short presentations and a brief intro/conclusion from Rep. Gara and Sen. Davis. What are your thoughts?

Thank you!
Katie

Katie Conway
Staff to Representative Les Gara
State Capitol Room 500, Juneau, AK 99801
Phone: (907) 465-6591
Fax: (907) 465-3518

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Deals Jobs Homes Cars Rentals

State called to do a better job with its kids in foster care

COMPASS: Other points of view

By REP. LES GARA and AMANDA METIVIER
Published: February 22nd, 2009 06:48 PM
Last Modified: February 22nd, 2009 06:49 PM

More Compass stories »

State called to do a better job with its kids in foster care

GOP backs stimulus plan but not Democrats' version

New recovery package is good for Alaska and America

Abundance-based fish, game management can benefit all

It's easy to miss what's in plain sight

It's time for reform in Alaska's foster care system. Just doing the same as last year isn't working. The State of Alaska is custodian to 2,000 foster youth. We're supposed to create hope and opportunity. Instead 40 percent of Alaska's foster youth end up homeless at some point in adulthood.

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Statistics paint a picture of blocked opportunity. Foster youth are more likely than their peers to end up in jail at a taxpayer cost of $40,000 a year. The smarter option is University of Alaska job training and college courses at $15,000 a year. Our children should benefit from federally mandated, monthly face-to-face meetings with social work staff who are trained in helping youth succeed. A recent federal review of Alaska foster care says many of our youth get this support once every eight months, not monthly. That's thanks in part to chronic staff turnover, poor pay and crushing workloads at the Office of Children's Services.

It's time for new ideas that will work. That's why we, and Sen. Bettye Davis (D-Anchorage), are pushing House Bill 126 and Senate Bill 105. The bills are products of last fall's Foster Care Summit and information from experts who've advised us about reforms being pushed in other states.

So, what can we do?

• **Stop bouncing foster youth between schools:** In Alaska we bounce foster youth between schools, as they bounce between homes, too often. Moving children between schools during the school year is a proven indicator that a child will underachieve. With each disruptive mid-semester change a child can fall behind in school by another four to six months.

Federal law provides partial funding to keep youth in the same school. The state needs to act so all children can, where it makes sense, stay in their school.

• **College and job training:** Alaska provides minimal support for those who'd seek success through a degree or job training at the University of Alaska. The university and state provide a small number of tuition-only scholarships to foster youth. Beyond that, foster youth face a problem all Alaskans face -- the second-stingiest financial aid system in the nation.

Foster youth have an additional problem. Most children can call their parents when they need a place to stay or when they need support. Foster youth don't have that lifeline. We should make sure all foster youth know that if they want to go to college or get job training, we will help them with tuition, fees and a place to live. Alaska's second-worst in the nation college aid plan needs to be fixed for all youth.

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The Alaska Commission on Postsecondary Education

Health Care Services
Pharmacist
Kodiak Area Native Association

Health Care Services
RN Staff - CVIU
Providence Health and Services Alaska

Management/Professional
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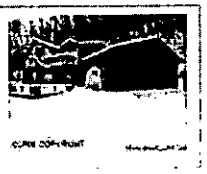

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State called to do a better job with its kids in foster care

COMPASS: Other points of view

By REP. LES GARA and AMANDA METIVIER
Published: February 22nd, 2009 06:48 PM
Last Modified: February 22nd, 2009 06:49 PM

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State called to do a better job with its kids in foster care

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It's easy to miss what's in plain sight

It's time for reform in Alaska's foster care system. Just doing the same as last year isn't working. The State of Alaska is custodian to 2,000 foster youth. We're supposed to create hope and opportunity. Instead 40 percent of Alaska's foster youth end up homeless at some point in adulthood.

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Statistics paint a picture of blocked opportunity. Foster youth are more likely than their peers to end up in jail at a taxpayer cost of $40,000 a year. The smarter option is University of Alaska job training and college courses at $15,000 a year. Our children should benefit from federally mandated, monthly face-to-face meetings with social work staff who are trained in helping youth succeed. A recent federal review of Alaska foster care says many of our youth get this support once every eight months, not monthly. That's thanks in part to chronic staff turnover, poor pay and crushing workloads at the Office of Children's Services.

It's time for new ideas that will work. That's why we, and Sen. Bettye Davis (D-Anchorage), are pushing House Bill 126 and Senate Bill 105. The bills are products of last fall's Foster Care Summit and information from experts who've advised us about reforms being pushed in other states.

So, what can we do?

• **Stop bouncing foster youth between schools:** In Alaska we bounce foster youth between schools, as they bounce between homes, too often. Moving children between schools during the school year is a proven indicator that a child will underachieve. With each disruptive mid-semester change a child can fall behind in school by another four to six months.

Federal law provides partial funding to keep youth in the same school. The state needs to act so all children can, where it makes sense, stay in their school.

• **College and job training:** Alaska provides minimal support for those who'd seek success through a degree or job training at the University of Alaska. The university and state provide a small number of tuition-only scholarships to foster youth. Beyond that, foster youth face a problem all Alaskans face -- the second-stinglest financial aid system in the nation.

Foster youth have an additional problem. Most children can call their parents when they need a place to stay or when they need support. Foster youth don't have that lifeline. We should make sure all foster youth know that if they want to go to college or get job training, we will help them with tuition, fees and a place to live. Alaska's second-worst in the nation college aid plan needs to be fixed for all youth.

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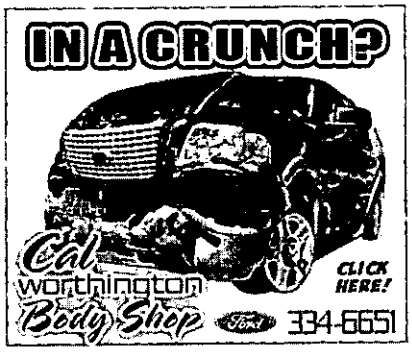

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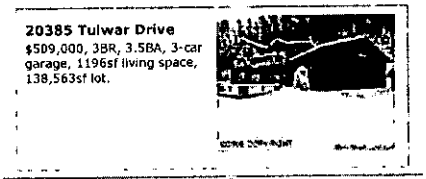

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Lynda Zaugg

From: Katie Conway
Sent: Monday, February 23, 2009 7:38 AM
To: Don Burrell; Lynda Zaugg
Subject: RE: Foster Care conference March 20th?

Thank you Don! Lynda, as soon as you know what the time parameters are for the March 20th meeting please let me know. I'm eager to set the agenda so the participants know exactly how much time they have for presenting, and so they can more confidently arrange their air travel.

Thank you both!
Katie

Katie Conway
Staff to Representative Les Gara
State Capitol Room 500, Juneau, AK 99801
Phone: (907) 465-6591
Fax: (907) 465-3518

From: Don Burrell
Sent: Sunday, February 22, 2009 7:21 PM
To: Katie Conway
Cc: Lynda Zaugg
Subject: RE: Foster Care conference March 20th?

Now that we have a positive date, I've discussed extending the hearing time to 2 hours as requested with Senator Davis and Lynda Zaugg, the H.S.S. Committee Aide. I suggested to Lynda that we might try and start the meeting earlier rather the run it later. I'm for sure the Senate Resources committee will be meeting in full force in March and there will be very little chance they will allow us to cut into their meeting time, which begins at 3:30. Follow up with Lynda to see if 1pm could work, scheduling-wise and I think everything will work fine to confirm the meeting once that's completed.

Thanks!!!

Don Burrell Jr.
Legislative Aide
Office of Senator Bettye Davis
State Capitol Building, Rm. 30
Juneau, Alaska 99801
P 907-465-3822
F 907-465-3756
don_burrell@legis.state.ak.us

From: Katie Conway
Sent: Saturday, February 21, 2009 3:21 PM
To: Don Burrell
Subject: Foster Care conference March 20th?

Hi Don,

I canvassed the potential participants for the mini Foster Care conference our bosses spoke about. I think everyone can make it that day, March 20th, including OCS, FFCA, Casey Family Programs, and others. Now we need to find out the time so they can book travel and we can figure out how much time each presentation would be allotted. Ideally, we'll have two hours for the entire thing. When we put on the full-day foster care conference this fall in Anchorage the presenters had a much longer amount of time to present, and the audience (including many legislators) had a longer amount of time for asking questions. Limiting us to two hours will already be a stretch. I think anything less than that will be quite challenging, though I understand the scheduling will be hard. Please let me know as soon as you do the time available for this event so I can work with the participants on finalizing an agenda.

Thanks!
☺

Katie Conway
Staff to Representative Les Gara
State Capitol Room 500, Juneau, AK 99801
Phone: (907) 465-6591
Fax: (907) 465-3518

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Lynda Zaugg

From: Apache [apache@wwwjnu02.legis.state.ak.us]
Sent: Thursday, March 19, 2009 10:55 AM
To: LIO Juneau; Peg Warren; Lynda Zaugg
Subject: Teleconference Order Form

Meeting: new

Sponsor and/or Committee Name: Sen H&SS

Date of Teleconference: 3/23/09

Start Time: 1:30

End Time: 3:00

Chairing Site: Juneau Capitol Building

Juneau Room: #205

Testimony: yes

Testimony Time Limit: other - see instructions

Executive Session: no

Contact Person: Lynda Zaugg

Telephone Number: 465-4906

Email Address: lynda_zaugg@legis.state.ak.us

LIO Sites:

anchorage
fairbanks

Other sites may add: yes

Offnet Name(s):

Subject of meeting and/or Bills on Agenda:

Joint meeting with Sen. Judical
Presentation: Alaska Internet Crimes Against Children Task Force, Detective Ron Tidler, Anch. Police Dept.
(Invited Testimony only)

- Sergeant Derek DeGraaf
- Alaska State Troopers
- Alaska Bureau of Investigation (ABI)
- Computer and Financial Crime Unit (CFCU)
- Anchorage

Alaska State Troopers

- Current Status of Alaska Internet Crimes Against Children (ICAC) Task Force participation
- Specifically, the Computer and Financial Crime Unit (CFCU)

Top Issue for ICAC

- Alaskan's Accessing and Distributing Child Pornography with File Sharing Software (Peer to Peer Network)
- Limewire, Bearshare, Phex

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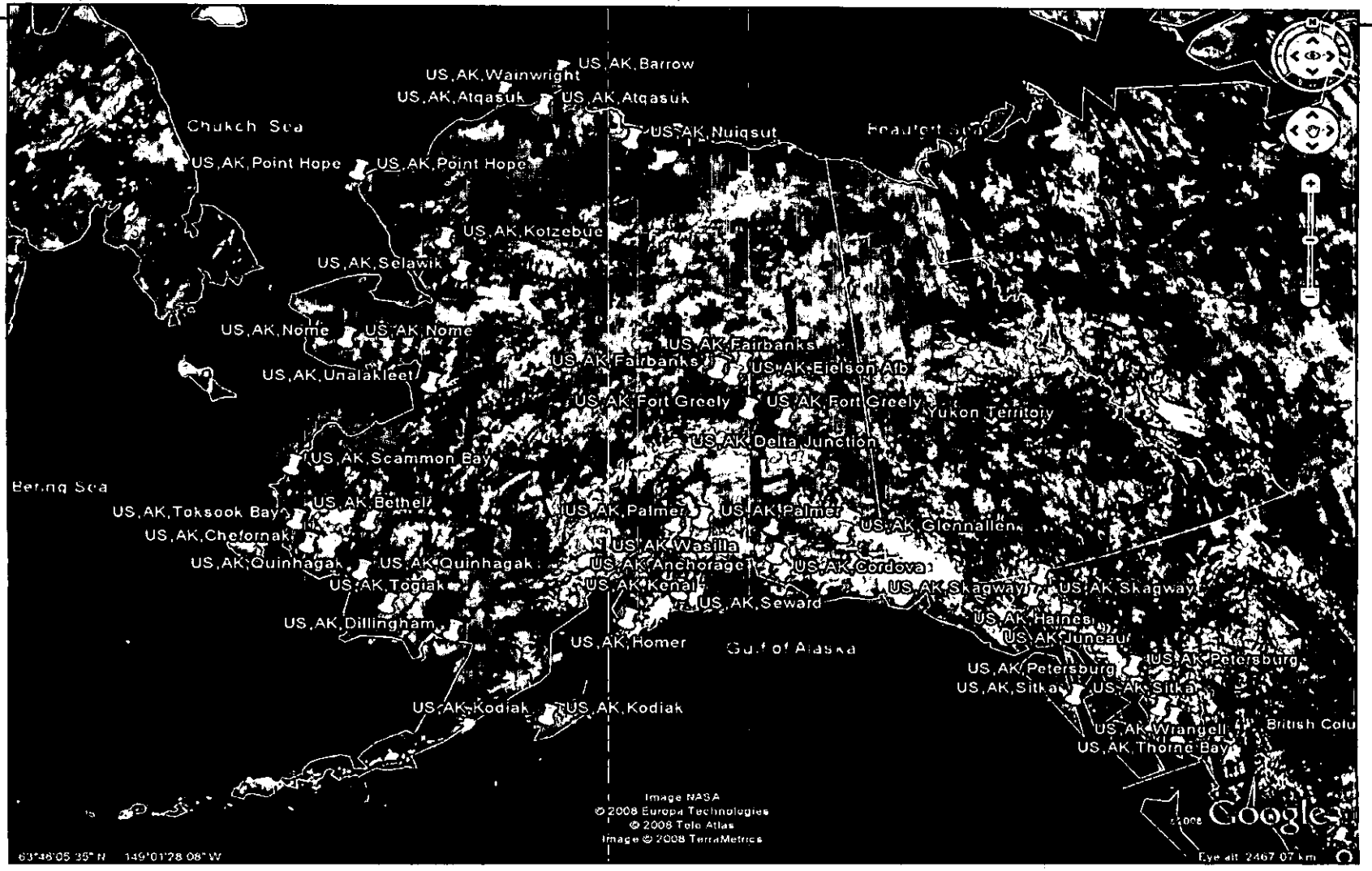
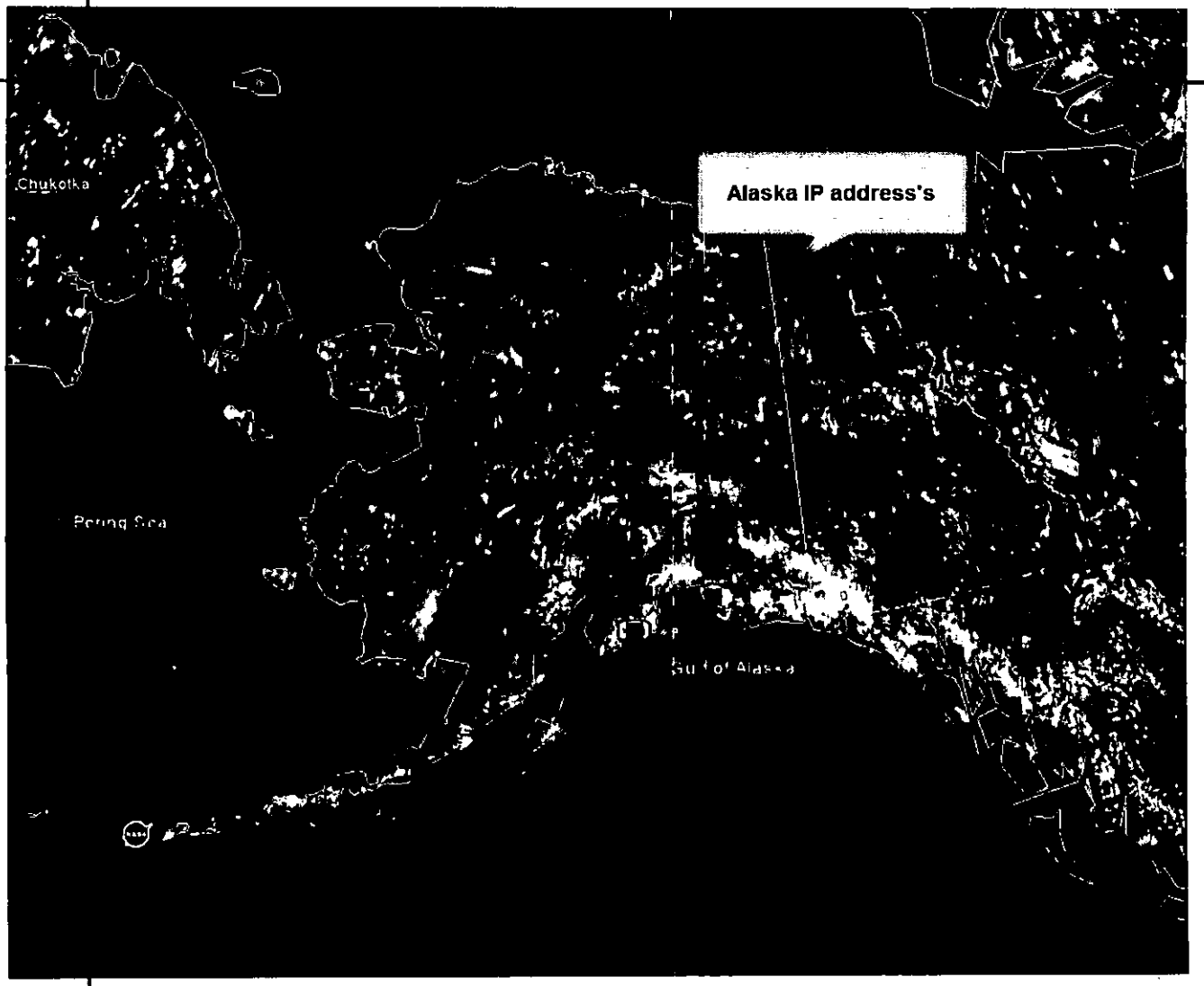
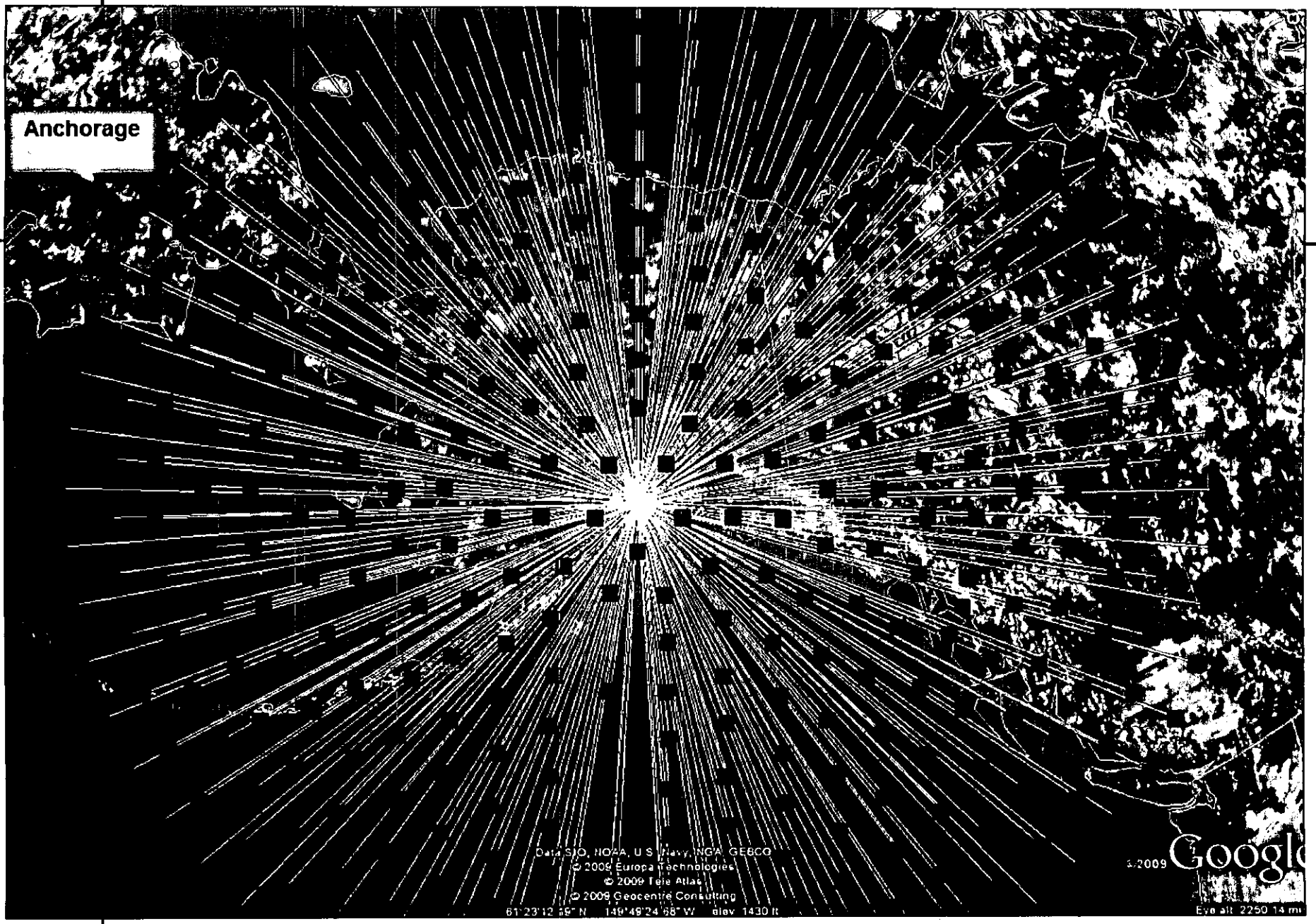
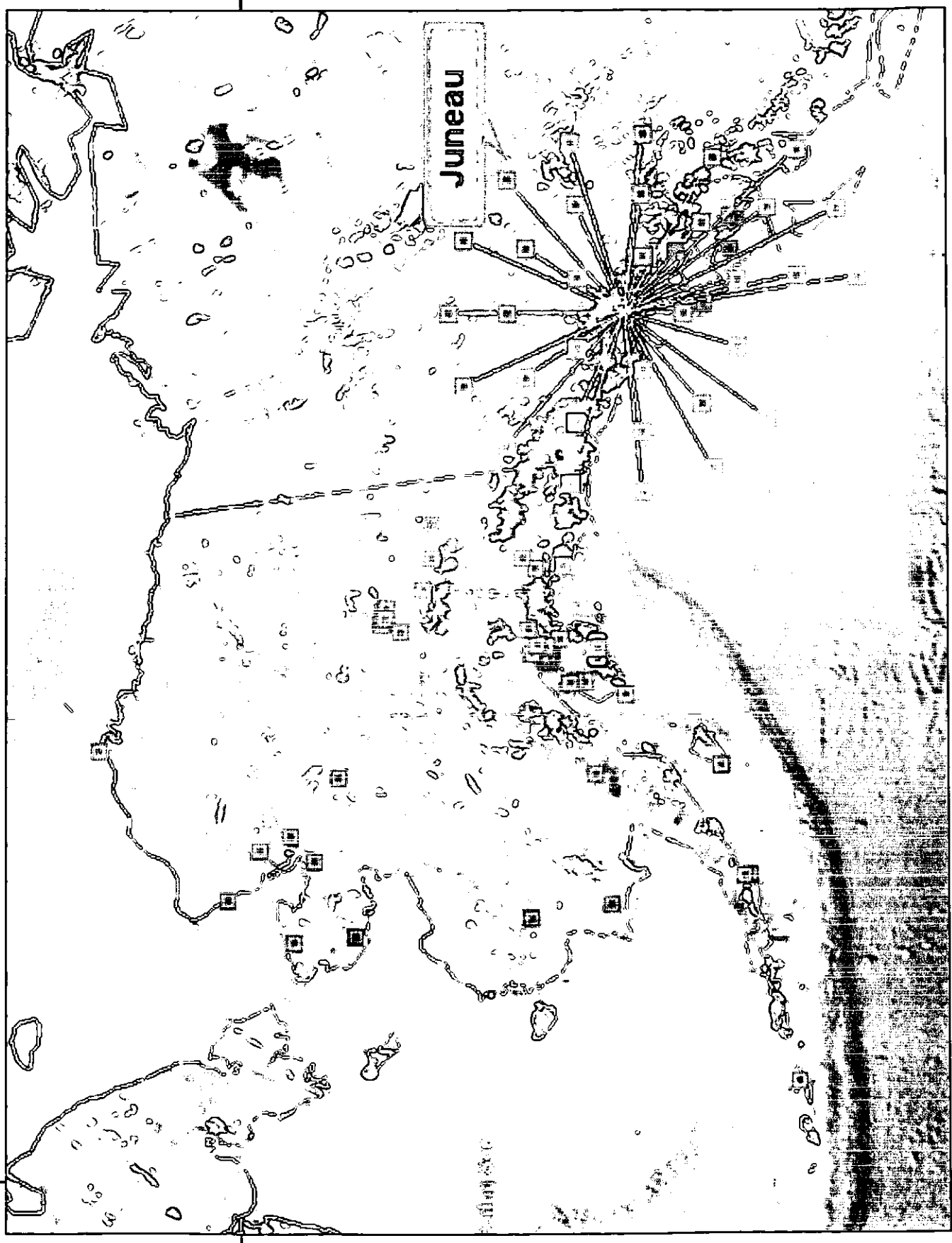


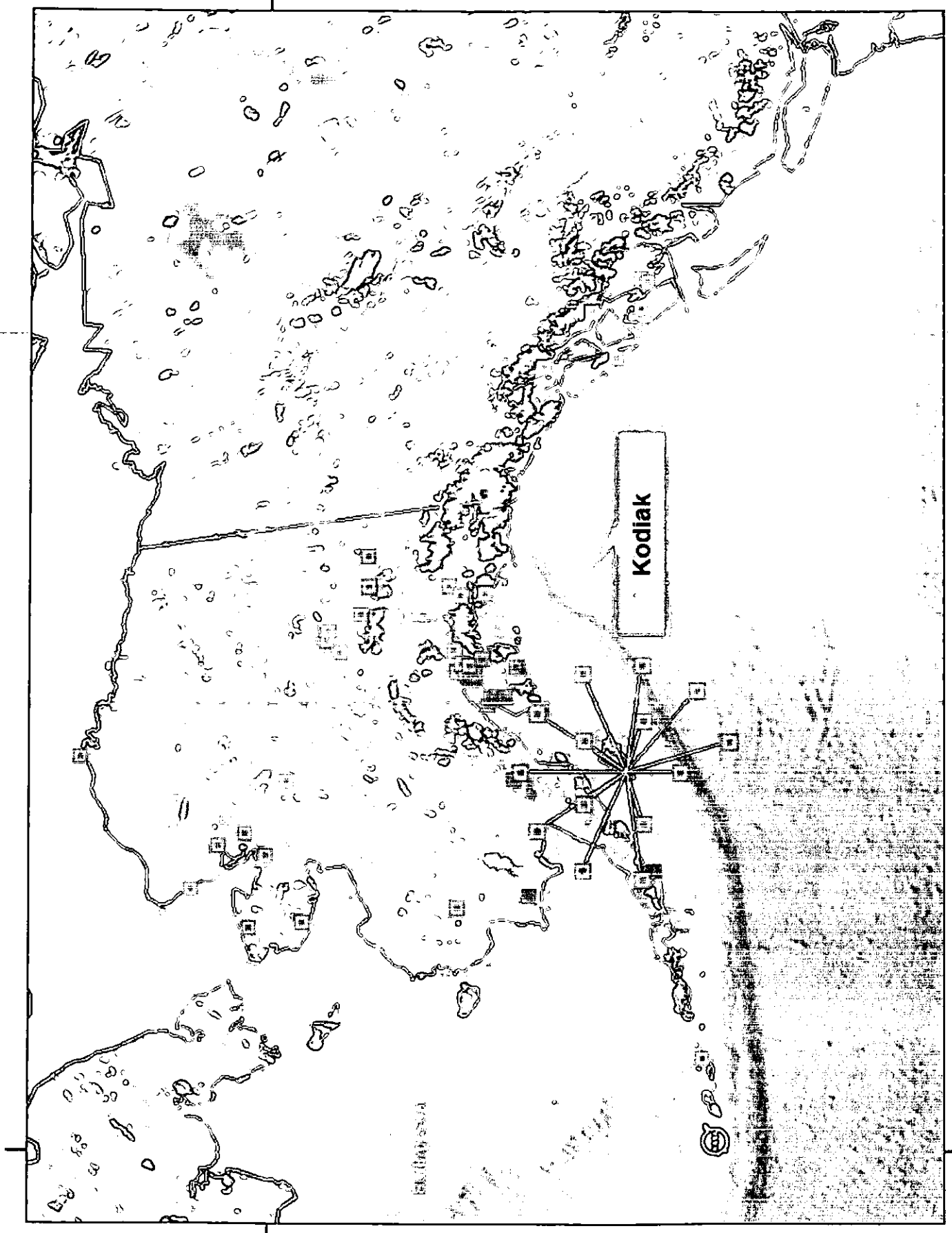
Statewide Problem




Anchorage
Data SIO, NOAA, U.S. Navy, NGA, GEBCO
© 2009 Europa Technologies
© 2009 Tele Atlas
© 2009 Geocentre Consulting
61°23'12.59" N 149°49'24.68" W elev 1430 ft
Eye alt 2250.14 mi

Fairbanks


Juneau


Kodiak

Barrow
Gulf of Alaska

- Thousands of leads available to LE
- NCMEC Leads
- Small Police Departments

Computer and Financial Crime Unit Issues

Two different Missions

- 1. Computer Crime
- 2. Financial Crime

One Sergeant (Trooper)

Two Investigators (Trooper)

Two Long Term Non-Perm positions (recently funded by Legislature)

- CFCU expected to cover the entire State of Alaska and investigate all Financial Crime and Technology related offenses
- Expected to provide assistance to smaller Police Agencies
- Expected to Provide training and support
- Few "white collar" or "corruption" cases are actually being worked due to case load

AST Response to ICAC Task Force

- Joined Internet Crimes Against Children Task Force last year
- Co-Located with Federal Agents, to include ICE, soon with FBI & USPIC
- Investigators trained in Peer to Peer Investigations, Forensics
- Recently hired one new investigator and one criminal justice tech II because of Legislature funding

- Invested heavily in Computer Forensic training to increase competency
- Invested heavily in equipment, to include software, forensic computers, cell phone analysis tools, server storage of evidence
- Conducted multi-agency search warrants
- Public Education, presentations
- Partnered with small police departments to provide assistance and training

Results

CFCU Computer Examinations

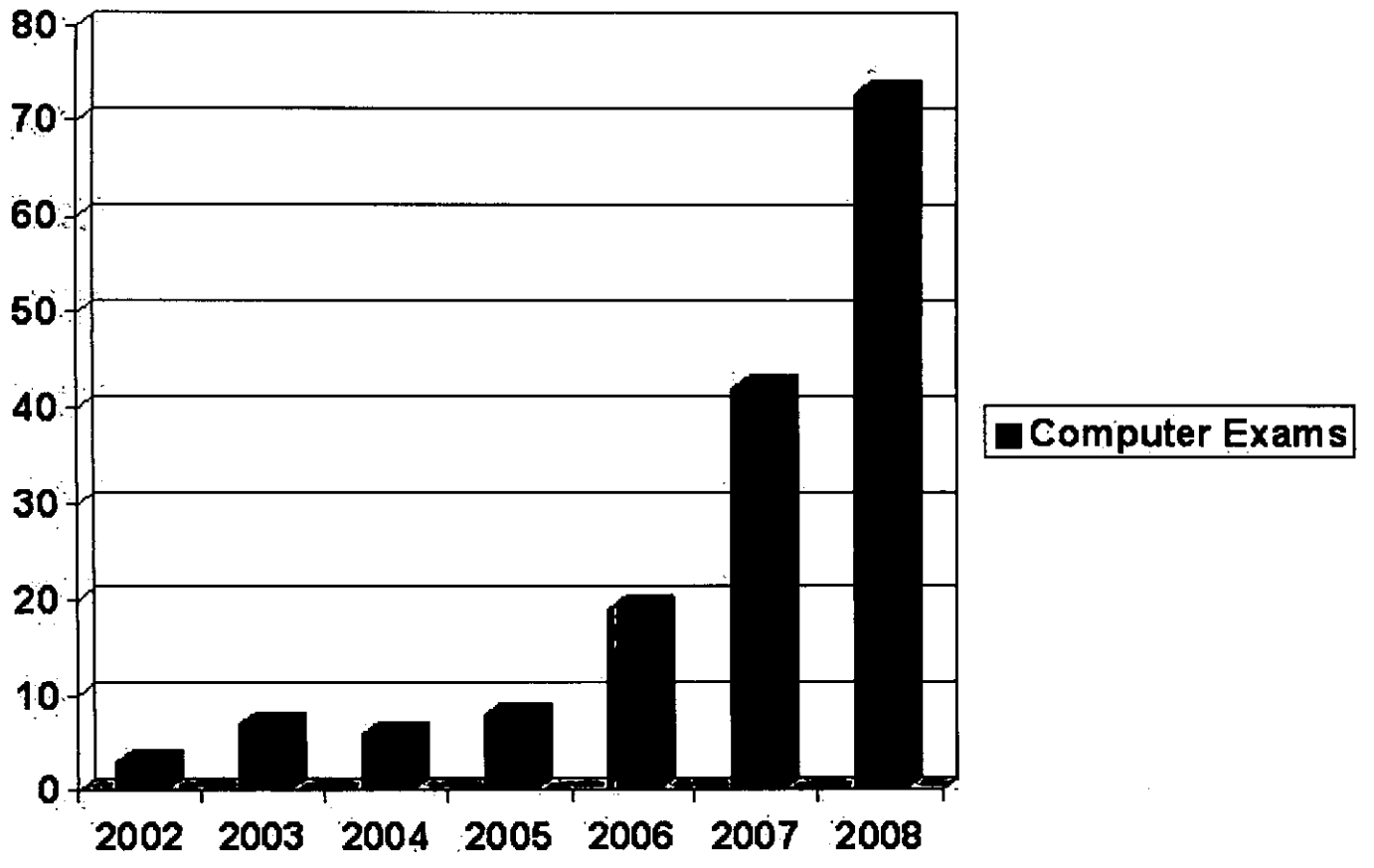
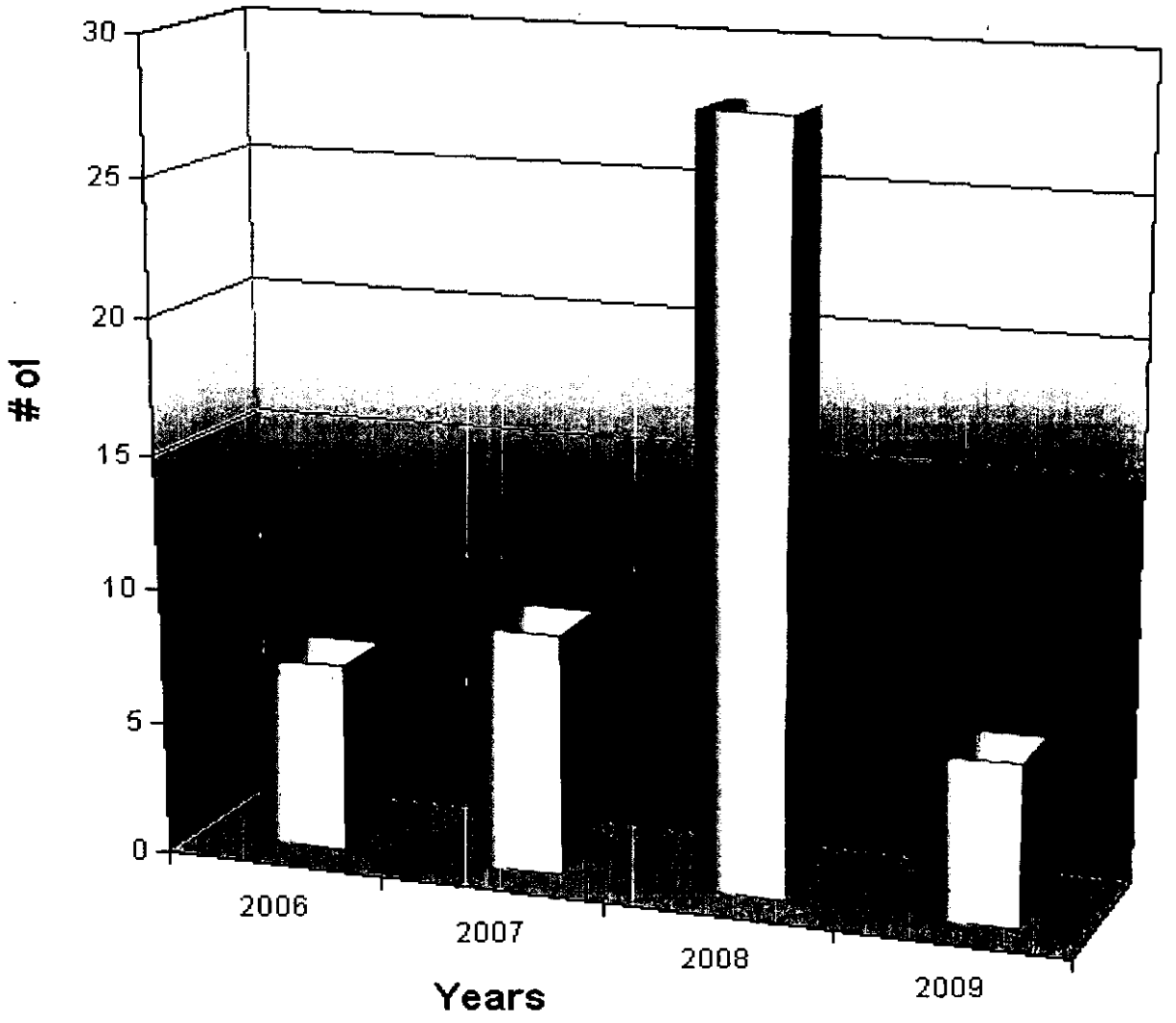


Chart Area

Child Pornography/ICAC cases within ABI CFCU
January 1, 2006 - March 19, 2009
Source: APSIN, 2009



- 400% increase in Child Exploitation Cases being investigated between 2006-2008
- We found the tip of the iceberg
- Problem is growing exponentially

Successes

- NCMEC tip received by ABI for Palmer resident
- Defendant was arrested for distributing and possessing child pornography images
- Investigators found defendant was taking pictures with telephoto lens of neighbor children
- Recently sentenced to 12/4 years (8 years)

- Talkeetna man, a registered sex offender was found to be chatting on-line through game with 13 Y.O. in CA
- He was grooming victim
- He was previously arrested by APD for Child Pornography possession
- ABI found more Child Pornography, continued behavior

- Soldotna man, was arrested for possessing CP images, was found to be actively abusing autistic boy
- What cases are falling through the cracks?

What is needed?

- Additional support for more ABI Investigators, including Forensic Computer Examiners
- Separate Financial Crime and Computer Crimes Units
- More directed response to rural residents of Alaska, they are not being adequately represented by LE

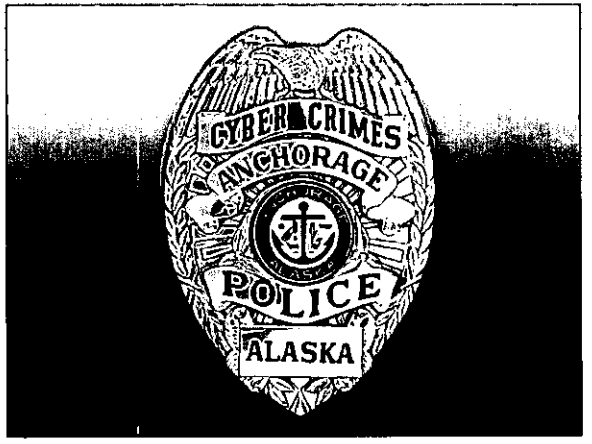
Conclusion

- ICAC is very necessary
- Co-location of agencies is key
- We are headed in the right direction
- We must continue to protect Alaska's children with pro-active investigation
- More Investigators are required
- Disparity of LE response to Rural residents
- We are not there yet…

Questions?

- Derek.DeGraaf@alaska.gov
- 907-271-3220

Alaska Internet Crimes Against Children Task Force 2008



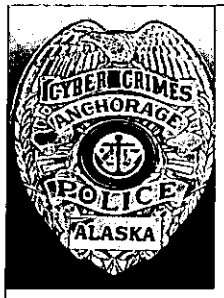
Det. Sgt. Ron Tidler
APD Cyber Crimes Unit

Det. Sgt. Tidler Bio

- 1991- Reserve Police Officer Anchorage Police Dept.
- 1993- Patrol Officer- APD
- Mt. View CAP Team; FTO; Gang Task Force; Level One Commercial Motor Vehicle Inspector; FBI Certified Bomb Technician
- 2003- Promoted Patrol Sgt.
- 2004- Transferred to Detectives. Supervised Crime Investigation Unit- which later became VICE Unit; Supervised Burglary Unit.
- 2006- assisted with formation of Cyber Crimes Unit
- 2007- Cyber Crimes Unit officially created- assigned as Supervisor.

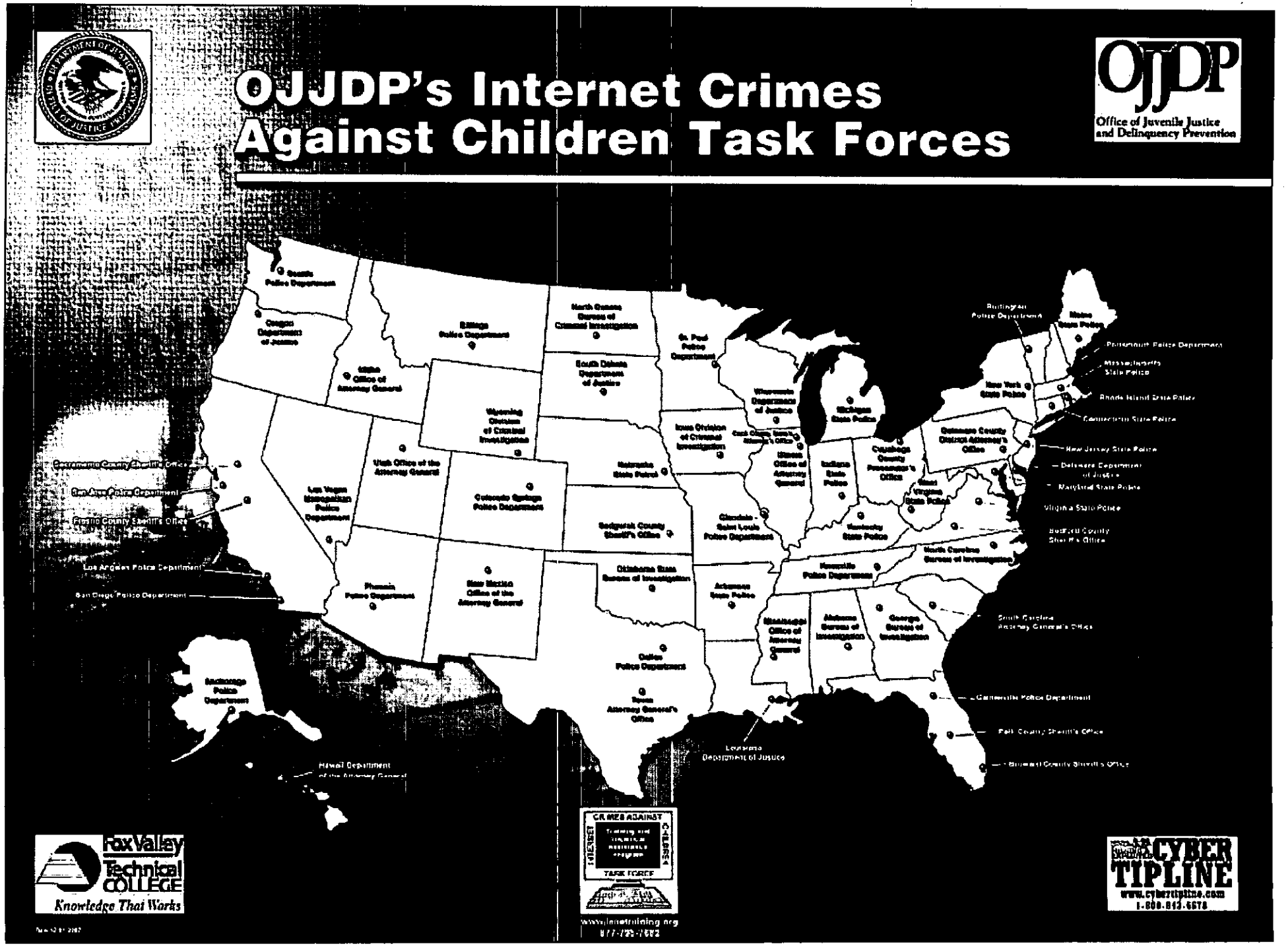
APD Cyber Crimes Unit

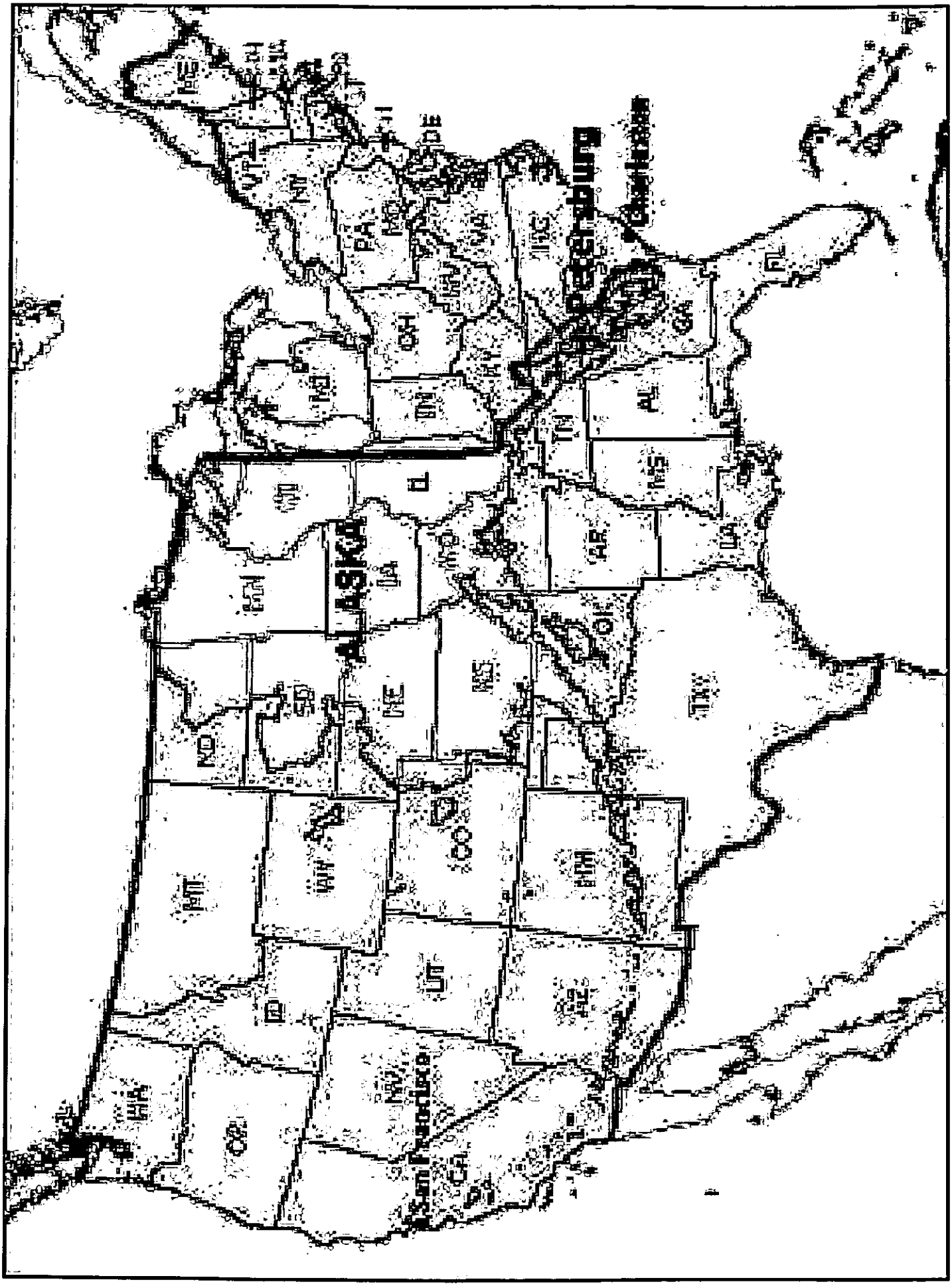
- 2002-2005- several Detectives working with the Financial Crimes Unit and Crimes Against Children Unit receive training in Computer Forensics and On-line Peer to Peer training.
- 2006-2007- 5 Detectives are relocated to one small office- 3 forensic examiners; two online investigators.
- 2007- Cyber Crimes Unit officially created with a Supervisor assigned. Larger office space.
- Current staffing: 6 team members:
  - 1 Supervisor
  - 1 dedicated forensic examiner;
  - 1 on-line / cell phone examiner;
  - 1 on-line investigator;
  - 1 on-line / forensic examiner;
  - 1 forensic examiner- On military deployment since 12/07



Rise of the ICAC

- 1998 Office of Juvenile Justice Department (OJJDP) initiates Internet Crimes Against Children Taskforce (ICAC)- 16 Task Forces created.
- Assists law enforcement in developing effective response to online sexual victimization of children.
- 2004- Alaska is an affiliate of the Seattle ICAC.
- 2005- Alaska Investigators trained on P2P.
- 2006- $50,000 is designated for Alaska Affiliates.
- 2007- APD awarded $300K 18 month Grant-
- 2008- Alaska ICAC TF created.


OJJDP's Internet Crimes Against Children Task Forces
OJJDP
Office of Juvenile Justice and Delinquency Prevention
Alaska State Troopers
Oregon Department of Justice
Idaho Office of Attorney General
Billings Police Department
North Dakota Bureau of Criminal Investigation
South Dakota Department of Justice
St. Paul Police Department
Wyoming Division of Criminal Investigation
Utah Office of the Attorney General
Nebraska State Patrol
Iowa Division of Criminal Investigation
Colorado Springs Police Department
Las Vegas Metropolitan Police Department
Sedgwick County Sheriff's Office
Phoenix Police Department
New Mexico Office of the Attorney General
Oklahoma State Bureau of Investigation
Dallas Police Department
Texas Attorney General's Office
Arkansas State Police
Louisiana Department of Justice
Mississippi Office of Attorney General
Alabama Bureau of Investigation
Georgia Bureau of Investigation
Florida Department of Law Enforcement
Hawaii Department of the Attorney General
Anchorage Police Department
Sacramento County Sheriff's Office
San Jose Police Department
Fresno County Sheriff's Office
Los Angeles Police Department
San Diego Police Department
Michigan State Police
Wisconsin Department of Justice
Illinois Office of Attorney General
Indiana State Police
Ohio Attorney General's Office
Cuyahoga County Prosecutor's Office
Kentucky State Police
Knoxville Police Department
West Virginia State Police
Delaware County District Attorney's Office
New York State Police
Buffalo Police Department
Rochester Police Department
Pennsylvania State Police
Massachusetts State Police
Rhode Island State Police
Connecticut State Police
New Jersey State Police
Delaware Department of Justice
Maryland State Police
Virginia State Police
Bedford County Sheriff's Office
North Carolina Bureau of Investigation
South Carolina Attorney General's Office
Gainesville Police Department
Polk County Sheriff's Office
Broward County Sheriff's Office
Fox Valley Technical College
Knowledge That Works
CRIMES AGAINST CHILDREN
TASK FORCE
www.ojjdptraining.org
877-706-7602
CYBER TIPLINE
www.cybertipline.com
1-800-843-5678


ALASKA

North America at Night

Alaska ICAC Federal Partners

- USAAK- Administrates PSC Program in Alaska; hosts TF Meetings; training; advice; Victim coordinator program.
- I.C.E. – resident agents; provides area for ICE and ABI to work together; pooling resources; joint investigations; foreign country investigation facilitation.
- FBI- Investigates; facilitates training / equipment; victim coordinator.
- US Postal Inspectors
- Military Investigators – AF OSI; Army CID; USN; & Coastguard

Alaska State Affiliates

- Alaska Bureau Investigations- Anchorage and Fairbanks based Investigators
- Dept. Of Corrections- Adult Probations Office- Sex Offender Unit- Several P.O.'s trained
- District Attorney's Offices- several prosecutors from various offices.
- University Of Alaska- Anchorage PD- facilitates training and meetings.
- University Of Alaska- Fairbanks PD- trained investigator

Local Affiliates

- Fairbanks Police Department- 1 investigator
- Kodiak Police Department- 1 investigator
- Sitka Police Department- 1 investigator
- Kenai Police Department- 1 investigator
- Soldotna Police Department- 1 investigator
- Unalaska Police Department- 1 investigator
- Juneau Police Department- 1 investigator

2008 Reported Statistics

Enter Name/Task Force:	Please submit stats form via e-mail by the 6th of each month.	Year: 2008	Page 1
ALASKA			

Monthly Measures			Jan	Feb	March	April	May	June	SA1	July	Aug	Sept	Oct	Nov	Dec	SA2	YTD
Documented Complaints	Traveler	Proactive	1						1								1
		Reactive			1		1	3	5	1				1		2	7
	Enticement	Proactive	4		1		1		6	3						3	9
		Reactive		1	1		1		3	1	3		1	1	3	9	12
	Obscenity Directed to Minors	Proactive	3		2				5	2	2					4	9
		Reactive					1	1	2	1	2				1	4	6
	Child Prostitution	Proactive						1	1	1				2		3	4
		Reactive											1	1	1	3	3
	Child Pornography — Manufacture	Proactive															
		Reactive											1			1	1
	Child Pornography — Distribution	Proactive	5	5		2		1	13					1		1	14
		Reactive	5	3	4	1		2	15	2	4	1	1	1	1	10	25
	Child Pornography — Possession	Proactive	4	1	1	4	3	4	17	1		1	1	2		5	22
		Reactive	7	9	8	4	4	2	34	6	4	6	3	2	8	29	63

Enter Name/Task Force: ALASKA	Please submit stats form via e-mail by the 6th of each month.	Year: 2008	Page 2

	Monthly Measures		Jan	Feb	March	April	May	June	SA1	July	Aug	Sept	Oct	Nov	Dec	SA2	YTD
Case Information	Arrests		7	2	2	2	4	1	18	1	2	3		1	3	10	28
	Case Dispositions	Unfounded	1	2		1	3	1	8	1	2		2	3	2	10	18
		Suspended	2	2		4	3		11	2	6	2	1	2		13	24
		Plea	1		2			2	5		1		1		1	3	8
		Trial					1		1		1				1	2	3
	Case Referrals	Federal				2	1		3		2					2	5
		State	8	4	4	2	2	3	23	1			1	1	2	5	28
		Local								3	2				2	7	7
	Submitted for Federal Prosecution				3			1	4			1				1	5
	Accepted for Federal Prosecution				3				3								3
	Submitted for State Prosecution		5	4	2	2	3	1	17	3	2	2	1		3	11	28
	Accepted for State Prosecution		5	4	2	2	3	1	17	3			1		3	7	24
Goals	Cybertips Received*		8	5	2	1	4	1	21	17	4	2	2	4	6	35	56
	CVIP Submissions (Cases)*		2	1	5			3	11	2	1		2			5	16
	Affiliated Agencies Added*		2		6	3	1	3	15					1		1	16
	Child Victims Identified	CVIP												1	1	2	2
		Cases*												1	1	2	2
Court Actions	Subpoenas or Court Orders	Federal			1	4		4	9	3	2	1	2	5		13	22
		State/Local										1				1	1
	Search Warrants	Federal		2		1		1	4		2	1				3	7
		State/Local	17	7	16	7	13	9	69	8	6	5	3	2	11	35	104

Enter Name/Task Force: ALASKA	Please submit stats form via e-mail by the 6th of each month.	Year: 2008	Page 3

Monthly Measures		Jan	Feb	March	April	May	June	SA1	July	Aug	Sept	Oct	Nov	Dec	SA2	YTD
Technical Assists	Technical Support	7	3	7	3	1	1	**22**	2	3	4	6	3	13	**31**	**53**
	Forensic Exams	27	8	21	9	11	8	**84**	5	20	12	15	17	24	**93**	**177**
Training	Training Sessions Provided	1		6		1	4	**12**		5		2	8	1	**16**	**28**
	Law Enforcement Trained	1	7	301	3	22	42	**376**		115		1	6		**122**	**498**
	Prosecutors Trained									6	1	241			**248**	**248**
	Other Professions Trained						15	**15**	1	85			302	20	**408**	**423**
	# Sent to ICAC T&TA Trng		1					**1**	1	1	13		1	1	**17**	**18**
	# Sent to Other Training				5		1	**6**	1	4	2		9		**16**	**22**
Community Outreach	**Presentations**	17	8	20	10	14	6	**75**	3	5	3	4	13	5	**33**	**108**
	Number of Attendees	880	566	746	289	393	80	**2954**	150	407	120	268	1107	665	**2717**	**5671**
	Public Events	1		3	2			**6**	1		1				**2**	**8**
	Number of Attendees	100		15	396			**511**	6						**6**	**517**
	Public Awareness	1		1	1			**3**	4	4					**8**	**11**
TF	**Sex Off. Home Visits**	10	5	6	7	10	12	**50**	38	36	28	20		51	**173**	**223**
	Sex Off. Comp Searches	3	1			1	4	**9**	4	1	3	2		7	**17**	**26**
	Cyber Bullying									2					**2**	**2**

Adult Probations

- Sex Offender Home Visits
- Probations Officers trained in capturing data from computers, via a thumb drive installed software.
- For 2008- 223 Home visits conducted
- For 2008- 26 computers searched

Internet Undercover Investigations Training

- Jan 2005 Seattle WA
- Classroom Experiences
- Webcams
- Internet has made our world much smaller.....
- No laws in AK...until 11-28-2005

Legislative Response

- SB 140 signed into law 8/30/2005 effective date 11-28-2005
- AS 11.41.452 Online Enticement of Minor
- AS 11.61.128 Electronic Distribution of Indecent Material to Minors

AK ICAC TF Training

- American Prosecutors Research Institute conducts SAFETY NET training at Microsoft Headquarters in Redmond, WA.
- Team based training class combining Investigator; Examiner; and Prosecutor.
- AK ICAC Team comprised of APD Cyber Crime Examiner; A.B.I. Investigator; and Asst. D.A. for Prosecutor.
- Part of the training included mock courtroom settings with participants having to present evidence and instruct juries on such topics as Internet Chatting and File Sharing.

Training Results

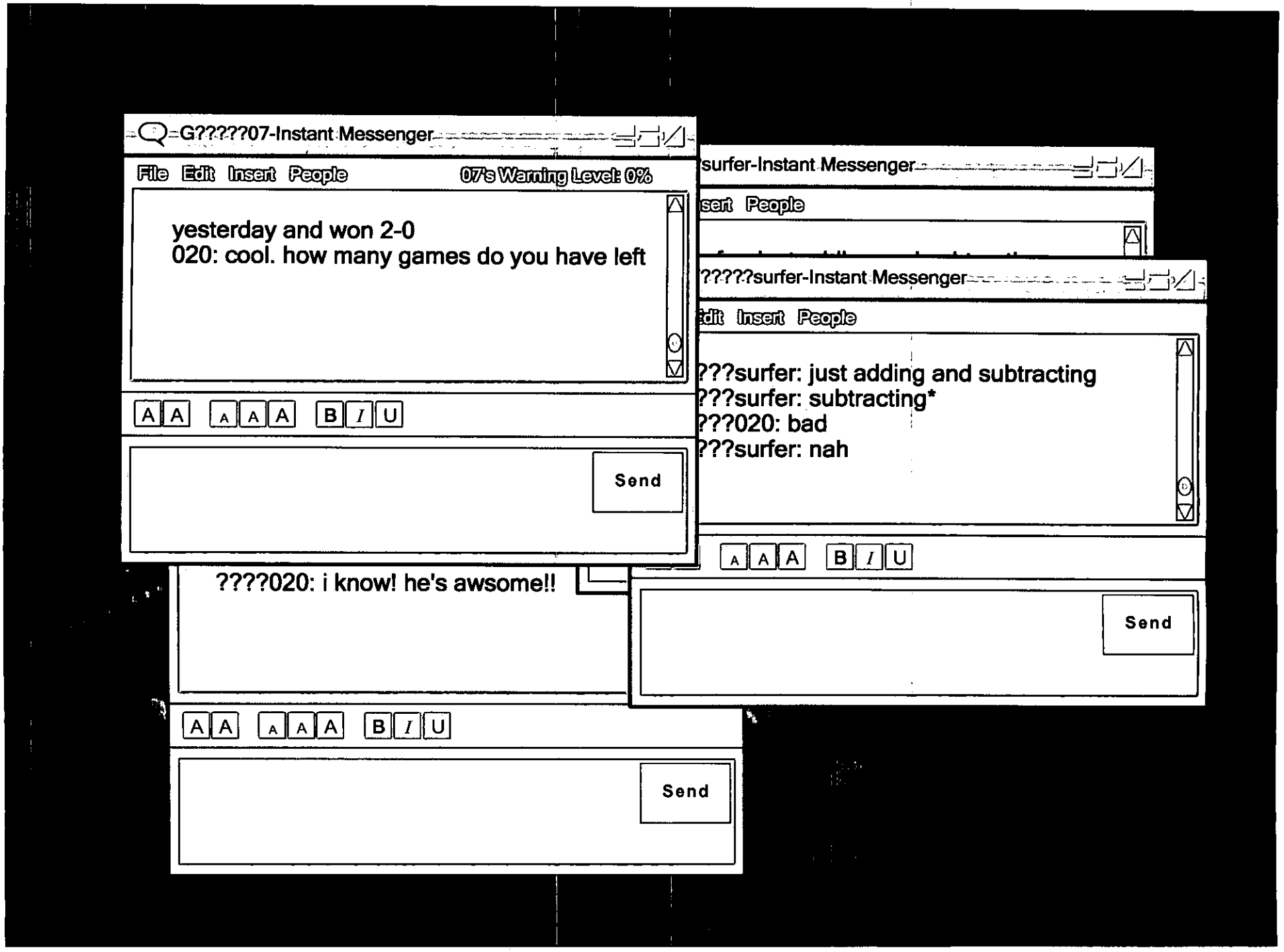
- First conviction by a jury under Alaska's On-line Enticement Statute.
- Suspect had solicited minors- under the age of 16- for sex, and had electronically transmitted Indecent Images to the minors. The minors were actually undercover APD Investigators.
- 12/8/08- James Clifton Moore-age 42- was convicted by an Anchorage Jury - Moore was found guilty on two counts of Online Enticement of a Minor and one count of the Electronic Distribution of Indecent Material to a Minor.
- ADA Prosecutor Aaron Sperbeck and the lead investigator had attended recent training in Redmond, WA, for courtroom presentations.
- Significant fact discussed during the proceedings: Investigators were following National ICAC Guidelines designed to catch online predators.

Where Did This Sexual Solicitation Occur?

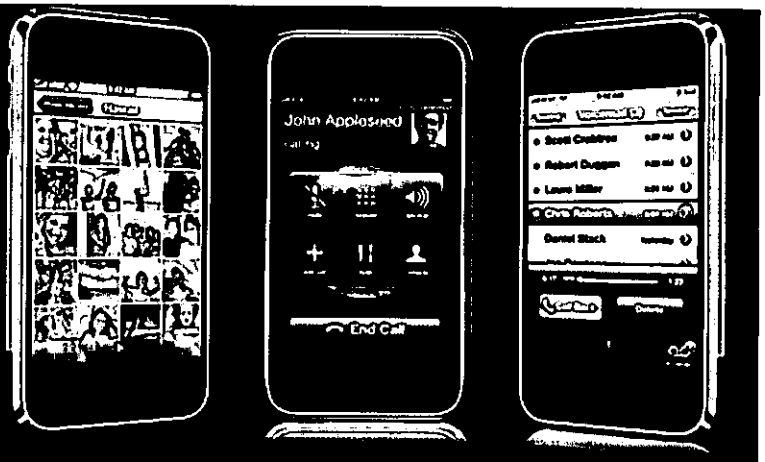
- Computer Location
  - 70% at home
  - 22% at someone else's home
  - 4% at school
  - 3% at library
- Internet
  - 65% in chatrooms
  - 24% in Instant Messages

Messengers

- AOL® Instant Messenger™ Service, ICQ Instant Messenger, Yahoo!® Messenger, MSN Messenger
- Online Internet "buddy" locators
- Allow file transfer, chat, and messaging
- Voice and video chat


G?????07-Instant Messenger
File Edit Insert People
07's Warning Level: 0%
yesterday and won 2-0
020: cool. how many games do you have left
A A A A A B I U
Send
surfer-Instant Messenger
sert People
?????surfer-Instant Messenger
dit Insert People
???surfer: just adding and subtracting
???surfer: subtracting*
???020: bad
???surfer: nah
A A A A A B I U
Send
????020: i know! he's awsome!!
A A A A A B I U
Send

Cellular Telephones



- Easy Access to the Internet
- Share and post digital photographs
- Send and receive text messages

Dynamics of a Peer 2 Peer Investigation

- Investigator goes online with proper training and equipment.
- Identifies Alaska based suspect who is actively sharing suspected Child Sexual Exploitation images.
- Records and downloads the images.
- Obtains Search warrant for identifying suspect from ISP.
- Conducts surveillance / field work on suspect.
- Obtain search warrant for suspect residence / work / interview.
- Plan / prepare / execute search warrant- seize evidence.
- Conduct forensic examination of digital media- sometimes this is done in field, at suspect's location.
- Analyze data- submit to NCMEC CVIP program.
- Consult with DA / AUSA for appropriate charges.
- Arrest and prosecute Suspect.

Peacock Case Study
APD #08-26835

- **6/13/08-** Anchorage Investigator generated a new Peer To Peer case involving an Alaskan suspect actively sharing child pornography on the internet.
- **6/20/08**- Anchorage Investigator continues to work up the Peer-to-Peer file sharing case, with the suspect, **JESS PEACOCK, Age 24,** identified in Barrow. **PEACOCK** works on the Slope at Kuparak Oil Field. Working directly with Conoco Phillips, transportation is secured from Anchorage to Kuparak for a search warrant. North Slope Police Department is contacted for assistance conducting the Barrow residential Search warrant.
- **6/27/08**- Two Anchorage Investigators travel to Kuparak Oil Field Camp on the North Slope, courtesy of Conoco Philips transportation. Suspect is contacted, and after some initial denials, when confronted with his documented online activity, he provides a detailed confession. PEACOCK'S laptop computer was discovered in his sleeping quarters, turned on and actively downloading and sharing Child Pornography titled internet files, while he worked his shift. North Slope Borough PD served a search warrant at PEACOCK'S home in Barrow, resulting in over 75 items of evidence being seized, and shipped to Anchorage. Conoco Phillip's has expressed that they were impressed with the professionalism displayed by the Investigators.

Peacock Case Study Continued…

- **08/08/08**- Investigators conduct computer forensics on the seized evidence.
- **08/22/08**- Forensic component is completed. Investigators now coordinate with ADA Rural Prosecutor.
- **09/05/08- Charging documents filed on Peacock.**
- **12/5/08-** JESS PEACOCK- accepts Plea Deal 6 years 4 suspended- one count Possession of CP.
- **3/4/09**- Peacock sentenced.

Traveler Case

Danny M. Harvey- 47yo

California man faces 55 years in prison

- The Associated Press
- November 23rd, 2008 12:13 AM
  A federal jury has convicted a California man who faced several child exploitation charges.
- Federal prosecutors say Danny Michael Harvey, of Lancaster, Calif., was convicted of: attempted aggravated sexual abuse, which carries a mandatory minimum 30 years in prison; attempted manufacture of child pornography, carrying a maximum term of 15 years in prison; and possession of child pornography, carrying an additional maximum term of 10 years in prison.
- Prosecutors say Harvey came to Alaska intending to sexually abuse a 5-year-old girl.
- The girl was the fictitious granddaughter of a federal agent posing as a grandfather with sole custody.

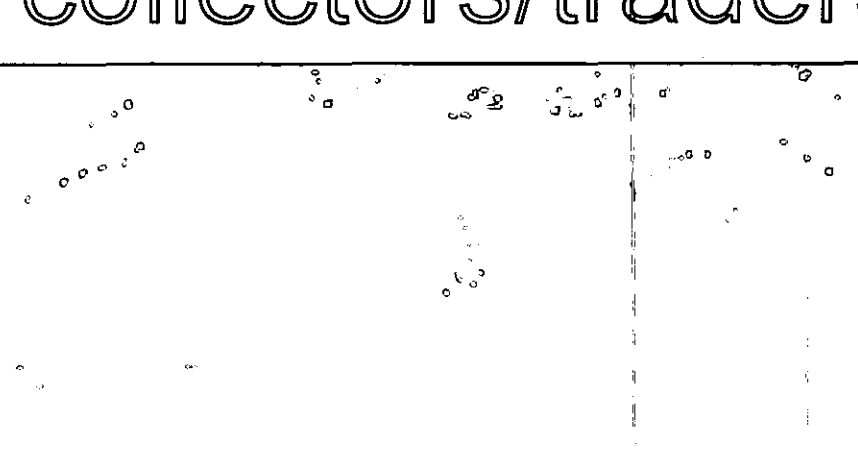
2009 Considerations

- Mobile Internet Devices
- Sexting
- Public Safety Administration in several Local agencies currently are limiting availability of personnel to attend training, and also conduct proactive investigations, based on personnel shortages.

Alaska ICAC Task Force monthly meetings

- Hosted by the Assistant US Attorney's Office in Anchorage.
- Monthly meetings where ICAC members can also attend telephonically.
- Case review; educational opportunities; industry trends; and requests for assistance are conducted.
- Pooling limited resources to target challenges faced by investigators and prosecutors.

Do we have child porn collectors/traders in Alaska?



Challenges

- A study conducted by APD Cyber Crimes Detectives showed that in January of 2008, there were over 5,000 Internet Protocol (IP) addresses in Alaska, that had suspected known images of Child Pornography.
- In January of 2009, the number has increased to over 11,000 IP addresses unique to Alaska.
- A recent study documented by the Federal Government (Hernandez Study) of convicted sex offenders showed that over 80% of persons arrested for possession of Child Pornography had already committed an undisclosed contact Child Sexual Abuse. The nature of the investigations alone demand attention by Law Enforcement.

Alaska has highest per-capita usage of Internet

State	Internet	PC
Alaska	68.5%	73.4%
Utah	62.6%	74.1%
N.H.	65.5%	71.7%
WA	62.3%	71.4%
CO	63.4%	70.3%

Source: US Census Bureau

Utah tops nation in Web porn-site subscribers

At more than five broadband users per thousand population, Utah leads the nation in subscriptions to internet adult entertainment sites. Montana is lowest at 1.92 per thousand.

Top 10 states

State	Rate per 1,000
Utah	5.47
Alaska	5.03
Mississippi	4.30
Hawaii	3.61
Oklahoma	3.21
Arkansas	3.12
N. Dakota	3.05
Louisiana	3.01
Florida	3.01
W. Virginia	2.94

Bottom 10 states

State	Rate per 1,000
Montana	1.92
Idaho	1.98
Tennessee	2.13
Ohio	2.20
Oregon	2.21
New Jersey	2.27
Delaware	2.28
Connecticut	2.28
Wyoming	2.29
Michigan	2.32

Source: Harvard Business School

The Salt Lake Tribune

Children that establish close Online Relationships

- 69% live in small town/rural or suburbs vs 29% in big cities/towns
- Children age 10-17 considered in study mean age 14.78

- Source: Crimes Against Children Research Center UNH 2003

Teens increasingly active online…

- 71% of teens have online profiles on social networking websites
- 69% of teens receive online messages from strangers
- 64% post photos or videos of themselves
- 58% post info about where they live

Source: Cox/NECMEC survey

Cont….

- Females far more likely to post personal photos or videos of themselves
- Nearly one in ten have posted their cell phone number online
- 20% of teens report being bullied online, this figure is on the rise.

Source: Cox/NECMEC survey 03/2007

What we know about children's use of the Internet

- On average children/teens use the Internet about 5 hrs per week
  - Homework 80%
  - E-Mail 70%
  - Games 69%
  - Music 50%
  - Chatting IM 42%

Nielsen/NetRatings

Online Victimization

- 1 in 3 are exposed to unwanted sexual material
- 1 in 7 received a sexual solicitation
- 45 million children ages 10 to 17 use the Internet
- 60% have received an E-mail or IM from someone they didn't know

- Source: Crimes Against Children Research Center UNH

Parental Involvement (What kids say)

20% Parents do not supervise
52% Parents moderately supervise
71% Parents stop after age 14
72% Internet related missing children are above age 15
62% Teens say parents know little or nothing about Internet/Computers

Source U.S. Attorney Generals Cyber Crimes Unit

myspace
a place for friends

- WWW.MYSPACE.COM est. Jan 2004
- Over 200 Million Registered Users Worldwide
- 350,000 new registrants daily
- 61% of kids 13-17 have MySpace page
- It splits 50.2% male, 49.8% female

MySpace is a social networking website offering an interactive network of photos, blogs, user profiles, groups, and an internal e-mail system. As of February 2006 it is the world's fifth most popular English language website (according to Alexa Internet[1]). MySpace has outstripped competitors such as Friendster and LiveJournal to become the most popular English language social networking website with higher traffic and over 59 million users. It is representative of both internet culture and teenage culture.

Alaskan MySpace Pages

- Random Sample from Anchorage, Mat Su Valley & Bethel
- Several presentations audience members knew children in photos…
- Items posted online are potentially there forever….With no expectation of privacy…

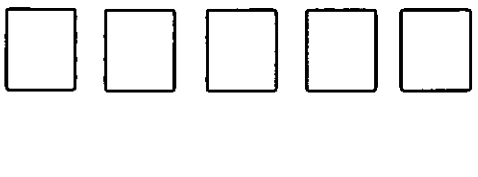
Other Websites Popular with Alaskan Kids

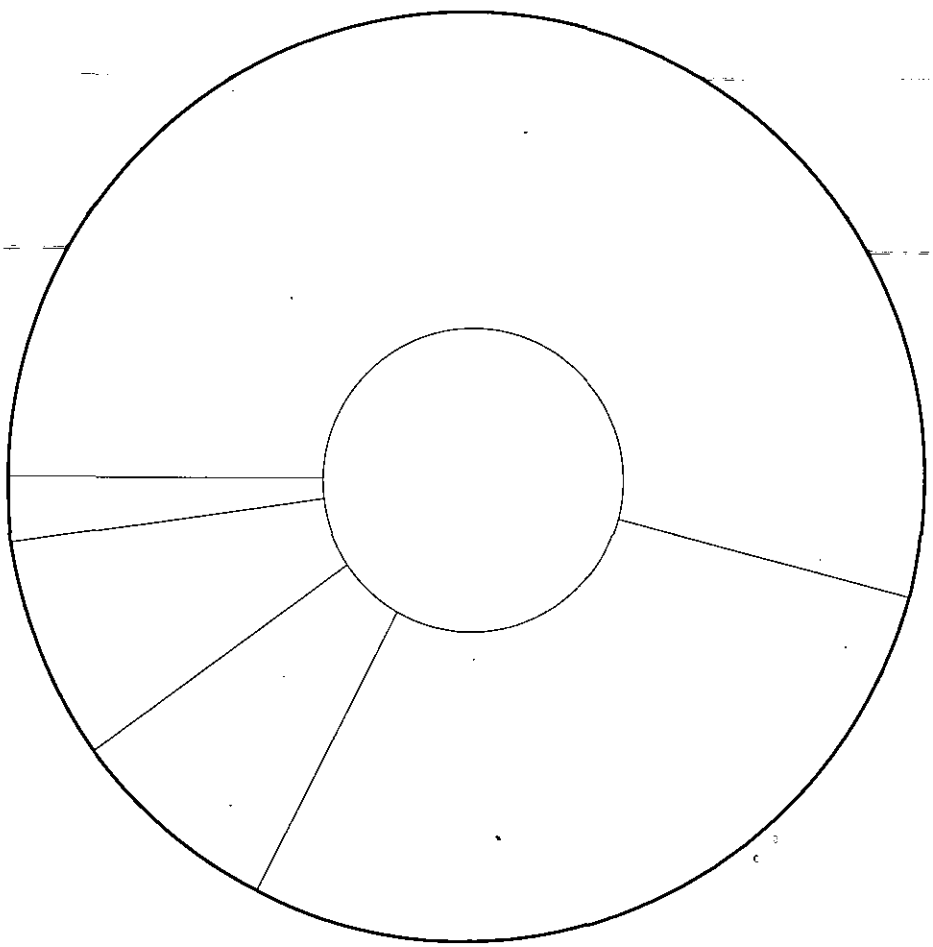
- www.wouldyouhitthis.com
- Over 2000 teenage girls registered in the Anch/Valley area
- Profiles/private pics/IM/Search capability
- www.ratemypic.com
- www.hotornot.com
- www.bebo.com

April 16, 2007

Child pornography on the Internet is becoming more brutal and graphic, and the number of images depicting violent abuse has risen fourfold since 2003

British-based Internet Watch Foundation





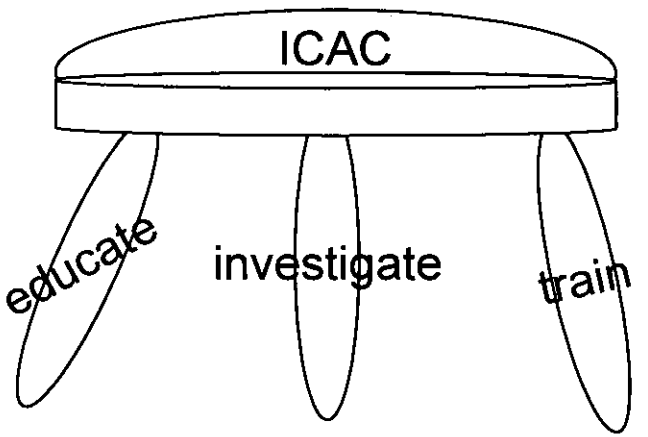
Internet Safety Resources

- www.netsmartz411.org
- www.webwisekids.com
- www.ikeepsafe.org
- www.wiredsafety.org
- www.fbi.gov (search Internet Safety)
- www.childsafenet.org
- www.muni.org/apd (Internet Safety)

How Do We Fight This?

- NATIONAL ICAC MODEL
- "Three leg stool"

- Education
- Investigation
- Training

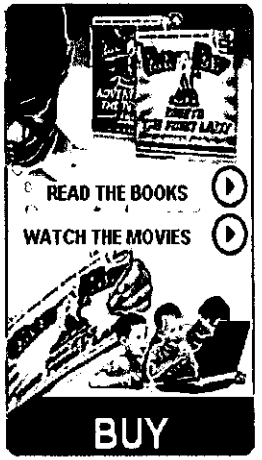


What Do We Need?

- Support- These investigations should be at a top priority for agencies involved.
- We need to continue to focus our efforts; pool resources; dedicate personnel; equipment; and funds to this effort.
- Current funding and staffing dedicated to this effort in Alaska is inadequate- realistically, we are targeting less than 1% of the estimated offenders. We will not arrest ourselves out of this problem- education- parental involvement- awareness is the long term solution.

PARENT RESOURCE CENTER
FOR KIDS
FOR EDUCATORS
YOUR STATE
From the First Lady
Choose Your State

NEW! VIDEO ADS ON INTERNET SAFETY NEW!
OUR PARTNERS
ABOUT IKEEPSAFE
IKEEPSAFE ESTORE NEW!



A MESSAGE FROM YOUR STATE

To the parents in Alaska:

The Internet is a powerful tool. As with any tool, we must instruct our children on how to use it safely. A recent study by the University of New Hampshire showed that one in five young people using the Internet received an online sexual solicitation in a one-year period. In an alarming 15% of those cases, the solicitor attempted to meet the child in person.

With the growing risk that the Internet poses to our children, I hope that this site will aid you as you teach your children to protect themselves from Internet predators.

To report a problem anytime, call 1-800-843-5678. This will connect you to the National Center for Missing and Exploited Children. Or you can visit the Center's website at www.missingkids.com.

Thank you for your commitment to our shared priority of protecting children.

Sincerely,

Governor

Sarah Palin

State of Alaska
Governor Sarah Palin

YOUR STATE MESSAGE

STATE LINKS

- Governor Sarah Palin

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SITE DESIGN BY sandman studios POWERED BY AOL

Alaska ICAC Task Force 2009

In a three day training period from 3/3-5/09, APD Cyber Crimes Investigators conducted Peer 2 Peer training for 3 Alaska State Trooper / ABI investigators.

During this training, Proactive investigations were initiated with potential suspects located in Fairbanks; Kotzebue; Bethel; and Anchorage.

Summary

- It is evident, based on our experience, that Alaska's interest in safeguarding the physical and psychological well-being of a minor is compelling.
- The victimization of a child continues when that act is memorialized in an image. The materials produced are a permanent record of the children's participation and the harm to the child is exacerbated by their circulation. Unfortunately, the victimization of the children involved does not end when the pornographer's camera is put away.
- Research has shown that the use of children as subjects of pornographic materials is harmful to the physiological, emotional, and mental health of the child.
- The possession of child pornography drives that industry and…the production of child pornography will decrease if those who possess the product are punished equally with those who produce it.
- The law will decrease the production of child pornography if it penalizes those who possess and view the product, thereby decreasing demand.
- The possession of child pornography inflames the desires of child molesters, pedophiles and child pornographers. Alaska has more than a passing interest in forestalling the damage caused by child pornography: preventing harm to children is one of its most important interests.

Thank you for your attention and concern for Alaska's Children

Det. Sgt. Ron Tidler
Anchorage Police Dept.
Cyber Crimes Unit
Alaska ICAC Task Force
786-2679

AK ICAC Task Force 2008

Background

Over the past decade, the tremendous proliferation of computers connected to the Internet led to a skyrocketing number of Internet crimes against children. In the year 2008, the Alaska Internet Crimes Against Children (ICAC) Task Force recorded the following:

- 176 investigations involving unlawful images of the sexual exploitation of minors.
- 56 incidents of Internet crimes against children reported from the National Center for Missing and Exploited Children's Cybertip hotline.
- 29 cases of the Internet facilitated luring of minors for sexual exploitation.
- 7 reported incidents of Internet related child prostitution.

Alaska Internet Crimes Against Children

In the twelve months between January 2008 and December 2008, a joint task force of Alaska and Federal investigators conducted a series of proactive Cyber crime enforcement operations targeting Internet criminals committing sex crimes against children; including the trafficking of unlawful images depicting the sexual exploitation of minors. This was done in conjunction with an education effort geared towards Internet crime prevention and awareness.

Law Enforcement Agencies

Investigators and Prosecutors affiliated with 16 law enforcement agencies partnered with the Alaska ICAC Task Force in a cooperative effort during 2008. Agencies participating included (alphabetically):

- Alaska Adult Probations- Sex Offender Unit (Investigations)
- Alaska Bureau Investigations (investigations and training)
- Alaska District Attorney Office (education and training)
- Anchorage PD - (investigation and enforcement)
- Fairbanks PD - (investigation and enforcement)
- F.B.I. - (investigation and enforcement)
- I.C.E. - (investigation and enforcement)
- Juneau PD (investigations)
- Kenai PD - (investigation and enforcement)
- Kodiak PD - (investigation and enforcement)
- Military Investigators (investigations)
- Sitka PD (investigations)
- Soldotna PD - (investigation and enforcement)
- Unalaska PD - (investigation and enforcement)
- U.S. Attorney's Alaska Office - (prosecution)

- U. S. Postal Inspection Service - (investigations)
- UAA PD (facilitation / support)
- UAF PD (investigations)

The Investigators' Work

Trained investigators endured witnessing disturbing cyber images and videos depicting brutal sexual torture of actual children. They use sophisticated computer investigative techniques combined with undercover tactics to identify offenders. They conducted surveillance operations, requested subpoenas, and wrote and executed dozens of search warrants. They seized thousands of items of computer evidence. Detectives and special agents conducted computer forensics examinations to identify contraband images. They interrogated offenders and interviewed witnesses. They conducted exhaustive searches of dwellings and wrote voluminous reports on their activities.

The proactive investigators agreed to participate in this undercover operation in addition to their regular duties that involve responding to citizens' complaints of Internet crimes. Through their proactive efforts investigators and special agents sought justice for thousands of children who could not call 911. Their fine efforts are greatly appreciated. They will work closely with prosecutors to prepare for trials.

Cases pursued by local agencies under Alaska State Law have been submitted to the local Alaska District Attorney's Office. Cases pursued by federal agencies under the US Code have been submitted to US Attorney's Office for the Alaska District. The justice system considers all suspects innocent until proven guilty in court.

Penalties

Unlawful images depicting the Sexual Exploitation of minors are described under Alaska State law in AS 11.41.455. Possession of these images is a class C felony under Alaska State law AS 11.61.127.

The luring and enticement of minors for sexual exploitation is described under Alaska State law in AS 11.41.452. It is a class C felony.

Training and Education

During the 2008 calendar year, members of the Alaska ICAC Task Force have attended training, funded in large part by the Alaska ICAC Grant.

Examples of the training classes attended during 2008:

- ICAC Training & Technical Assistance Program (ICAC T&TA) – Investigative techniques course
- ICAC T&TA- Undercover Chat Investigations Program
- ICAC T&TA- Unit Supervisor Training Program
- ICAC T&TA- Project Safe Childhood(PSC) Team Training

- PSC and ICAC National Conference- several training seminars
- Safety Net Prosecutor Team training
- Access Data Forensic Tool Kit training
- Encase basic and advance software training
- National White Collar Crime Conference-(NWC3)
- BK Forensics- Cell Phone Forensic course.
- Access Data Windows registry training

In January 2009, several AK ICAC Members attended the International Consumer Electronic Show, the premier showcase of all the new digital media products that are being developed and marketed.

On March 3-6, 2009, APD Cyber Crimes Unit conducted Peer 2 Peer training for ABI Investigators. This training allows ABI investigators the ability to go on-line proactively to target individuals who are collecting and trading electronic images depicting Child Sexual Exploitation. Alaska ICAC members also conduct public safety presentations bringing the message of Internet safety to children and adults.

Organizations that can provide more information about Internet crime prevention:

- Anchorage Police Department- Internet Safety: www.muni.org
- Enough is Enough: www.enough.org
- FBI: www.fbi.gov/innocent.htm
- Get Net Wise: www.getnetwise.org
- ICE: www.ice.gov/pi/childexploitation/index.htm
- ISafe: www.isafe.org
- National Association to Protect Children: www.protect.org
- National Center for Missing and Exploited Children's Netsmartz Program: www.netsmartz.org

More Information

Alaska ICAC Task Force

The Alaska Internet Crimes Against Children (ICAC) Task Force efforts are partially funded by grants from the US Department of Justice, Office of Juvenile Justice and Delinquency Prevention. The ICAC program is a nationwide network of 59 state task forces representing 1,800 local and regionally affiliated agencies engaged in investigations, forensics examinations, prosecutions and community education. We are pleased to know that the recently announced Federal stimulus package provides a much needed $50 million dollar nationwide boost to the program. We hope to see some of those funds in Alaska.

Within Alaska, the ICAC Task Force is affiliated or partnered with 16 law enforcement and prosecutorial agencies statewide. Since 2008, Alaska detectives and special agents have conducted over 176 investigations resulting in the incarceration of 28 offenders.

Unlawful Images

Images depicting the sexual exploitation of minors are commonly called child pornography. The images and videos are contraband. The images that investigators found were not of babies in bathtubs. Some of the unlawful videos included acts of bestiality between minors and animals including the horrible audio sounds of human suffering. Detailed descriptions of the images will not be fully provided here.

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2008 Alaska ICAC Task Force Frequently Asked Questions

- What undercover tactics are used?
  - We cannot release details of our tactics because investigations are still underway using the same undercover techniques. Those details will probably not be available until they come out at trial.

- Are the search warrant affidavits public records?
  - Affidavits are sealed by the courts because the investigations using these same techniques are continuing.

- Are these investigations into chat rooms and social networking sites?
  - Many avenues of cyberspace, including but not limited to chat rooms and social networking sites were investigated during this year.

- Are these investigations into P2P file sharing?
  - Many avenues of cyberspace, including but not limited to P2P sources were investigated during this year.

- Where on the Internet were the suspects found?
  - We cannot release that information because investigations are still pending using the same undercover tactics. Those details will not be available until trial.

- Was this an organized ring of people working together?
  - At this time the evidence does not indicate that the offenders know of each others activities.

- What training did the investigators have in order to work on these cases?
  - The average investigator assigned to conduct these investigations has received over several hundred hours of specialized training specific to Internet crimes and/or computer forensics coursework.

- Are the images and videos available for viewing pursuant to a public records request?
  - No - Images depicting the sexual exploitation of minors are contraband. Even in a courtroom setting, the prosecutors try to protect the gallery, the media and everyone but the judge, jury, defense and prosecution from seeing the images.

- Can citizens go on-line and volunteer to go undercover like they did on Dateline with Perverted Justice?
  - Citizen cyber-vigilantism is not supported by the agencies involved in this enforcement operation.

- Can the media "ride along" and accompany the cyber crime investigators?
  - Because child pornography is contraband, we do not permit anyone except those investigating or prosecuting the offenses to be exposed to the images.

- Media exposure of our undercover investigative tactics will make our jobs more difficult by making offenders aware of the techniques we use.

- What Internet safety tips can you provide to citizens about unlawful images?
  - Homeowners: Pay attention to what is occurring on your home computer. Take responsibility for the control of your computer.
  - Business owners: Watch what your employees are doing on their work computers. Law enforcement intervention can result in an embarrassing disruption of services to your customers.
  - Parents: Monitor your child's use of cell phone cameras. A troubling number of minors are using cell phone cameras to create felony images depicting the sexual exploitation of themselves and others. The images are then being shared throughout cyberspace and the images will never be retrieved.

- What Internet safety tips can you provide to citizens about luring/enticement?
  - Parents: Closely monitor your child's use of the computer and know who your child is contacting on line. Be aware that some children have multiple on line profiles. They may show one profile to their parents while keeping another secret profile that they use to communicate with friends and strangers.
  - Also, while you are protecting your children at home, be aware that some children go to places where free Internet access is provided to communicate with others. Coffee shops, libraries and colleges offer free Internet service where young people may be communicating with predators.

- Were any "hands on" contact victims discovered as the result of these investigations?
  - **Yes** – We also have encouraged the families and friends of other suspects to call us if they wish to report contact offenses. We know that victims are understandable reluctant to come forward for fear of embarrassment and because they do not wish to relive the abuse by subjecting themselves to the criminal justice system. We know from the scientific research conducted on the subject of unlawful images that a significant number of possessors are also contact offenders. We encourage victims to report abuse so that we can bring offenders to justice. Complicating our investigative endeavors is the fact that it is impossible for some of the victims, who are as young as infants, to notify the police. How can you call 911 when you are not yet old enough to count or to use a telephone?

- Are women ever arrested for Internet crimes against children?
  - Sometimes, but 99% of the offenders in theses cases are men. During this time period, no women were arrested.

- Where can I go on-line for more information?
  - Anchorage Police Department Internet Safety Tips: www.muni.org
  - Enough is Enough: www.enough.org
  - FBI: www.fbi.gov/innocent.htm
  - Get Net Wise: www.getnetwise.org

- ICE: www.ice.gov/pi/childexploitation/index.htm
- ISafe: www.isafe.org
- National Association to Protect Children: www.protect.org
- National Center for Missing and Exploited Children's Netsmartz Program: www.netsmartz.org

- What is the number to call to report Internet crimes against children?
  - Local crimes can be reported through the telephone 911 service.
  - The National Center for Missing and Exploited Children operates the Cybertip line **1-800-843-5678**, where crimes can be reported on-line. The web site is: www.cybertipline.com

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4/13/09 FINAL REPORT: ALASKA CHILD & FAMILY SERVICES

EXECUTIVE SUMMARY
Final Report: Alaska Child and Family Services Review
February 2009

INTRODUCTION

This document presents the findings of the Child and Family Services Review (CFSR) for the State of Alaska. The CFSR is the Federal Government's program for assessing the performance of State child welfare agencies with regard to achieving positive outcomes for children and families. It is authorized by the Social Security Amendments of 1994 requiring the U.S. Department of Health and Human Services (HHS) to promulgate regulations for reviews of State child and family services programs under titles IV-B and IV-E of the Social Security Act. The CFSR is implemented by the Children's Bureau (CB) of the Administration for Children and Families within HHS.

The Alaska CFSR was conducted the week of September 8, 2008. The period under review for the onsite case review process was from April 1, 2007, through September 12, 2008. The findings were derived from the following documents and data collection procedures:

- The Statewide Assessment, prepared by the Alaska Department of Health and Social Services, Office of Children's Services (OCS)
- The State Data Profile, prepared by CB, which provides Alaska's child welfare data for the CFSR target 12-month period ending March 31, 2007
- Reviews of 65 cases (40 foster care and 25 in-home services cases) at three sites, including 31 cases in Anchorage, 17 cases in Bethel, and 17 cases in Juneau, all of which were open child welfare agency cases at some time during the period under review
- Interviews and focus groups (conducted at all three sites and at the State level) with stakeholders including, but not limited to, children, youth, parents, foster and adoptive parents, all levels of child welfare agency personnel, collaborating agency personnel, service providers, court personnel, child advocates, Tribal representatives, and attorneys

Background Information

The CFSR assesses State performance on 23 items relevant to seven outcomes and 22 items pertaining to seven systemic factors. In Section A: Outcomes of the CSFR Final Report, an overall rating of Strength or Area Needing Improvement (ANI) is assigned to each of the 23 items reviewed. An item is assigned an overall rating of Strength if 90 percent of the applicable cases reviewed were rated as a Strength. The ratings for the items are used to determine the performance of a State on the seven outcomes, each of which incorporates one or more of the individual items. Depending on item ratings, an outcome can be Substantially Achieved, Partially Achieved, or Not Achieved. For a State to be in substantial conformity with a particular outcome, 95 percent of the cases reviewed

must be rated as having Substantially Achieved the outcome. Two outcomes—Safety Outcome 1 and Permanency Outcome 1—also are evaluated based on State performance with regard to six national data indicators. For a State to be in substantial conformity with these outcomes, both the national standards for each data indicator and the case review requirements must be met.

In Section B: Systemic Factors, each item incorporated in each systemic factor is rated as either a Strength or an ANI based on whether State performance on the item meets Federal policy requirements as specified for the Child and Family Services Plan (CFSP). Information relevant to each systemic factor comes primarily from the Statewide Assessment and the stakeholder interviews conducted during the week of the Onsite Review. Depending on item ratings, a systemic factor can be either "in substantial conformity" or "not in substantial conformity." The criteria for the rating for each systemic factor are shown in the table below.

Rating the Systemic Factor			
Not in Substantial Conformity		**In Substantial Conformity**	
1	2	3	4
None of the CFSP or program requirements are in place.	Some or all of the CFSP or program requirements are in place, but more than one of the requirements fail to function as described in each requirement.	All of the CFSP or program requirements are in place, and no more than one of the requirements fails to function as described in each requirement.	All of the CFSP or program requirements are in place and functioning as described in each requirement.

A State that is not in substantial conformity with a particular outcome or systemic factor must develop and implement a Program Improvement Plan (PIP) to address that outcome or systemic factor. Because the focus of the CFSR process is on continuous quality improvement, standards are set high to ensure ongoing attention to the goal of achieving positive outcomes for children and families with regard to safety, permanency, and well-being.

Many changes have been made between the first and second CFSR review cycles. These changes were based on lessons learned during the first round and in response to feedback from the child welfare field. Consequently, a State's performance in the second round of the CFSR is not directly comparable to its performance in the first round, particularly with regard to comparison of percentages for performance on the outcomes and items. Key changes in the process that make comparing performance difficult across reviews include, but are not limited to, the following:

- An increase in the sample size from 50 to 65 cases
- Stratification of the sample to ensure a minimum number of cases in key program areas, resulting in variations in the number of cases relevant for specific outcomes and items
- Changes in criteria for specific items to increase consistency and to ensure an assessment of critical areas, such as child welfare agency efforts to involve noncustodial parents

CFSR Findings Regarding Outcomes

Alaska's 2008 CFSR identified the following areas of high performance with regard to achieving outcomes:

- Item 5, which pertains to foster care reentry, was rated as a Strength in 91 percent of applicable cases.
- Item 11, which pertains to proximity of placements in foster care to parents and close relatives, was rated as a Strength in 90 percent of applicable cases.
- Item 12, which pertains to placement of siblings together, was rated as a Strength in 91 percent of applicable cases.
- The State met the national standard for the data indicator of Permanency Composite 3—Achieving permanency for children in foster care for extended time periods.

Despite these areas of high performance, the State performance was at a low level for all case review outcomes. The highest performing outcome was Well-Being Outcome 2 (Children receive services to meet their educational needs), with 76.1 percent of cases found to have substantially achieved the outcome. Less than 50 percent of the cases were found to have substantially achieved four of the CFSR outcomes.

The most critical concerns identified with regard to outcomes for children and families pertained to Safety Outcome 1 (Children are, first and foremost, protected from abuse and neglect), Safety Outcome 2 (Children are safely maintained in their homes when possible and appropriate), Permanency Outcome 1 (Children have permanency and stability in their living situations), and Well-Being Outcome 1 (Families have enhanced capacity to provide for children's needs). Safety Outcome 1 was substantially achieved in only 47.1 percent of the cases. The primary concern for this outcome pertained to delays in initiating investigations of child abuse and neglect allegations. Although stakeholders suggested that delays occurred primarily with regard to allegations assigned as priority 2 or 3, there were four maltreatment allegations among the cases reviewed that were assigned as priority 1 reports (i.e., emergency situations) but were not investigated in the timeframe established by State policy.

Safety Outcome 2 (Children are safely maintained in their homes whenever possible and appropriate) was found to be substantially achieved in only 38.5 percent of the cases. The primary concern in these cases centered on children being left at risk in their own homes because of a lack of service provision, safety and risk assessment, and monitoring.

Well-Being Outcome 1 (Families have enhanced capacity to provide for their children's needs) was found to be substantially achieved in only 23.1 percent of the cases, with the primary concern being the lack of caseworker contact with parents and the lack of engagement of parents in case planning and services. However, it is important to note that there also was a lack of sufficient contact with children in the cases, particularly children in the in-home services cases, some of whom were never seen during the CFSR period under review. Also, although there was less contact with the fathers than with the mothers and less effort to engage the fathers than to engage the mothers, contact with the mothers and engagement of the mothers in case planning also was limited. The lack of contact

applicable Juneau cases. Both item 1 (timeliness of investigations) and item 2 (repeat maltreatment) were rated as ANIs. Alaska also did not meet the national standards for the data indicators pertaining to the absence of maltreatment recurrence and the absence of maltreatment of children in foster care by foster parents or facility staff.

Additional findings for this outcome were the following:

- There were 22 maltreatment reports that occurred during the period under review for which an investigation was not initiated in the timeframes required by State policy. Of these, 11 were priority 3 reports, 5 were priority 2 reports, and 4 were priority 1 reports. One report was never screened or assigned, and one report was assigned to the differential response program, but the children who were the subject of the report were never seen.
- In addition to the recurrence of substantiated maltreatment in a number of cases, case reviewers expressed concern about the many cases involving multiple reports (both substantiated and not substantiated) on the family during the life of the case. For example, in 12 cases there were 15 or more maltreatment reports during the life of the case, with 4 of these cases having more than 20 reports.

Alaska also was not in substantial conformity with Safety Outcome 1 during its first CFSR conducted in fiscal year 2002 and was required to address this outcome in its PIP. Both items assessed for this outcome were rated as ANIs in the 2002 CFSR. Key concerns identified in the 2002 CFSR were the following:

- The State did not meet the national standards for the measure of maltreatment recurrence or the measure of maltreatment of children in foster care by foster parents or facility staff.
- Although the agency initiated investigations of reports involving imminent risk (priority 1 reports) within the required timeframes, the initiation of investigations of maltreatment reports not involving imminent risk (i.e., reports assigned a priority 2 or 3 level) did not consistently meet required timeframes.

To address these concerns, Alaska included the following key strategies in its PIP:

- Revised policies relating to the investigative process, including specifying definitions for "face-to-face contact" and "initiation of investigation," and trained supervisors and caseworkers on the policies
- Established a protocol to review cases that involve a recurrence of maltreatment
- Developed a new safety assessment model (training of staff on the model did not begin until the spring of 2006)

The State met its target goals for this outcome by the end of its PIP implementation period.

Safety Outcome 2: Children are safely maintained in their homes when possible and appropriate

Performance on Safety Outcome 2 is assessed through two indicators. One indicator (item 3) addresses the issue of child welfare agency efforts to prevent children's removal from their homes by providing services to the families that ensure children's safety while

Depending on the child's permanency goal, the remaining indicators focus on the child welfare agency's efforts to achieve permanency goals (such as reunification, guardianship, adoption, or permanent placement with relatives) in a timely manner (items 8 and 9), or to ensure that children who have other planned permanent living arrangement (OPPLA) as a case goal are in stable placements and adequately prepared for eventual independent living (item 10).

Alaska is not in substantial conformity with Permanency Outcome 1. This determination was based on the following findings:

- The outcome was substantially achieved in 15 percent of the 40 foster care cases, which is less than the 95 percent required for an overall rating of substantial conformity. The outcome was substantially achieved in 20 percent of Anchorage cases and 10 percent of Bethel and Juneau cases.
- The State did not meet the national standards for the national data indicators pertaining to the timeliness and permanency of reunification (Composite 1), the timeliness of adoptions (Composite 2), and placement stability (Composite 4).

Alaska met the national standards for the data indicator pertaining to achieving permanency for children in foster care for extended time periods (Composite 3).

For this outcome, item 5 was rated as a Strength, but all other items assessed for the outcome were rated as ANIs. Key findings of the 2008 CFSR were the following:

- Alaska had a very low percentage of reentries into foster care (7.5 percent) compared to the performance of all States nationally.
- Many children in the cases reviewed were in multiple placement settings during the period under review. In nine cases, the children had three or more placements during the period under review, with three of these children having five or more placements.
- The child's permanency goal frequently was not established in a timely manner.
- There was a general lack of sufficient effort to achieve reunification or guardianship in a timely manner.
- Agency practice was inconsistent with regard to filing for termination of parental rights (TPR) in accordance with the Adoption and Safe Families Act (ASFA) requirements.
- There were frequent and considerable delays associated with the home study process for adoption—either completing or approving the home studies, resulting in considerable delays in achieving adoptions in a timely manner.

Alaska also was not in substantial conformity with Permanency Outcome 1 in its 2002 CFSR. At that time, all relevant items except item 5 (foster care reentry) were rated as ANIs. The following key concerns were identified:

- The agency was not consistent with regard to ensuring placement stability for children in foster care.
- Case goals often were not changed even when there were indications that the goal was not likely to be achieved.
- The goals of guardianship and reunification were not achieved in a timely manner in many cases.
- There were many agency-related delays in achieving adoptions in a timely manner, including lack of timely decision-making and lack of follow-up with the child and pre-adoptive family.

To address these concerns, Alaska implemented the following strategies as part of its PIP:

- Standardized practice for setting and changing permanency goals when concurrent planning occurs
- Improved the structure of administrative reviews and permanency planning conferences, with enhanced focus on permanency goals and concurrent planning
- Developed the continuous QA review system to monitor cases
- Established Regional Adoption Specialists who participate in administrative and permanency planning reviews to ensure that goals are established in a timely manner and are documented
- Implemented a statewide contract for post-adoption services

The State met its target goals for this outcome by the end of its PIP implementation period.

Permanency Outcome 2: The continuity of family relationships and connections is preserved for children

Permanency Outcome 2 incorporates six indicators that assess the child welfare agency's performance in (1) placing children in foster care in close proximity to their parents and close relatives (item 11); (2) placing siblings together (item 12); (3) ensuring frequent visitation among children and their parents and siblings in foster care (item 13); (4) preserving connections of children in foster care with extended family, community, cultural heritage, religion, and schools (item 14); (5) seeking relatives as potential placement resources (item 15); and (6) promoting the relationship between children and their parents while the children are in foster care (item 16).

Alaska is not in substantial conformity with Permanency Outcome 2. The outcome was determined to be substantially achieved in 62.5 percent of the 40 foster care cases, which is less than the 95 percent required for substantial conformity. The outcome was determined to be substantially achieved in 65 percent of Anchorage cases, 60 percent of Bethel cases, and 60 percent of Juneau cases. Although items 11 and 12 were rated as Strengths, all other items assessed for this outcome were rated as ANIs.

Key findings for this outcome in the 2008 CFSR were the following:

- In most of the applicable cases, the child was placed in close proximity to parents or, if placed far away, the placement was determined to be necessary to meet the needs of the child and/or support attainment of the child's permanency goal.
- In most of the applicable cases, the child was placed with other siblings in foster care when appropriate.
- There was a lack of concerted effort to ensure visitation between children in foster care and their mothers, fathers, and siblings.
- There was a lack of concerted effort to maintain the child's connections with extended family, particularly with siblings who were not in foster care.
- Relatives were not consistently sought as placement resources for children in foster care.

- There was a lack of concerted effort to support and/or strengthen the bond between parents and children through activities such as encouraging parent participation in school activities and/or doctor's appointments or providing therapy to the family to address their relationship issues.

Alaska also was not in substantial conformity with Permanency Outcome 2 in its 2002 CFSR. At that time, items 11 and 12 were rated as Strengths, but all other relevant items were rated as ANIs. During the 2002 CFSR, the agency was found to be inconsistent with respect to facilitating and supporting visits between children and their parents and siblings, preserving children's connections, seeking relatives as potential placement resources, and promoting or maintaining the parent-child bond.

To address these concerns, Alaska implemented the following strategies as part of its PIP:

- Developed policies and guidelines to clarify supervised and unsupervised visitation requirements to enhance visitation opportunities
- Made paternity testing available statewide to ensure identification of the fathers
- Improved policy and training regarding maintaining connections between children in foster care and their families and communities

The State met its target goals for this outcome by the end of its PIP implementation period.

Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs

Well-Being Outcome 1 incorporates four indicators. One pertains to the agency's efforts to ensure that the service needs of children, parents, and foster parents are assessed and that the necessary services are provided to meet identified needs (item 17). A second indicator examines agency efforts to actively involve parents and children (when appropriate) in the case planning process (item 18). The two remaining indicators examine the frequency and quality of caseworker contacts with the children in their caseloads (item 19) and with the children's parents (item 20).

Alaska is not in substantial conformity with Well-Being Outcome 1. The outcome was determined to be substantially achieved in 23.1 percent of the 65 cases, which is less than the 95 percent required for substantial conformity. The outcome was substantially achieved in 35 percent of Anchorage cases, 6 percent of Bethel cases, and 18 percent of Juneau cases. Also, the outcome was substantially achieved in 35 percent of the foster care cases compared to 4 percent of the in-home services cases (only one in-home services case was determined to have substantially achieved this outcome). All four items assessed for this outcome were rated as ANIs.

Key findings with regard to this outcome in the 2008 CFSR were the following:

- For the foster care cases, the agency was considerably less consistent in assessing and meeting service needs of mothers and fathers than it was in assessing and meeting the needs of the children. However, even for children, needs were adequately assessed

and met in only 73 percent of the foster care cases and 44 percent of the in-home services cases. The agency was least consistent in assessing and meeting needs of the fathers in both types of cases, although the percentage was particularly low (13 percent) in the in-home services cases.

- There was a general lack of involvement of mothers, fathers, and children (when appropriate) in case planning in both the foster care and in-home services cases. However, in both types of cases, mothers were more likely to be involved in case planning than were fathers or children. In addition, mothers, fathers, and children were more likely to be involved in case planning in the foster care cases than in the in-home services cases.
- In many cases, the frequency of caseworker visits was not sufficient to meet the needs of the child, and if visits did occur, they did not focus on issues pertinent to case planning, service delivery, and goal attainment. Caseworkers were more likely to visit children in foster care at least once a month than they were to visit children in the in-home services cases. In five in-home services cases, the children were never seen by the caseworker during the CFSR period under review.
- The frequency of visits with mothers and fathers was not sufficient and, if visits did occur, the quality was not sufficient to meet the needs of the children or further achievement of case goals.

Alaska also was not in substantial conformity with this outcome in its 2002 CFSR, with all items rated as ANIs. The key concerns identified in the 2002 CFSR were the following:

- In many cases, the service needs of children, parents, and foster parents were neither assessed nor addressed.
- The child welfare agency did not consistently involve parents and children in the case planning process.
- In the majority of cases reviewed, the frequency and quality of visitation with both children and parents was not adequate to meet the needs of the child or promote attainment of case goals.

To address the concerns identified in the 2002 CFSR, the State developed and implemented the following strategies:

- Enhanced and revised policy and procedure for administrative review feedback to the administration in July 2005
- Developed case planning protocols to identify required services
- Strengthened caseworker training in conducting initial assessments
- Developed the expectation that supervisors are to work with their staff regarding the assessment of child and family needs and the incorporation of these needs into a strengths-based case and service planning process
- Implemented statewide tracking of caseworker visits

The State met its PIP target goals for this outcome by the end of its PIP implementation period.

Well-Being Outcome 2: Children receive appropriate services to meet their educational needs

Well-Being Outcome 2 pertains to the agency efforts to address and meet the educational needs of children in both foster care and in-home services cases (item 21).

Alaska is not in substantial conformity with Well-Being Outcome 2, which includes only one item—item 21: Educational needs of the child. Reviewers determined that the outcome was substantially achieved in 76.1 percent of the applicable cases, which is less than the 95 percent required for substantial conformity. The outcome was substantially achieved in 90 percent of applicable Anchorage cases, 42 percent of applicable Bethel cases, and 85 percent of applicable Juneau cases. The outcome was substantially achieved in 78 percent of the 37 applicable foster care cases and 67 percent of the 9 applicable in-home services cases. A key finding was a lack of consistency with regard to both assessing children's educational needs and providing services when educational needs were identified.

Alaska also was not in substantial conformity with this outcome in its 2002 CFSR. A key concern of that review was that children in the in-home services cases had education-related issues to which the agency was not responding. To address this concern, the State implemented the following strategies in its PIP:

- Amended court orders to authorize OCS to gather educational information about children in out-of-home care
- Established an interdepartmental work group to ensure enhanced relationships between the agency and school administrators at the local level
- Provided training regarding a new policy requiring workers to assess, address, and document the educational needs of children in the cases in which children remain in their homes

The State met its PIP target goals for this outcome by the end of its PIP implementation period.

Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs

This outcome incorporates two indicators that assess agency efforts to meet children's physical health (item 22) and mental health (item 23) needs.

Alaska is not in substantial conformity with Well-Being Outcome 3. The outcome was determined to be substantially achieved in 52.5 percent of the applicable cases, which is less than the 95 percent required for substantial conformity. The outcome was substantially achieved in 70 percent of applicable Anchorage cases, 12.5 percent of applicable Bethel cases, and 62.5 percent of applicable Juneau cases. Also, the outcome was substantially achieved in 62.5 percent of the 40 foster care cases compared to 32 percent of the 19 applicable in-home services cases. Both items assessed for this outcome were rated as ANIs.

Key findings of the 2008 CFSR were that children's physical and mental health service needs were not consistently assessed nor addressed.

Alaska also was not in substantial conformity with Well-Being Outcome 3 in its 2002 CFSR, with both relevant items rated as ANIs. The key concerns identified in the 2002 CFSR were the following:

- Agency performance was inconsistent with regard to providing health screenings for children at entry into foster care and providing foster parents with children's health records.
- Agency performance was inconsistent with regard to assessing children's mental health needs and providing the necessary mental health services.

To address these concerns, Alaska implemented the following strategies as part of its PIP:

- Training was provided to caseworkers regarding completing the Early Periodic Screening, Diagnosis, and Treatment screenings of children within State guidelines and using the health-care provider's recommendations as a guide for all health treatment decisions.
- Physical and mental health issues were added as a topic of discussion in the administrative review process.
- Policy was established to ensure that all children in foster care received mental health evaluations.

The State met its target goals for this outcome by the end of its PIP implementation period.

II. KEY FINDINGS RELATED TO SYSTEMIC FACTORS

Statewide Information System

Substantial conformity with the systemic factor of Statewide Information System is determined by whether the State is operating a information system that can inform users immediately with the status, demographic characteristics, location, and case goals for the placement of every child in foster care.

Alaska is in substantial conformity with the systemic factor of Statewide Information System. The key finding of the 2008 CFSR is that Alaska's statewide information system—Online Resources for Children in Alaska—can readily identify the legal status, demographic characteristics, location, and case goals for each child in foster care. The State also was in substantial conformity with this systemic factor during its 2002 CFSR and therefore was not required to address this factor in its PIP.

Case Review System

Five indicators are used to assess the State's performance for the systemic factor of a Case Review System. The indicators examine development of case plans and parent involvement in that process (item 25), the consistency of 6-month case reviews (item 26) and 12-month permanency hearings (item 27), implementation of procedures to seek TPR in accordance with the timeframes established in

ASFA (item 28), and notification and inclusion of foster and pre-adoptive parents and relative caregivers in case reviews and hearings (item 29).

Alaska is not in substantial conformity with the systemic factor of Case Review System. Because the Alaska Statewide Assessment did not provide data on any of the key items associated with this systemic factor, the CFSR determinations were based on anecdotal information in the Statewide Assessment and on stakeholder interviews conducted during the onsite CFSR. Using this information, items 26 and 27 were rated as Strengths, and items 25, 28, and 29 were rated as ANIs. In general, the 2008 CFSR determined that periodic reviews and permanency hearings were being held in a timely manner and that they addressed the issues that are relevant to moving a child toward permanency. However, the 2008 CFSR also determined the following:

- Parents are not consistently involved in the development of their case plans.
- TPR petitions are not being filed in a timely manner on a consistent basis.
- Notification of caregivers regarding hearings and reviews involving the children in their care and the caregivers' right to be heard in these proceedings is inconsistent across the State.

Alaska also was not in substantial conformity with this factor during its 2002 CFSR and was required to address the factor in its PIP. In the 2002 review, items 26 and 28 were rated as Strengths. The following concerns were identified in the 2002 CFSR with regard to items 25, 27, and 29:

- There was a lack of goal-oriented case plans.
- The system did not consistently involve parents and children (when appropriate) in case planning.
- Permanency hearings were not consistently held in a timely manner.
- Foster parents and other caregivers were not consistently notified regarding permanency hearings nor were they provided with an opportunity to be heard at the hearings.

The following key strategies were implemented in Alaska's PIP to address these concerns:

- Policy and procedure changes were developed and implemented to strengthen and enhance the use of case plans, ensure that case plans are developed in conjunction with parents and children (when appropriate), and incorporate case planning for in-home services cases.
- In collaboration with the Court Improvement Project, a data system called Court View was implemented to enable the court to track court hearings (operates in only a few jurisdictions).
- In collaboration with the Attorney General's office, a new protocol was developed for notifying foster parents of court hearings. In 2005, Alaska statutes were changed to require that notification of all court hearings in a child's case be provided to the child, each parent, the Tribe, foster parent or other out-of-home care provider, guardian, and guardian *ad litem*. In some circumstances, written notice of all court hearings in a child's case must be provided to a grandparent of the child.

Alaska met its target goals for this systemic factor by the end of its PIP implementation period.

Quality Assurance (QA) System

Performance with regard to the systemic factor of QA System is based on whether the State has developed standards that ensure the safety and health of children in foster care (item 30) and whether the State is operating a statewide QA system that evaluates the quality and effectiveness of services and measures program strengths and ANIs (item 31).

Alaska is not in substantial conformity with the systemic factor of QA System. Both items assessed for this factor were rated as ANIs. Key findings were the following:

- Although the State has developed standards to ensure quality services to protect the safety and health of children, many of the standards are not being implemented on a consistent basis and, at the time of the onsite CFSR, many were not fully operational.
- Although the State has a QA system in place, it does not incorporate a process for following up on QA findings with the field offices to determine whether program improvements have been implemented in response to findings and to assess the effectiveness of program improvement efforts that have been implemented.

Alaska also was not in substantial conformity with this systemic factor in its 2002 CFSR and was required to address the factor in its PIP. In the 2002 CFSR, item 30 was rated as a Strength, but item 31 was rated as an ANI. The key concern identified in the 2002 CFSR was that Alaska did not have a statewide QA process and had no formal process for clients or stakeholders to evaluate agency performance.

To address this concern through its PIP, the State developed and implemented a comprehensive QA system that incorporates both case reviews and interviews with case-related stakeholders. In addition, the PIP focused on ongoing improvement of supervisory case reviews and administrative reviews.

Alaska met its target goals for this systemic factor by the end of its PIP implementation period.

Training

The systemic factor of Training incorporates an assessment of the State's training program for new caseworkers (item 32), ongoing training for agency staff (item 33), and training for foster and adoptive parents (item 34).

Alaska is not in substantial conformity with the systemic factor of Training. All three items assessed for this systemic factor were rated as ANIs. The key findings were the following:

- Initial training provided to staff is not sufficient to prepare them to carry out their responsibilities.
- The State does not require caseworkers or supervisors to receive ongoing training as part of their jobs. In addition, training opportunities that are available for caseworkers and supervisors are limited, particularly outside of Anchorage, and agency staff

often cannot access ongoing training either because of workload responsibilities or constraints related to the cost and time needed for travel.

- Foster parents are not receiving sufficient training to carry out their responsibilities. Although initial training for foster parents is available, it is not required. In addition, although there is a requirement for annual training for foster parents (10 to 15 hours), the Statewide Assessment reports that in 2008, 23 percent of foster parents did not complete this requirement.

Alaska was in substantial conformity with this systemic factor in its 2002 CFSR and therefore was not required to address the factor in its PIP.

Service Array

The assessment of the systemic factor of Service Array addresses three questions: Does the State have in place an array of services that meets the needs of children and families served by the child welfare agency (item 35)? Are the services accessible to families and children throughout the State (item 36)? Can services be individualized to meet the unique needs of the children and families served by the child welfare agency (item 37)?

Alaska is not in substantial conformity with the systemic factor of Service Array. All three items assessed for this systemic factor were rated as ANIs. Key findings of the 2008 CFSR were the following:

- Substance abuse and mental health services, in-home family preservation services, and foster family homes (particularly Native foster homes) are four key service gaps in the State.
- The Children's Services offices are not effective in ensuring that resources are available in all political jurisdictions. Although the Statewide Assessment attributes this to the remoteness of some of Alaska's communities and the resultant transportation difficulties, stakeholders indicated that there is a lack of necessary resources to ensure that people who reside in the more remote areas can access services. They noted that even basic child protective and case management services are limited in these areas because staffing plans for the agencies that serve these communities do not take into account the length of time required to travel to the more remote communities.
- Although there are flexible funding resources and culturally appropriate services in the State, they are not sufficient to meet the needs of the children and families for whom individualized services are critical.

Alaska also was not in substantial conformity with this systemic factor in its 2002 CFSR and was required to address the factor in its PIP. The key concerns identified in the 2002 CFSR were the following:

- Key services were not available in sufficient quantity in either rural or urban communities.
- Many critical services were not available in all communities in the State.

- In many situations, the types of services provided to children and families were more likely to be influenced by what was available rather than by what was needed to meet their particular needs. To address these concerns in its PIP, OCS implemented the following strategies:
- Conducted an assessment of strengths and service gaps using a collaborative approach with community providers and stakeholders
- Collaborated with other State agencies and departments to ensure the efficient use of available resources for shared populations
- Used Tribal, paraprofessional, and village-based resources to assist in case planning
- Developed grant programs to expand services and worked with grantees to develop a baseline of current services and identify changes that are needed to evaluate services (including post-adoption services)

Alaska met its target goals for this systemic factor by the end of its PIP implementation period.

Agency Responsiveness to the Community

Performance with regard to the systemic factor of Agency Responsiveness to the Community incorporates an assessment of the State's consultation with external stakeholders in developing the CFSP (items 38 and 39) and the extent to which the State coordinates child welfare services with services or benefits of other Federal or Federally-assisted programs serving the same population (item 40).

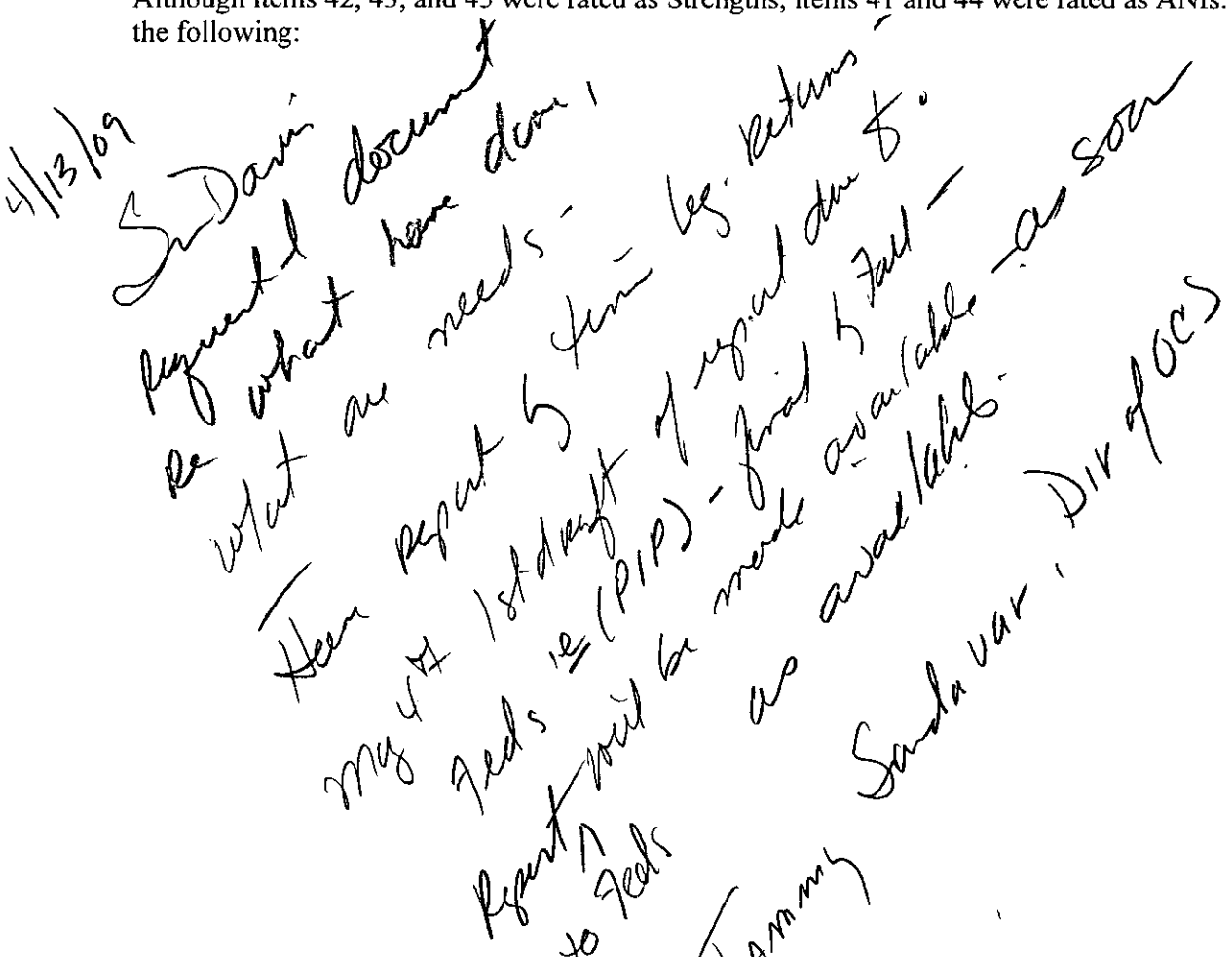
Alaska is not in substantial conformity with the systemic factor of Agency Responsiveness to the Community. Items 38 and 39 were rated as ANIs, although item 40 was rated as a Strength. The State was found to be effective in coordinating with other Federal or Federally-funded agencies in providing services. However, OCS does not have a formal process to consistently seek input from and engage stakeholders, including local child welfare agency staff, in the development of its goals and objectives for the State child and family services programs or in the development of its Annual Progress and Services Report.

The State was in substantial conformity with this systemic factor in its 2002 CFSR and, therefore, did not address this factor in its PIP. Findings from the 2008 CFSR are presented below.

Foster and Adoptive Parent Licensing, Recruitment, and Retention

The assessment of this systemic factor focuses on the State's standards for foster homes and child care institutions (items 41 and 42), the State's compliance with Federal requirements for criminal background checks for foster and adoptive parents (item 43), the State's efforts to recruit foster and adoptive parents who reflect the ethnic and racial diversity of foster children (item 44), and the State's activities with regard to using cross-jurisdictional resources to facilitate permanent placements for waiting children (item 45).

Alaska is not in substantial conformity with the systemic factor of Foster and Adoptive Parent Licensing, Recruitment, and Retention. Although items 42, 43, and 45 were rated as Strengths, items 41 and 44 were rated as ANIs. The key findings of the 2008 CFSR were the following:



- Alaska claims title IV-E funds only for children placed in foster homes that are fully licensed.
- Alaska complies with Federal requirements and completes criminal records checks on all fully licensed foster homes, adoptive homes, and relative placement homes.
- Alaska is effective in using cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children.
- While there are licensing standards established, many licensed homes with ongoing placements do not meet the full licensing standards.
- Alaska does not have a statewide process in place to recruit foster homes despite significant shortages of all types of foster homes; local offices do not have recruitment plans, recruitment resources are limited, and efforts to recruit foster homes are not sufficient.

Alaska also was not in substantial conformity with this factor in its 2002 CFSR and therefore was required to address the factor in its PIP. The 2002 CFSR identified the following key concerns in regard to this factor:

- The State granted variances to the licensing standards with the result that full licensing standards are not equally applied to all foster homes.
- The State did not have an effective recruitment plan for recruiting foster and adoptive parents who meet the needs of the children in foster care.

To address these concerns, the State implemented the following strategies:

- Implemented efforts to improve the licensing process, particularly with regard to the use of variances
- Developed a statewide foster care recruitment plan with the assistance of the National Resource Center for Foster Care and Permanency
- Increased recruitment of Native Alaskan foster parents through increased collaboration with Tribes

Alaska met its target goals for this systemic factor by the end of its PIP implementation period.

Table 1. Alaska CFSR Ratings for Safety and Permanency Outcomes and Items

Outcomes and Items	Outcome Ratings			Item Ratings	
	In Substantial Conformity?	Percent Substantially Achieved*	Met National Standards?	Rating**	Percent Strength
Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect	No	47.1	No		
Item 1: Timeliness of investigations				ANI	56
Item 2: Repeat maltreatment				ANI	81
Safety Outcome 2: Children are safely maintained in their homes when possible and appropriate	No	38.5			
Item 3: Services to prevent removal				ANI	51
Item 4: Risk of harm				ANI	39
Permanency Outcome 1: Children have permanency and stability in their living situations	No	15.0	Met C3; did not meet C1, C2, or C4		
Item 5: Foster care reentry				Strength	91
Item 6: Stability of foster care placements				ANI	72.5
Item 7: Permanency goal for child				ANI	45
Item 8: Reunification, guardianship, and placement with relatives				ANI	33
Item 9: Adoption				ANI	18
Item 10: Other planned living arrangement				ANI	60
Permanency Outcome 2: The continuity of family relationships and connections is preserved	No	62.5			
Item 11: Proximity of placement				Strength	90
Item 12: Placement with siblings				Strength	91
Item 13: Visiting with parents and siblings in foster care				ANI	62
Item 14: Preserving connections				ANI	77.5
Item 15: Relative placement				ANI	83
Item 16: Relationship of child in care with parents				ANI	47

* 95 percent of the applicable cases reviewed must be rated as having substantially achieved the outcome for the State to be in substantial conformity with the outcome.

** Items may be rated as a Strength or an ANI. For an overall rating of Strength, 90 percent of the cases must be rated as a Strength.

Table 2. Alaska CFSR Ratings for Child and Family Well-Being Outcomes and Items

Outcomes and Indicators	Outcome Ratings		Item Ratings	
	In Substantial Conformity?	Percent Substantially Achieved	Rating**	Percent Strength
Well-Being Outcome 1: Families have enhanced capacity to provide for children's needs	No	23.1	[redacted]	[redacted]
Item 17: Needs/services of child, parents, and foster parents	[redacted]	[redacted]	ANI	32
Item 18: Child/family involvement in case planning	[redacted]	[redacted]	ANI	37
Item 19: Caseworker visits with child	[redacted]	[redacted]	ANI	26
Item 20: Caseworker visits with parents	[redacted]	[redacted]	ANI	20
Well-Being Outcome 2: Children receive services to meet their educational needs	No	76.1	[redacted]	[redacted]
Item 21: Educational needs of child	[redacted]	[redacted]	ANI	76
Well-Being Outcome 3: Children receive services to meet their physical and mental health needs	No	52.5	[redacted]	[redacted]
Item 22: Physical health of child	[redacted]	[redacted]	ANI	71
Item 23: Mental health of child	[redacted]	[redacted]	ANI	55

* 95 percent of the applicable cases reviewed must be rated as having substantially achieved the outcome for the State to be in substantial conformity with the outcome.

** Items may be rated as a Strength or an ANI. For an overall rating of Strength, 90 percent of the cases reviewed for the item (with the exception of item 21) must be rated as a Strength. Because item 21 is the only item for Well-Being Outcome 2, the requirement of a 95-percent Strength rating applies.

Table 3: Alaska CFSR Ratings for Systemic Factors and Items

Systemic Factors and Items	Substantial Conformity?	Score*	Item Rating**
Statewide Information System	Yes	3	
Item 24: The State is operating a statewide information system that, at a minimum, can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care			Strength
Case Review System	No	2	
Item 25: The State provides a process that ensures that each child has a written case plan to be developed jointly with the child's parents that includes the required provisions			ANI
Item 26: The State provides a process for the periodic review of the status of each child, no less frequently than once every 6 months, either by a court or by administrative review			Strength
Item 27: The State provides a process that ensures that each child in foster care under the supervision of the States has a permanency hearing in a qualified court or administrative body no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter			Strength
Item 28: The State provides a process for TPR proceedings in accordance with the provisions of the Adoption and Safe Families Act (ASFA)			ANI
Item 29: The State provides a process for foster parents, pre-adoptive parents, and relative caregivers of children in foster care to be notified of, and have an opportunity to be heard in, any review or hearing held with respect to the child			ANI
Quality Assurance System	No	2	
Item 30: The State has developed and implemented standards to ensure that children in foster care are provided quality services that protect the safety and health of children			ANI
Item 31: The State is operating an identifiable quality assurance system that is in place in the jurisdictions where the services included in the Child and Family Services Plan (CFSP) are provided, evaluates the quality of services, identified Strengths and needs of the service delivery system, provides relevant reports, and evaluations program improvement measures implemented			ANI
Training	No	2	
Item 32: The State is operating a staff development and training program that supports the goals and objectives in the CFSP, addresses services provided under titles IV-B and IV-E, and provides initial training for all staff who deliver these services			ANI
Item 33: The State provides for ongoing training for staff that addresses the skills and knowledge base needed to carry out their duties with regard to the services included in the CFSP			ANI
Item 34: The State provides training for current or prospective foster parents, adoptive parents, and staff of State licensed or approved facilities that care for children receiving foster care or adoption assistance under title IV-E that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children			ANI

Systemic Factors and Items	Substantial Conformity?	Score	Item Rating**
Service Array	No	2	
Item 35: The State has in place an array of services that assess the strengths and needs of children and families and determine other service needs, address the needs of families in addition to individual children in order to create a safe home environment, enable children to remain safely with their parents when reasonable, and help children in foster and adoptive placements achieve permanency			ANI
Item 36: The services in item 35 are accessible to families and children in all political jurisdictions covered in the State's CFSP			ANI
Item 37: The services in item 35 can be individualized to meet the unique needs of children and families served by the agency			ANI
Agency Responsiveness to the Community	No	2	
Item 38: In implementing the provisions of the CFSP, the State engages in ongoing consultation with Tribal representatives, consumers, services providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals and objectives of the CFSP			ANI
Item 39: The agency develops, in consultation with these representatives, Annual Progress and Services Reports delivered pursuant to the CFSP			ANI
Item 40: The State's services under the CFSP are coordinated with services or benefits of other Federal or federally assisted programs serving the same population			Strength
Foster and Adoptive Parent Licensing, Recruitment, and Retention	No	2	
Item 41: The State has implemented standards for foster family homes and child care institutions which are reasonably in accord with recommended national standards			ANI
Item 42: The standards are applied to all licensed or approved foster family homes or child care institutions receiving title IV-E or IV-B funds			Strength
Item 43: The State complies with Federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children			Strength
Item 44: The State has in place a process for ensuring the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom adoptive homes are needed			ANI
Item 45: The State has in place a process for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children			Strength

* Scores range from 1 to 4. A score of 1 or 2 means that the factor is not in substantial conformity. A score of 3 or 4 means that the factor is in substantial conformity.

** Items may be rated as a Strength or as an ANI.

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Final Report
Alaska Child and Family Services Review
February 2009

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

INTRODUCTION

This document presents the findings of the Child and Family Services Review (CFSR) for the State of Alaska. The CFSR is the Federal Government's program for assessing the performance of State child welfare agencies with regard to achieving positive outcomes for children and families. It is authorized by the Social Security Amendments of 1994 requiring the Department of Health and Human Services (HHS) to promulgate regulations for reviews of State child and family services programs under titles IV-B and IV-E of the Social Security Act. The CFSR is implemented by the Children's Bureau (CB) of the Administration for Children and Families within HHS.

The Alaska CFSR was conducted the week of September 8, 2008. The period under review for the onsite case review process was from April 1, 2007, to September 12, 2008. The findings were derived from the following documents and data collection procedures:

- The Statewide Assessment, prepared by the Alaska Department of Health and Social Services (DHSS), Office of Children's Services (OCS)
- The State Data Profile, prepared by CB, which provides Alaska's child welfare data for the CFSR target 12-month period ending March 31, 2007
- Reviews of 65 cases (40 foster care and 25 in-home services cases) at three sites: 31 cases in Anchorage, 17 cases in Bethel, and 17 cases in Juneau
- Interviews and focus groups (conducted at all three sites and at the State level) with stakeholders including, but not limited to, children, youth, parents, foster and adoptive parents, all levels of child welfare agency personnel, collaborating agency personnel, service providers, court personnel, child advocates, Tribal representatives, and attorneys

All 65 cases were open child welfare agency cases at some time during the period under review. The key characteristics of the 65 cases reviewed are presented in the table at the end of this section. The percentages presented in this table and in subsequent tables in the report may not always total to 100 percent due to rounding.

The first section of the report (Section A: Outcomes) presents the CFSR findings relevant to Alaska's performance in achieving specified outcomes for children in the areas of safety, permanency, and well-being. For each outcome, there is a table presenting the data for the case review findings and national indicators (when relevant). The table is followed by a discussion of Alaska's status with regard to substantial conformity with the outcome at the time of the State's first CFSR review, which was held in fiscal year (FY) 2002; the State's status relevant to the current review; and a presentation and discussion of each item (indicator) assessed under the outcome. Differences in findings across the sites included in the Onsite Review are described. Variations in outcome and item ratings as a function of type of case (i.e., foster care or in-home services) also are identified when appropriate. The second section of the report (Section B: Systemic Factors) provides an assessment and discussion of the systemic factors relevant to the child welfare agency's ability to achieve positive outcomes for children.

Table of Key Characteristics

Case Characteristics	Foster Care Cases	In-Home Cases
Total Cases	**40**	**25**
When case was opened		
Case was opened prior to the period under review	34 (85%)	13 (52%)
Case was opened during the period under review	6 (15%)	12 (48%)
Child entered foster care during the period under review	11 (27.5%)	NA
Child's age at start of period under review		
Younger than age 10	22 (55%)	*
At least 10 but younger than 13	4 (10%)	*
At least 13 but younger than 16	6 (15%)	*
16 and older	8 (20%)	*
Race/Ethnicity		
American Indian/Alaskan Native	24 (60%)	*
Black (Non-Hispanic)	1 (2.5%)	*
White (Non-Hispanic)	9 (22.5%)	*
Hispanic (of any race)	2 (5%)	*
Two or More Races (Non-Hispanic)	4 (10%)	*
Primary reason for opening case		
Neglect (not including medical neglect)	15 (37.5%)	9 (36%)
Substance abuse by parent	15 (37.5%)	5 (20%)
Physical abuse	3 (7.5%)	2 (8%)
Sexual abuse	2 (5%)	3 (12%)
Medical neglect	0	2 (8%)
Mental/physical health of parent	1 (2.5%)	1 (4%)
Mental/physical health of child	2 (5%)	0
Domestic violence in child's home	0	2 (8%)
Emotional maltreatment	1 (2.5%)	1 (4%)
Abandonment	1 (2.5%)	0

* Information on these characteristics for in-home services cases is not provided because all children in the family are considered in these cases.

SECTION A: OUTCOMES

In the Outcomes Section of the CSFR Final Report, an overall rating of Strength or Area Needing Improvement (ANI) is assigned to each of the 23 indicators (items) reviewed. An item is assigned an overall rating of Strength if 90 percent of the applicable cases reviewed were rated as a Strength. The item ratings are used to determine the performance of a State on the seven outcomes, each of which incorporates one or more of the individual items. The evaluation options for these outcomes are Substantially Achieved, Partially Achieved, and Not Achieved. For a State to be in substantial conformity with a particular outcome, 95 percent of the applicable cases reviewed must be rated as having substantially achieved the outcome. Two outcomes—Safety Outcome 1 and Permanency Outcome 1—also are evaluated based on State performance with regard to six national data indicators. For a State to be in substantial conformity with these outcomes, the national standards for each data indicator must be met as well as the case review requirements. A State that is not in substantial conformity with a particular outcome must develop and implement a program improvement plan (PIP) to address the areas of concern identified for that outcome.

CB has established a very high standard of performance for the CFSR. The standards are based on the belief that because child welfare agencies work with our nation's most vulnerable children and families, only the highest standards of performance should be considered acceptable. The standards are set high to ensure ongoing attention to achieving positive outcomes for children and families with regard to safety, permanency, and well-being. This is consistent with the goal of the CFSR to promote continuous improvement in performance on these outcomes.

It should be noted, however, that States are not required to attain either the 95-percent standard established for the CFSR Onsite Review or the national standards for the six data indicators by the end of their PIP implementation. CB recognizes that the kinds of systemic and practice changes necessary to bring about improvement in particular outcome areas often take time to implement. Also, improvements are likely to be incremental rather than dramatic. Instead, States work with CB to establish a specified amount of improvement or to determine specified activities for their PIP. That is, for each outcome that is not in substantial conformity or item that is an ANI, each State (working in conjunction with CB) specifies the following: (1) how much improvement the State will demonstrate and/or the activities that it will implement to address the ANIs and (2) the procedures for demonstrating the achievement of these goals. Both the improvements specified and the procedures for demonstrating improvement vary across States. Therefore, a State can meet the requirements of its PIP and still not perform at the 95-percent (for outcomes) or the 90 percent (for items) levels established for the CFSR.

The second round of the CFSR assesses a State's current level of performance by once more applying the high standards and a consistent, comprehensive case review methodology. The results of this effort are intended to serve as the basis for continued PIPs addressing areas in which a State still needs to improve, even though prior PIP goals may have been achieved. The purpose is to ensure that program improvement is an ongoing process and does not end with the completion of a PIP.

In the following sections, information is provided pertaining to how the State performed on each outcome in the first round of the CFSR. If the outcome was not substantially achieved during the first round, the key concerns observed at that time are identified as well as the strategies implemented in the PIP to address those concerns.

Because many changes were made in the CFSR process based on lessons learned during the first round and in response to feedback from the child welfare field, a State's performance in the second round of the CFSR is not directly comparable to its performance in the first round, particularly with regard to comparisons of data indicators or percentages regarding Strength and ANI ratings. Key changes in the CFSR process that make it difficult to compare performance across reviews include, but are not limited to, the following:

- An increase in the sample size from 50 to 65 cases
- Stratification of the sample to ensure a minimum number of cases in key program areas, resulting in variations in the number of cases relevant for specific outcomes and items
- Changes in criteria for specific items to enhance consistency and ensure an assessment of critical areas such as child welfare agency efforts to involve noncustodial parents in planning for their children

I. SAFETY

Safety Outcome 1

Outcome S1: Children are, first and foremost, protected from abuse and neglect					
Number of cases reviewed by the team according to degree of outcome achievement					
Outcome Achievement	**Anchorage**	**Bethel**	**Juneau**	**Total**	**Percent**
Substantially Achieved	9	4	3	16	**47.1**
Partially Achieved	6	2	3	11	**32.4**
Not Achieved or Addressed	1	2	4	7	**20.6**
Total Applicable Cases	**16**	**8**	**10**	**34**	
Not Applicable Cases	15	9	7	31	
Total Cases	**31**	**17**	**17**	**65**	

Conformity of statewide data indicators with national standards			
Data Indicators	**National Standard (%)**	**State's Percentage**	**Meets Standard?**
Absence of maltreatment recurrence	94.6 or higher	90.7	No
Absence of maltreatment of children in foster care by foster parents or facility staff	99.68 or higher	99.57	No

Status of Safety Outcome 1

Alaska is not in substantial conformity with Safety Outcome 1. The outcome was determined to be substantially achieved in only 47.1 percent of applicable cases, which is less than the 95 percent or higher required for a rating of substantial conformity. The outcome was substantially achieved in 56 percent of applicable Anchorage cases, 50 percent of applicable Bethel cases, and 30 percent of applicable Juneau cases. In addition, as shown in the table, Alaska does not meet the national standards for the two data indicators relevant to Safety Outcome 1. Alaska was not in substantial conformity with Safety Outcome 1 during its first CFSR conducted in FY 2002 and was required to address this outcome in its PIP.

Key Concerns From the 2002 CFSR

In the 2002 CFSR, both items assessed for this outcome were rated as ANIs. Key concerns identified in the 2002 CFSR were the following:

- The State did not meet the national standards for (1) the percentage of children experiencing more than one substantiated or indicated child maltreatment report within a 6-month period or (2) the percentage of children experiencing maltreatment from caregivers while in foster care.
- Although the agency initiated investigations of reports involving imminent risk (priority 1 reports) within the required timeframes, the initiation of investigations of maltreatment reports not involving imminent risk (i.e., reports assigned as priority 2 or 3) did not consistently meet required timeframes.

To address these concerns, Alaska included the following key strategies in its PIP:

- Revised policies relating to the investigative process, including specifying the definitions for "face-to-face contact" and "initiation of investigation"
- Provided training to supervisors and caseworkers regarding new policy
- Established a protocol to review repeat maltreatment cases
- Developed a new safety assessment model (training of staff on the model in spring 2006)

The State met its target goals for this outcome by the end of its PIP implementation period.

Key Findings of the 2008 CFSR

The findings for Alaska's 2008 CFSR pertaining to the specific items assessed under Safety Outcome 1 are presented below.

Item 1. Timeliness of initiating investigations of reports of child maltreatment

____ Strength __X___ Area Needing Improvement

Case Review Findings

The assessment of item 1 was applicable for 34 (52 percent) of the 65 cases. Cases were not applicable when there were no child maltreatment reports during the period under review. In assessing item 1, reviewers were to determine whether the response to a maltreatment report occurring during the period under review had been initiated in accordance with the State child welfare agency policy requirements.

According to the Statewide Assessment:

"The Alaska Office of Children's Services policy defines the following timeframes:

"Priority 1 [P1] reports mandate that a response to, and an investigation of, a report must be made within 24 hours of the initial report to OCS. P1 reports are defined as reports that indicate a present danger to the child and require an immediate response.
"Priority 2 [P2] reports mandate that a response to, and an investigation of, a report must be made within 72 hours of the initial report to OCS. P2 reports are defined as reports where the situation is serious; however, information available does not indicate the child is in immediate danger.
"Priority 3 [P3] reports mandate that a response to, and an investigation of, a report must be made within 7 calendar days of the initial report to OCS. P3 reports are defined as reports in which a delay in assessing the situation will not result in significant additional harm to the child."

The Statewide Assessment also indicates that some areas of the State have a differential response program. According to the policy document, staff responding to maltreatment reports that are assigned to the differential response program are expected to meet the same timeframe requirements as P3 reports—i.e., a response must be initiated within 7 calendar days of the initial report to OCS. Anchorage is the only site included in the onsite CFSR that has a differential response program.

The results of the assessment of item 1 are presented in the table below.

Item 1 Ratings	**Anchorage**	**Bethel**	**Juneau**	**Total**	**Percent**
Strength	11	5	3	19	**56**
Area Needing Improvement	5	3	7	15	**44**
Total Applicable Cases	**16**	**8**	**10**	**34**	
Not Applicable	15	9	7	31	
Total Cases	**31**	**17**	**17**	**65**	

Item 1 was rated as a Strength in 69 percent of applicable Anchorage cases, 62.5 percent of applicable Bethel cases, and 30 percent of applicable Juneau cases. The item was rated as a Strength when the investigation was initiated and face-to-face contact was made within the timeframes required by State policy or law.

Item 1 was rated as an ANI in 15 cases in which the investigation of at least one maltreatment report on the family was not initiated and/or face-to-face contact was not made within the required timeframes. For the 15 cases rated as ANIs, there were 22 maltreatment reports that did not meet the timeframes required by State policy. Of these, 11 were P3 reports, 5 were P2 reports, and 4 were P1 reports. One report was never screened or assigned, and one report was assigned to the differential response program, but the children who were the subject of the report were never seen.

Rating Determination
Item 1 is assigned an overall rating of ANI. In 56 percent of the applicable cases, reviewers determined that the agency had initiated an investigation of a maltreatment report in accordance with required timeframes. This percentage is less than the 90 percent or higher required for an overall item rating of Strength. This item also was rated as an ANI in Alaska's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, the State's Quality Assurance (QA) reviews found that P1 referrals are consistently responded to and investigated in a timely manner. However, the QA reviews also found that there are challenges in meeting the response timeframes for P2 and P3 reports. It was noted in the Statewide Assessment that these challenges affect the State's overall results regarding compliance with item 1.

The Statewide Assessment also reports that for the P2 and P3 reports, when initial efforts to locate the child or family are not successful, the case "can fall between the cracks and a follow-up effort does not take place until the required timelines have been exceeded." In addition, the Statewide Assessment notes that although Alaska faces many geographically related challenges, the QA team reported that in the cases reviewed, weather and/or remoteness was seldom the reason that an investigation was not initiated in a timely manner.

Stakeholder Interview Information
Most stakeholders commenting on this item expressed the opinion that investigations of P1 reports generally are initiated within the required timeframes. However, they also noted that because of staff shortages of caseworkers who conduct investigations, when P1 reports are received, P2 and P3 reports tend to get pushed back and may be delayed. Anchorage stakeholders indicated that there are no limits on the number of cases that can be assigned to an investigations caseworker and as a result, the Anchorage office experiences a backlog in investigations. However, Anchorage stakeholders also noted that concerted efforts have been made to clear up the backlog, and it is not as large as it used to be.

Several stakeholders also indicated that although State policy as written specifies that the timeframe for initiating an investigation is to begin with the actual referral call to OCS, many agency caseworkers and supervisors believe that the timeframe for initiating an investigation does not actually begin until the screening decision is made by the intake supervisor, and the report is then assigned to the investigator. As a result, sometimes it is difficult to determine how long cases sit at the desk of the supervisor prior to the screening decision. A few stakeholders indicated that it can be difficult to gather all of the information necessary to make a screening decision in a timely manner.

Bethel and Juneau stakeholders said they were concerned about the lack of standardized criteria for accepting (i.e., screening in) referrals. Stakeholders at these sites expressed the opinion that the lack of standardized criteria can result in children with serious

problems not getting the attention they need because the screener does not accept the report. Several stakeholders suggested that this is a particular problem with sexual abuse reports, chronic neglect reports, and reports involving adolescents; they noted that such reports often are screened out without a clear reason.

Item 2. Repeat maltreatment

____ Strength __X__ Area Needing Improvement

Case Review Findings

The assessment of item 2 was applicable for 26 (40 percent) of the 65 cases. Cases were not applicable for this item if there was no substantiated or indicated maltreatment report during the period under review. For all applicable cases, reviewers were to determine if there had been a substantiated or indicated maltreatment report on the family during the period under review, and if so, whether another substantiated or indicated report involving similar circumstances had occurred within a 6-month period before or after that identified report. The results of the assessment of item 2 are presented in the table below.

Item 2 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	11	4	6	21	**81**
Area Needing Improvement	2	2	1	5	**19**
Total Applicable Cases	**13**	**6**	**7**	**26**	
Not Applicable	18	11	10	39	
Total Cases	**31**	**17**	**17**	**65**	

Item 2 was rated as a Strength in 85 percent of applicable Anchorage cases, 67 percent of applicable Bethel cases, and 86 percent of applicable Juneau cases. Item 2 was rated as a Strength when there was only one substantiated or indicated maltreatment report on the family within a 6-month period. Item 2 was rated as an ANI in five cases when there were at least two substantiated maltreatment reports on the family within a 6-month period.

In addition to the recurrence of substantiated maltreatment reports, reviewers expressed concern about the many cases involving multiple reports on the family during the life of the case. The "life of the case" refers to the time span from the date of the first allegation of abuse or neglect to the time of the Onsite Review. The following are key findings with regard to this concern:

- In 18 cases, there were at least 5 reports during the life of the case but fewer than 10 reports.
- In 9 cases, there were between 10 and 14 reports during the life of the case.
- In 12 cases, there were 15 or more maltreatment reports during the life of the case, with 4 cases having more than 20 reports.

Rating Determination
Item 2 is assigned an overall rating of ANI. In 81 percent of the cases, reviewers determined that there was no recurrence of maltreatment. This percentage is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, the State's QA team reported that when repeat maltreatment is identified in the QA review, it generally occurs in cases in which an investigation took place but services were not provided and the case was eventually closed. As indicated in the Statewide Assessment, lack of ongoing monitoring and follow-up post-investigation appears to contribute to the repeat maltreatment incidents that occur in these cases. The Statewide Assessment did not provide QA data for this item.

Stakeholder Interview Information
Anchorage stakeholders commenting on this item during the onsite CFSR expressed the opinion that repeat maltreatment is a problem at that site and that it may be attributed in part to a lack of follow through by the assigned caseworker after the initial contact. These stakeholders suggested that OCS is closing cases prematurely or letting cases remain open without efforts to work with the family.

In addition, some stakeholders indicated that maltreatment reports on open cases may be passed directly to the existing caseworker on the case. Sometimes, in these instances, the maltreatment allegation is not reported to intake and there is no full investigation of the new allegation or formal finding regarding substantiation of the allegation. Some Anchorage stakeholders indicated that often when contracted service providers working on an open case need to make a maltreatment report, they will call the ongoing caseworker rather than make a report through the intake process. Stakeholders suggested that at that point, the ongoing caseworker may or may not inform intake of the report so that it can be formally investigated.

Safety Outcome 2

Safety Outcome S2: Children are safely maintained in their homes whenever possible and appropriate					
Number of cases reviewed by the team according to degree of outcome achievement					
Outcome Achievement	**Anchorage**	**Bethel**	**Juneau**	**Total**	**Percent**
Substantially Achieved	16	3	6	25	**38.5**
Partially Achieved	4	4	4	12	**18.5**
Not Achieved or Addressed	11	10	7	28	**43.1**
Total Cases	**31**	**17**	**17**	**65**	

Status of Safety Outcome 2

Alaska is not in substantial conformity with Safety Outcome 2. The outcome was determined to be substantially achieved in only 38.5 percent of the cases reviewed, which is less than the 95 percent or higher required for a rating of substantial conformity. The outcome was substantially achieved in 52 percent of Anchorage cases, 18 percent of Bethel cases, and 35 percent of Juneau cases. Alaska also did not achieve substantial conformity with Safety Outcome 2 in its 2002 CFSR and was required to address the outcome in its PIP.

Key Concerns From the 2002 CFSR

In the 2002 CFSR, both items assessed for this outcome were rated as ANIs. The following key concerns were identified at that time:

- The services offered to families often were not adequate to ensure children's safety and reduce risk of harm, and did not address underlying issues contributing to the maltreatment.
- Frequently, when services were offered to families, there was insufficient monitoring on the part of the agency to assess whether services were actually provided, whether parents were fully participating in services, and/or whether the children were safe.

To address these concerns, the State implemented the following key strategies:

- Issued new policies regarding in-home cases focusing on using Structured Decision Making (SDM) tools for assessments and case planning
- Provided training on reassessment and review of in-home case plans using the Future Risk of Harm form
- Implemented data collection through the QA process to evaluate the use and effectiveness of SDM tools

The State met its target goals for this outcome by the end of its PIP implementation period.

Key Findings of the 2008 CFSR

The findings for the 2008 CFSR pertaining to the specific items assessed under Safety Outcome 2 are presented below.

Item 3. Services to family to protect child(ren) in the home and prevent removal

____ Strength __X__ Area Needing Improvement

Case Review Findings

An assessment of item 3 was applicable for 47 (72 percent) of the 65 cases. Cases were excluded from this assessment if the children entered foster care prior to the period under review and there were no other children in the home or if there was no substantiated or indicated maltreatment report or identified risk of harm to the children in the home during the period under review. For this item, reviewers assessed whether, in responding to a substantiated maltreatment report or risk of harm, the agency made diligent efforts to provide services to families to prevent placement of children in foster care while at the same time ensuring their safety. The results of this assessment are presented in the table below.

Item 3 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	10	6	8	24	**51**
Area Needing Improvement	11	8	4	23	**49**
Total Applicable Cases	**21**	**14**	**12**	**47**	
Not Applicable	10	3	5	18	
Total Cases	**31**	**17**	**17**	**65**	

Item 3 was rated as a Strength in 48 percent of applicable Anchorage cases, 43 percent of applicable Bethel cases, and 67 percent of applicable Juneau cases. Item 3 was rated as a Strength in 24 cases when reviewers determined that services were provided to the parents and children to prevent removal or that children were appropriately removed from the home without service provision because the removal was necessary to ensure the child's safety. Item 3 was rated as an ANI in 23 cases when reviewers determined the following:

- The services provided were insufficient to ensure the safety of the child while the child remained in the home (18 cases).
- The child was removed from the home, and the agency did not make concerted efforts to provide services to prevent the removal (three cases).
- No efforts were made to identify services that would ensure the safety of children residing with a relative (two cases). (In these cases, the child was not in foster care.)

Rating Determination
Item 3 is assigned an overall rating of ANI. In 51 percent of the cases, reviewers determined that the agency had made concerted efforts to maintain children safely in their own homes. This percentage is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, high caseloads for investigators across the State make it difficult to provide in-home services to ensure safety. The Statewide Assessment also reports that accessing services that meet the complex needs of families also tends to be a challenge. Data provided in the Statewide Assessment indicate that in the State's 2008 QA review, approximately 68 percent of Anchorage cases, 28 percent of Bethel cases, and 78 percent of Juneau cases were found to have had services provided to prevent removal. (The actual percentages are estimates based on the charts provided in the Statewide Assessment. The sites specified in the Statewide Assessment data as Anchorage, Bethel, and Juneau pertain to the same geographic areas as those sites reviewed in the Onsite Review.)

Stakeholder Interview
Some stakeholders in Anchorage and Bethel expressed the opinion that children may not be maintained safely in their homes because of a lack of in-home services and follow up by the caseworker to monitor the family and ensure that services are being provided. The lack of caseworker follow-up was attributed to their high caseloads. A few Anchorage stakeholders also indicated that children may be removed from their homes because there are waiting lists for substance abuse treatment services for the parents and concern that the children cannot be left in the home if parents are not accessing these services.

Some Anchorage stakeholders reported that the caseworkers responsible for case management of in-home services also are responsible for investigations and, as a result, they do not have the time to follow up on these cases. One Anchorage stakeholder indicated that a specific in-home services unit was created recently to work with these families, but that there was no statewide guidance on working with these cases since they are mostly voluntary cases.

Item 4. Risk of harm to child

____ Strength __X__ Area Needing Improvement

Case Review Findings
An assessment of item 4 was applicable for all 65 cases. In assessing item 4, reviewers were to determine whether the agency had made, or was making, diligent efforts to address the risk of harm to the children involved in each case. The results of this assessment are shown in the table below.

Item 4 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	16	3	6	25	**38**
Area Needing Improvement	15	14	11	40	**62**
Total Cases	**31**	**17**	**17**	**65**	

Item 4 was rated as a Strength in 52 percent of Anchorage cases, 18 percent of Bethel cases, and 35 percent of Juneau cases. The item was rated as a Strength when reviewers determined that the risk of harm to children was appropriately addressed by the agency through the following: (1) conducting initial and ongoing assessments of risk and safety either in the children's home or in the children's foster home, and (2) addressing all safety-related concerns identified through the assessment.

Item 4 was rated as an ANI in 40 cases when reviewers determined one or more of the following:

- There was a lack of adequate safety and risk assessments in the home prior to case closure or prior to a trial home visit (nine cases).
- There was a lack of ongoing safety and risk assessments in the children's home during the period under review (23 cases).
- There were continued risk concerns in the home that were not addressed and/or monitored by the agency and the children were at risk in the home (17 cases).
- The case was closed without the child welfare agency ever having had any contact with the children in the home and without an initial risk assessment (one case).
- There was a lack of risk and safety assessments of the foster home (four cases).

Rating Determination
Item 4 is assigned an overall rating of ANI. Reviewers determined that the agency had appropriately addressed the risk of harm to the children in only 38 percent of the applicable cases. This percentage is less than the 90 percent or higher required for an overall rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, QA reviews have found that children in foster care receive quality care and that abuse in foster care is rare. However, the Statewide Assessment reports that QA reviews also have found that OCS struggles with effectively

reducing risk of harm to children who remain in their own homes. The Statewide Assessment notes that QA case reviews reveal that often families who are receiving in-home services are seen only once in several months and that there is a lack of consistent ongoing monitoring that weakens OCS's ability to ensure the safety of children in their own home. However, no QA data were provided for this item in the Statewide Assessment.

Stakeholder Interview Information
Several State-level, Anchorage, and Juneau stakeholders commenting on this item during the onsite CFSR expressed the opinion that the new safety model, although well-liked, is requiring more time and training than initially anticipated because it involves moving from an incidence-driven system to a more comprehensive holistic decision-based system. However, they also noted that because almost all in-home cases are voluntary, there can be some problems with the family but are not sufficient to keep a case open. Some Juneau stakeholders indicated that there is a lack of clear instruction or policy regarding reassessing the family prior to closing a case. They suggested that although assessments often are conducted, they are not being documented.

Several stakeholders also expressed concern about the safety of children who are being placed in nonlicensed homes because background checks are not completed on these homes prior to the placement and often not until the child has been in the home for several months.

A few stakeholders noted that in some differential response cases the children may need placement services while the contracted agencies are working with the families. However, these stakeholders suggested that OCS often does not address the placement concerns for these children because the case has been assigned to the differential response program.

II. PERMANENCY

Permanency Outcome 1

Outcome P1: Children have permanency and stability in their living situations					
Number of cases reviewed by site according to degree of outcome achievement					
Outcome Achievement	**Anchorage**	**Bethel**	**Juneau**	**Total**	**Percent**
Substantially Achieved	4	1	1	6	**15.0**
Partially Achieved	15	8	6	29	**72.5**
Not Achieved or Addressed	1	1	3	5	**12.5**
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Conformity of statewide data indicators with national standards			
Data Indicators	**National Standard (Scaled Score)**	**State's Composite Score**	**Meets Standard?**
Composite 1: Timeliness and permanency of reunification	122.6 +	122.4	No
Composite 2: Timeliness of adoptions	106.4 +	81.1	No
Composite 3: Permanency for children in foster care for extended time periods	121.7 +	125.4	Yes
Composite 4: Placement stability	101.5 +	73.1	No

Status of Permanency Outcome 1

Alaska is not in substantial conformity with Permanency Outcome 1. This determination was based on the following findings:

- The outcome was substantially achieved in only 15 percent of the cases, which is less than the 95 percent required for an overall rating of substantial conformity. The outcome was substantially achieved in 20 percent of Anchorage cases and 10 percent of Bethel and Juneau cases.
- The State did not meet the national standards for the national data indicators pertaining to the timeliness and permanency of reunification (Composite 1), the timeliness of adoptions (Composite 2), and placement stability (Composite 4).

The State met the national standards for the data indicator pertaining to achieving permanency for children in foster care for extended time periods (Composite 3). Alaska's performance on the individual measures included in each composite data indicator is presented in the discussion of the items related to the measure.

Alaska was not in substantial conformity with Permanency Outcome 1 in its 2002 CFSR and was required to address the outcome in its PIP.

Key Concerns From the 2002 CFSR

During the 2002 CFSR, all relevant items except item 5 (foster care reentry) were rated as ANIs. The following key concerns were identified:

- The agency was not consistent with regard to ensuring placement stability for children in foster care, which was attributed primarily to a lack of effort to match children and foster parents.
- Case goals often were in place for extended periods of time even when there were indications that the goal was not likely to be achieved.
- Appropriate case goals often were not established in a timely manner.
- The goals of guardianship and reunification were not achieved in a timely manner.
- There were many agency-related delays in achieving adoptions in a timely manner, including lack of timely decision-making and lack of follow-up with the child and pre-adoptive family.

To address these concerns, Alaska implemented the following strategies as part of its PIP:

- Standardized practice for setting and changing permanency goals when concurrent planning occurs
- Improved the structure of administrative reviews and permanency planning conferences, with enhanced focus on permanency goals and concurrent planning
- Developed the continuous QA review system to monitor cases
- Established Regional Adoption Specialists who participate in administrative and permanency planning reviews to ensure that goals are established in a timely manner and are documented
- Implemented a statewide contract for post-adoption services

The State met its target goals for this outcome by the end of its PIP implementation period.

Key Findings of the 2008 CFSR

Findings of the 2008 CFSR pertaining to the specific items assessed under Permanency Outcome 1 are presented below.

Item 5. Foster care reentries

__X__ Strength ____ Area Needing Improvement

Case Review Findings

An assessment of item 5 was applicable for 11 (27.5 percent) of the 40 foster care cases. Cases were not applicable for assessment if the child did not enter foster care during the period under review. In assessing this item, reviewers determined whether the entry into foster care during the period under review occurred within 12 months of discharge from a prior foster care episode. The results of this assessment are presented in the table below.

Item 5 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	5	3	2	10	**91**
Area Needing Improvement	1	0	0	1	**9**
Total Applicable Foster Care Cases	**6**	**3**	**2**	**11**	
Not Applicable Foster Care Cases	14	7	8	29	
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Item 5 was rated as a Strength in 10 cases in which the child's entry into foster care during the period under review did not take place within 12 months of discharge from a prior episode. The item was rated as an ANI in one case in which the child reentered foster care within 12 months of discharge from a prior foster care episode. In this case the child was on a trial home visit that lasted longer than 6 months and was re-removed from the home due to the mother's continued substance abuse problem, which had not been adequately treated.

Rating Determination

Item 5 is assigned an overall rating of Strength. In 91 percent of the applicable cases, the child had not reentered foster care in less than 12 months. This percentage exceeds the 90 percent required for a rating of Strength. This item also was rated as a Strength in the State's 2002 CFSR.

Performance on Composite 1: Measure relevant to the permanency of reunification

The data below are presented to provide additional information about foster care reentry. There is no national standard for the measure of foster care reentry. National standards with regard to permanency have been established only for the scaled composite scores. The measure of foster care reentry is part of Composite 1: Timeliness and permanency of reunification. The State's performance on Composite 1 is shown in the table for Permanency Outcome 1.

The following is the State's performance for the CFSR 12-month target period for the data indicators. The CFSR 12-month target period for the data indicators was from April 1, 2006, to March 31, 2007. With regard to the individual measure of foster care reentry (measure C1.4) included in the Composite 1 data indicator—Timeliness and permanency of reunification, 7.5 percent of the children exiting foster care to reunification in the 12-month period prior to the CFSR 12-month target period reentered foster care in less than 12 months from the time of discharge. This percentage is lower than the 25th percentile of 9.9 percent. For this measure, lower percentages are associated with higher levels of performance.

Statewide Assessment Information
According to the Statewide Assessment, efforts to prevent reentries into foster care are a strength for OCS. The Statewide Assessment attributes this positive performance in part to the fact that caseworkers mitigate the safety threats for children and determine that needed changes have taken place before the child is returned home. However, the Statewide Assessment also notes that stakeholders expressed concern that the strength noted in this area may be gained at the cost of "length of time in care."

Stakeholder Interview Information
Stakeholders did not comment on this item during the onsite CFSR.

Item 6. Stability of foster care placement

____ Strength __X__ Area Needing Improvement

Case Review Findings
All 40 foster care cases were applicable for an assessment of item 6. In assessing this item, reviewers were to determine whether the child experienced multiple placement settings during the period under review and, if so, whether the changes in placement settings were necessary to achieve the child's permanency goal or meet the child's service needs. Reviewers also assessed the stability of the child's current placement setting. The results of this assessment are presented in the table below.

Item 6 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	16	7	6	29	**72.5**
Area Needing Improvement	4	3	4	11	**27.5**
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Item 6 was rated as a Strength in 80 percent of Anchorage cases, 70 percent of Bethel cases, and 60 percent of Juneau cases. Item 6 was rated as a Strength when reviewers determined that the child's current placement was stable and that the child either did not experience a placement change during the period under review or that the placement changes experienced were in the child's best

interests (i.e., they were intended to further achievement of the child's permanency goal or to provide specialized services to the child).

Item 6 was rated as an ANI in 11 cases when reviewers determined one or both of the following:

- The child was in multiple placement settings during the period under review and at least one placement change was not planned by the agency to further attainment of the child's permanency goal (11 cases).
- The child's current placement setting (at the time of the onsite CFSR) was not stable (two cases).

Additional findings of the case review were the following:

- Seventeen children had one placement during the period under review.
- Fourteen children had two placements during the period under review.
- Nine children had three or more placements during the period under review, with three of these children having five or more placements.

Rating Determination

Item 6 is assigned an overall rating of ANI. In 72.5 percent of the foster care cases, reviewers determined that children experienced placement stability or that changes in placements were in the best interests of the child. This percentage is less than the 90 percent or higher required for a rating of Strength. Item 6 also was rated as an ANI in the State's 2002 CFSR.

Performance on Composite 4: Measures of placement stability

The data below are presented to provide additional information about placement stability. There are no national standards for the individual measures of placement stability. National standards have been established only for the scaled composite scores for Composite 4: Placement stability. The State's performance on Composite 4 is shown in the table for Permanency Outcome 1.

Alaska's performance for the CFSR 12-month target period for the data indicators on the individual measures included in Composite 4: Placement stability is as follows:

- 65.8 percent of the children in foster care for at least 8 days but less than 12 months experienced two or fewer placement settings. This percentage is less than the national median of 83.3 percent.
- 50.7 percent of the children in foster care for at least 12 months but less than 24 months experienced two or fewer placement settings. This percentage is less than the national median of 59.9 percent.
- 25.8 percent of the children in foster care for at least 24 months experienced two or fewer placement settings. This percentage is less than the national median of 33.9 percent.

Statewide Assessment Information
According to the Statewide Assessment, OCS and stakeholders agree that placement stability is an ANI for the State. The Statewide Assessment notes that placement stability can be affected by the age of foster children, the lack of therapeutic resource families to meet the needs of the child, the lack of consistent and available support resources for families, and the turnover in OCS caseworkers. The Statewide Assessment also notes that there is a lack of foster homes in the State, particularly those homes willing to care for adolescents. In addition, as reported in the Statewide Assessment, there are not enough therapeutic foster homes for youth with fetal alcohol spectrum disorders (FASDs) or significant mental health issues.

Stakeholder Interview Information
Most stakeholders commenting on this item during the onsite CFSR expressed the opinion that ensuring placement stability for children in foster care is a challenge for OCS. Various stakeholders attributed this problem to the following:

- A lack of foster families that are willing to foster children with complex needs and problems
- A lack of support for foster families, particularly respite services
- A lack of support for relative caregivers who are not licensed and whose needs often are ignored
- An insufficient pool of foster families, including Indian Child Welfare Act (ICWA) placement families, to ensure appropriate matching between children and foster parents
- Too frequent use of emergency placements and shelters, even for children younger than age 12
- A lack of training of caseworkers on how and when to support foster parents

A few stakeholders also indicated that foster parents are not always provided with complete information on the child placed in their home and this often "sets them up for failure."

Some Anchorage stakeholders indicated that Team Decision Meetings (TDMs) often are used to prevent placement changes and that some caseworkers are very skilled in this process. However, these stakeholders also reported that TDMs are available only in Anchorage and are not available to all families in that location.

Item 7. Permanency goal for child

____ Strength __X__ Area Needing Improvement

Case Review Findings
All 40 foster care cases were applicable for an assessment of item 7. In assessing this item, reviewers were to determine whether the agency had established a permanency goal for the child in a timely manner and whether the most current permanency goal was

appropriate. Reviewers also were to determine whether the agency had sought termination of parental rights (TPR) in accordance with the requirements of the Adoption and Safe Families Act (ASFA). The results of this assessment are shown below.

Item 7 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	11	5	2	18	**45**
Area Needing Improvement	9	5	8	22	**55**
Total Applicable Foster Care Cases	**20**	**10**	**10**	**40**	

Item 7 was rated as a Strength in 55 percent of Anchorage cases, 50 percent of Bethel cases, and 20 percent of Juneau cases. Item 7 was rated as a Strength when reviewers determined that the child's permanency goal was appropriate and had been established in a timely manner. The item was rated as an ANI when reviewers determined one or more of the following:

- The child's current permanency goal (at the time of the onsite CFSR) was not appropriate given the case situation and the needs of the child (four cases).
- The child's permanency goal was not established in a timely manner (15 cases).
- The agency had not sought TPR in accordance with the requirements of ASFA, particularly with regard to documenting in the case file compelling reasons for not seeking TPR (seven cases).

Case review findings pertaining to the case goals were as follows:

- Ten children had a goal of reunification with parents or relatives only.
- Nineteen children had a goal of adoption only.
- Three children had a goal of other planned permanent living arrangement (OPPLA) only. (OPPLA is a living arrangement other than adoption, reunification, living with other relatives, or guardianship that involves the child remaining in State custody until reaching the age of majority.)
- Two children had a goal of guardianship only.
- Three children had concurrent goals of adoption and reunification with parents.
- Two children had concurrent goals of guardianship and OPPLA.
- One child had concurrent goals of guardianship and reunification with parents.

Case review findings pertaining to meeting ASFA requirements for TPR were as follows:

- At the time of the onsite CFSR, 30 of the 40 children in the foster care cases had been in foster care for 15 of the most recent 22 months. ASFA requirements with regard to seeking TPR and documenting compelling reasons when TPR was not sought were

applicable for 29 of these foster care cases. In one case, ASFA requirements were not applicable because the child was in a foster care placement with a relative during the child's entire time in foster care.

- ASFA requirements were not met in 7 (24 percent) of the 29 cases for which the requirements were applicable.

Rating Determination

Item 7 is assigned an overall rating of ANI. Reviewers determined that the agency had established an appropriate permanency goal for the child in a timely manner and acted in accordance with the requirements of ASFA in only 45 percent of the applicable cases. This percentage is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Performance on Composite 3: Measures pertaining to achieving permanency for children in foster care for extended time periods

The data below are presented to provide additional information about achieving permanency for children in foster care for extended time periods. There are no national standards for the individual measures included in Composite 3. National standards have been established only for the scaled composite scores for Composite 3. The State's performance on Composite 3 is shown in the table for Permanency Outcome 1.

Alaska's performance for the CFSR target 12-month period on the individual measures included in Permanency Composite 3 (achieving permanency for children in foster care for extended time periods) is as follows:

- 20.6 percent of the children in foster care for 24 months or longer at the start of the target period were discharged from foster care to a permanent home (i.e., adoption, reunification with parents or other relatives, or guardianship) by the end of the target period (measure C3-1). This percentage is less than the national median of 25 percent.
- 99.4 percent of the children exiting foster care during the target period who were legally free for adoption at the time of exit were discharged to a permanent home (measure C3-2). This percentage exceeds the 75th percentile of 98 percent.
- 35.7 percent of the children who were discharged from foster care during the 12-month target period with a discharge reason of emancipation (or who turned age 18 while still in foster care) had been in foster care for 3 years or longer (measure C3.3). This percentage is less than the 25th percentile of 37.5 percent. For this measure, lower percentages indicate higher performance levels.

Statewide Assessment Information

According to the Statewide Assessment, the State QA reviews show an improvement in the establishment of permanency goals. However, no data were provided in the Statewide Assessment with regard to State QA findings for this item. In addition, although the Statewide Assessment notes that the incorporation of Regional Adoptions Specialists in administrative reviews and permanency planning conferences has increased the timeliness of goal establishment for children in out-of-home care, no evaluation data were provided to support this statement.

The Statewide Assessment indicates that stakeholders interviewed as part of the Statewide Assessment process expressed concern that OCS caseworkers do not understand the purpose of concurrent plans and that concurrent plans are not being developed as early as they could be in some cases. These stakeholders suggested that additional OCS staff training is needed in the development, use, and purpose of concurrent planning.

Stakeholder Interview Information
Several stakeholders commenting on this item during the onsite CFSR expressed opinions regarding concurrent planning. Some stakeholders indicated that concurrent planning is occurring and that caseworkers are working toward concurrent goals simultaneously. However, a few stakeholders also noted that although the State's automated child welfare information system can accommodate concurrent goals, many caseworkers are not entering concurrent goals into the system, particularly when there is a goal of adoption.

Other stakeholders expressed the opinion that caseworkers generally are not implementing concurrent planning early on in a case and when there are concurrent goals, caseworkers are not working both goals simultaneously. Some Bethel stakeholders, for example, noted that concurrent planning is not considered at all until the 9-month permanency hearing.

A few stakeholders also indicated that sometimes permanency goals other than reunification may not be established in a timely manner because of the extensive turnover in both the caseworker and supervisor positions. These stakeholders said that new caseworkers and supervisors usually want to start over again with the family regardless of how long the child has been in foster care. Other stakeholders suggested that permanency goals may not be changed from reunification because the required services for the parents have not been available and the court will rule that reasonable efforts were not made.

Item 8. Reunification, guardianship, or permanent placement with relatives

____ Strength __X__ Area Needing Improvement

Case Review Findings
Item 8 was applicable for 18 (45 percent) of the 40 foster care cases. In assessing these cases, reviewers were to determine whether the agency had achieved the permanency goals of reunification, guardianship, or permanent placement with relatives in a timely manner, or if the goals had not been achieved, reviewers were to determine whether the agency had made, or was in the process of making, diligent efforts to achieve the goals. The results of this assessment are shown in the table below.

Item 8 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	3	1	2	6	**33**
Area Needing Improvement	4	6	2	12	**67**
Total Applicable Foster Care Cases	**7**	**7**	**4**	**18**	
Not Applicable Foster Care Cases	13	3	6	22	
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Item 8 is rated as a Strength in 43 percent of applicable Anchorage cases, 14 percent of applicable Bethel cases, and 50 percent of applicable Juneau cases. Item 8 was rated as a Strength when reviewers determined that the goal had been achieved in a timely manner or that the agency was making concerted efforts to achieve the goal in a timely manner. Item 8 was rated as an ANI when reviewers determined that the agency had not made concerted efforts to achieve reunification or guardianship in a timely manner. Some of the concerns identified in the cases pertained to problems or delays in completing paperwork, particularly for guardianships, and to a lack of visitation opportunities for parents and children.

Rating Determination
Item 8 is assigned an overall rating of ANI. Reviewers determined that the agency had made diligent efforts to attain the goals of reunification, permanent placement with relatives, or guardianship in a timely manner in only 33 percent of the cases. This percentage is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Performance on the Individual Composite 1: Measures pertaining to timeliness of reunification
The data below are presented to provide additional information about the timeliness of reunification. There are no national standards for the individual measures included in Composite 1. National standards have been established only for the scaled composite score for Composite 1. The State's performance on Composite 1 is shown in the table for Permanency Outcome 1.

Alaska's performance for the 12-month CFSR target period on the three "timeliness" measures included in Permanency Composite 1: (timeliness and permanency of reunification) is presented below.

- 67.3 percent of the reunifications occurred in at least 8 days but less than 12 months of the child's entry into foster care. This percentage is less than the national median of 69.9 percent.
- The median length of stay in foster care for children discharged to reunification was 7 months. This median length of stay is more than the national median length of stay of 6.5 months. For this measure, a lower number of months equates to a higher level of performance.

- 32.2 percent of children entering foster care in the last 6 months prior to the 12-month target period were discharged from foster care to reunification in less than 12 months of entry into foster care. This percentage is less than the national median of 39.4 percent.

Statewide Assessment Information
According to the Statewide Assessment, the QA review team indicated that there are challenges in moving cases to permanency, and they reported that this may be due in part to the fact that some treatment processes take longer than expected. The Statewide Assessment notes that drug and alcohol treatment, in particular, may be delayed because of the lack of available inpatient treatment, which results in waiting lists. The Statewide Assessment also notes that the achievement of permanency goals, such as timely reunification, is thwarted by the lack of consistent caseworker practice due to high staff turnover.

Stakeholder Interview Information
Most stakeholders commenting on this item during the onsite CFSR expressed the opinion that there are barriers to achieving reunification in a timely manner and that one key barrier is a lack of adequate services for the parents. Stakeholders noted that this is a problem in the urban areas as well as in the bush. In particular, many stakeholders identified mental health and substance abuse treatment services for adults and supervised visitation as services that were not readily available to families and therefore resulted in delays in reunification.

Item 9. Adoption

____ Strength __X__ Area Needing Improvement

Case Review Findings
Item 9 was applicable for 22 (55 percent) of the 40 foster care cases. In assessing this item, reviewers were to determine whether diligent efforts had been, or were being, made to finalize adoptions in a timely manner. The results are shown in the table below.

Item 9 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	3	0	1	4	**18**
Area Needing Improvement	10	4	4	18	**82**
Total Applicable Foster Care Cases	**13**	**4**	**5**	**22**	
Not Applicable Foster Care Cases	7	6	5	18	
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Item 9 was rated as a Strength in 23 percent of applicable Anchorage cases, none of the applicable Bethel cases, and 20 percent of applicable Juneau cases. Item 9 was rated as a Strength when reviewers determined that the State had made diligent efforts to achieve finalized adoptions in a timely manner. Item 9 was rated as an ANI in 18 cases due to one or more of the following concerns:

- Delays in filing for TPR (nine cases)
- Delays in the TPR process after filing (two cases)
- Delays in completing or approving home studies (six cases)
- Delays in searching for absent parents (four cases)
- Delays due to the Tribe wanting to ensure that there are no available relatives before they agree to adoption by a nonrelative foster parent (one case)
- Delays due to not addressing key service needs of child (two cases)

In six of the 18 cases rated as ANIs for this item, the child had been in foster care for longer than 3 years at the time of the onsite CFSR or at the time of adoption finalization. During the period under review, adoption was finalized in only 5 of the 22 cases with a case goal of adoption. There was no case in which finalization occurred in less than 24 months of the child's entry into foster care.

Rating Determination

Item 9 is assigned an overall rating of ANI. Reviewers determined that the agency had made diligent efforts to achieve adoptions in a timely manner in only 18 percent of the applicable cases. This percentage is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Performance on the Individual Composite 2: Measures pertaining to the timeliness of adoptions

The data below are presented to provide additional information about the timeliness of adoptions. There are no national standards for the individual measures included in Composite 2. National standards have been established only for the scaled composite score for Composite 2. The State's performance on Composite 2 is shown in the table for Permanency Outcome 1.

Alaska's performance during the CFSR 12-month target period on the individual measures included in Permanency Composite 2 (timeliness of adoptions) is as follows:

- 22 percent of adoptions occurred in less than 24 months from the time of entry into foster care (measure C2-1). This percentage is less than the national median of 26.8 percent.
- The median length of stay in foster care for children adopted was 31.5 months (measure C2-2). This median length of stay is less than the national median of 32.4 months but higher than the 25th percentile of 27.3 months. For this measure, a lower number of months equates to a higher level of performance.

- 16.4 percent of children in foster care for 17 months or longer on the first day of the 12-month CFSR target period were discharged to a finalized adoption by the last day of the target period (measure C2-3). This percentage is less than the national median of 20.2 percent.
- 8.5 percent of children in foster care for 17 months or longer on the first day of the CFSR 12-month target period became legally free for adoption (i.e., there was a TPR for both mother and father) within 6 months (measure C2-4). This percentage is less than the national median of 8.8 percent.
- 40.8 percent of children who were legally free for adoption were adopted within 12 months of becoming legally free (C2-5). This percentage is less than the national median of 45.8 percent.

Statewide Assessment Information

According to the Statewide Assessment, Alaska statutes and OCS policy outline processes for improving timeliness to adoption by addressing timeframes for TPR. Statutes and policy require that when a child has been placed out-of-home for 15 of the last 22 months, a petition for TPR must be filed unless there are compelling reasons for not filing a petition. Additionally, Alaska's statutes and policy address the consent to adoption by parent, which provides expedited achievement of timely adoptions particularly in cases of Alaska Native children. This process offers parents the opportunity to consent to adoption without a relinquishment or TPR.

The Statewide Assessment reports that there is agreement between OCS and stakeholders that delays in adoption may be attributed to insufficient staff training on this issue and that newly assigned caseworkers may resist moving toward TPR. Instead, new caseworkers sometimes want to give parents additional chances to reunify with their child. This is especially problematic when cases move from one worker to another due to staff turnover. Newly assigned caseworkers can be hesitant to move forward with TPR on unfamiliar cases and therefore delays often occur.

The Statewide Assessment also reports that a lack of available mental health and substance abuse services for OCS families is an obstacle for timely TPR. As noted in the Statewide Assessment, the State QA review team observed that there are a number of factors that may affect the timeliness of adoptions. For example, concurrent planning often is not considered early in a case even when there is little hope of successful reunification, and some courts will not accept concurrent plans until 15 months of placement has passed even in poor prognosis cases. Finally, a limited number of cases get lost in the system when cases are transferred from one caseworker to another. These cases may appear stable to the new caseworker and therefore do not get the attention needed to finalize an adoption.

Stakeholder Interview Information

Several stakeholders commenting on this item indicated that, although there are challenges in achieving adoptions in a timely manner, the hiring of Regional Adoption Specialists has greatly improved the situation. However, there was a consensus among stakeholders that adoptions are taking too long to complete and that the most significant barrier to achieving adoptions in a timely manner is the home study process. Many stakeholders indicated that home studies, most of which are done by private contractors, take an extremely

long time to complete and can delay an adoption anywhere from 6 to 12 months. They noted that although the State has adopted stricter time requirements for the home study, it remains a significant cause of adoption delays.

Various stakeholders identified the following as additional barriers to timely adoptions:

- An insufficient number of adoptive homes, particularly ICWA adoptive homes and homes for children with behavior problems
- Delays in achieving TPR, including the need in some areas of the State for the caseworker to prepare a full case summary as part of the petition process
- Delays in scheduling TPR hearings because other types of cases have priority
- High staff caseloads that result in a lack of services to the biological family and, therefore, findings of no reasonable efforts in case
- Delays due to lengthy subsidy negotiations, which cannot take place until after the home study is completed
- The belief of some agency staff that there is an OCS policy requiring that a child be in a home for 3 months before a home study can be requested and 6 months before an adoption can be finalized

Item 10. Permanency goal of other planned permanent living arrangement

____ Strength __X__ Area Needing Improvement

Case Review Findings

Item 10 was applicable for 5 (12.5 percent) of the 40 foster care cases. In assessing these cases, reviewers were to determine if the agency had made, or was making, diligent efforts to assist children in attaining their goals related to OPPLAs. The results are presented in the table below.

Item 10 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	2	1	0	3	**60**
Area Needing Improvement	0	0	2	2	**40**
Total Applicable Foster Care Cases	**2**	**1**	**2**	**5**	
Not Applicable Foster Care Case	18	9	8	35	
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Item 10 was rated as a Strength in three cases when reviewers determined that the agency had made concerted efforts to ensure a long-term placement for the child and to provide the necessary service to prepare the child for independent living. Item 10 was rated as an ANI in two cases when reviewers determined that the child was not in a permanent placement and there were delays in providing the child with Independent Living (IL) services.

Rating Determination
Item 10 is assigned an overall rating of ANI. In 60 percent of the applicable cases, reviewers determined that the goal of OPPLA was being addressed in an appropriate way. This percentage is less than the 90 percent or higher required for a rating of Strength. Item 10 also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, since the 2002 CFSR, OCS has established Regional Independent Living Specialists (RILS) in each of the four OCS regions. RILS work with foster youth and former foster youth on building IL and transitional living skills. RILS participate in case reviews to ensure that the identified needs are addressed prior to releasing custody and that custody is maintained if those needs have not been addressed. However, the Statewide Assessment also reports that, statewide, the availability of IL services and transitional living programs is limited.

Stakeholder Interview Information
Most stakeholders commenting on this item during the onsite CFSR indicated that IL services are provided to older youth in foster care. Anchorage stakeholders praised the IL services provider and coordinator in that site, although some expressed the opinion that the eligibility age of 16.5 years should be lowered to age 14 or 15. Juneau stakeholders also praised the RILS and noted that this person is effective in reaching out to youth and engaging them in IL services.

Some Anchorage stakeholders indicated that although there are exit plans for most youth, often youth who transition out of foster care do not have a permanent adult resource person in the community.

Permanency Outcome 2

Outcome P2: The continuity of family relationships and connections is preserved for children					
Number of cases reviewed by site according to degree of outcome achievement					
Outcome Achievement	**Anchorage**	**Bethel**	**Juneau**	**Total**	**Percent**
Substantially Achieved	13	6	6	25	**62.5**
Partially Achieved	7	4	3	14	**35.0**
Not Achieved	0	0	1	1	**2.5**
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Status of Permanency Outcome 2

Alaska is not in substantial conformity with Permanency Outcome 2. The outcome was determined to be substantially achieved in 62.5 percent of the cases, which is less than the 95 percent or higher required for substantial conformity. The outcome was determined to be substantially achieved in 65 percent of Anchorage cases and 60 percent of Bethel and Juneau cases. Alaska was not in substantial conformity with Permanency Outcome 2 in its 2002 CFSR and was required to address the outcome in its PIP.

Key Concerns From the 2002 CFSR

In the 2002 CFSR, all items assessed for Permanency Outcome 2 were rated as ANIs except for items 11 (proximity of placement) and 12 (placement with siblings). The following key concerns were identified in the 2002 CFSR:

- Agency practice was inconsistent with respect to facilitating and supporting visits between children and their parents and siblings.
- There was a lack of concerted efforts to preserve children's connections and to seek relatives as potential placement resources.
- In many cases, efforts were not made to promote or maintain the parent-child bond.

To address these concerns, Alaska implemented the following strategies as part of its PIP:

- Developed policies and guidelines to clarify supervised and unsupervised visitation requirements
- Made paternity testing available statewide to ensure identification of noncustodial fathers
- Improved policy and training regarding maintaining connections between children in foster care and their families and communities

The State met its target goals for this outcome by the end of its PIP implementation period.

Key Findings of the 2008 CFSR

The findings of the 2008 CFSR pertaining to the specific items assessed under Permanency Outcome 2 are presented below.

Item 11. Proximity of foster care placement

__X__ Strength ____ Area Needing Improvement

Case Review Findings

Item 11 was applicable for 31 (77.5 percent) of the 40 foster care cases. Cases determined to be not applicable were those in which (1) TPR had been attained prior to the period under review, (2) contact with parents was not considered to be in the child's best interests,

and/or (3) parents were deceased or their whereabouts were unknown. In assessing item 11, reviewers were to determine whether the child's most current foster care setting was in close proximity to the child's parents or close relatives. The results of this assessment are presented in the table below.

Item 11 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	13	8	7	28	**90**
Area Needing Improvement	0	2	1	3	**10**
Total Applicable Foster Care Cases	**13**	**10**	**8**	**31**	
Not Applicable Foster Care Cases	7	0	2	9	
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Rating Determination
Item 11 was assigned an overall rating of Strength. In 90 percent of the cases, reviewers determined that the agency had made diligent efforts to ensure that children were placed in foster care placements that were in close proximity to their parents or relatives, or that were necessary to meet special needs. This percentage equals the 90 percent required for a rating of Strength. This item also was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, QA reviews indicate that OCS is very effective in placing foster children close to their birth parents or their own communities. The Statewide Assessment reports that in the vast majority of QA case reviews, most field offices are performing well in this area.

Stakeholder Interview Information
Stakeholders did not comment on this item during the onsite CFSR.

Item 12. Placement with siblings

__X__ Strength ____ Area Needing Improvement

Case Review Findings
Item 12 was applicable for 32 (80 percent) of the 40 foster care cases. Cases were not applicable if the child did not have a sibling in foster care at any time during the period under review. In assessing item 12, reviewers were to determine whether siblings were, or had been, placed together and, if not, whether the separation was necessary to meet the needs (service or safety needs) of one or more of the children. The results of this assessment are presented in the table below.

Item 12 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	14	7	8	29	**91**
Area Needing Improvement	2	1	0	3	**9**
Total Applicable Foster Care Cases	**16**	**8**	**8**	**32**	
Not Applicable Foster Care Cases	4	2	2	8	
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Item 12 was rated as a Strength in 87.5 percent of applicable Anchorage cases, 87.5 percent of applicable Bethel cases, and 100 percent of applicable Juneau cases. The item was rated as a Strength when reviewers determined the following:

- The child was in a placement with all siblings (14 cases).
- The child was not in a placement with some siblings, but the separation was necessary to meet the special needs of one or more of the siblings (15 cases).

Item 12 was rated as an ANI in three cases when reviewers determined that the agency had not made concerted efforts to place siblings together and the separation was not intended to meet special needs.

Rating Determination

Item 12 was assigned an overall rating of Strength. Reviewers determined that the agency placed siblings together in foster care (when appropriate) in 91 percent of the applicable cases. This percentage exceeds the 90 percent required for a rating of Strength. This item also was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, QA review data indicate that OCS is placing siblings together in the majority of cases. The chart presented in the Statewide Assessment shows 100 percent compliance for this item with regard to placement with siblings for cases reviewed in Anchorage, Bethel, Mat-Su, and Juneau, and approximately 75 percent for cases reviewed in Fairbanks.

Stakeholder Interview Information

Stakeholders did not comment on this item in a substantive way during the onsite CFSR.

Item 13. Visiting with parents and siblings in foster care

____ Strength __X__ Area Needing Improvement

Case Review Findings

Item 13 was applicable for 34 (85 percent) of the 40 foster care cases. Cases were not applicable for an assessment of this item if the child had no siblings in foster care and if one of the following conditions was met with regard to the parents: (1) TPR was established prior to the period under review and parents were no longer involved in the child's life (or parents were deceased), or (2) visitation with a parent was considered to not be in the best interests of the child. In assessing this item, reviewers were to determine the following: (1) whether the agency had made, or was making, diligent efforts to facilitate visitation between children in foster care and their parents and siblings in foster care, and (2) whether these visits occurred with sufficient frequency to meet the needs of children and families. The findings of this assessment are presented in the table below.

Item 13 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	10	6	5	21	**62**
Area Needing Improvement	5	4	4	13	**38**
Total Applicable Foster Care Cases	**15**	**10**	**9**	**34**	
Not Applicable Foster Care Cases	5	0	1	6	
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Item 13 was rated as a Strength in 67 percent of applicable Anchorage cases, 60 percent of Bethel cases, and 56 percent of applicable Juneau cases. The item was rated as a Strength when reviewers determined that (1) the frequency and quality of visitation with parents and siblings met the needs of the children, or (2) the agency made concerted efforts to promote frequent visitation even when the current visitation frequency did not meet the child's needs.

Item 13 was rated as an ANI in 13 cases when reviewers determined one or more of the following:

- The agency did not make concerted efforts to promote visitation with the mother (nine cases).
- The agency did not make concerted efforts to promote visitation with the father (eight cases).
- The agency did not make concerted efforts to promote visitation with siblings in foster care (six cases).

Specific information about visitation frequency is provided in the table below. As shown in the table, for the applicable cases, children visited with their mothers at least once a month in 44 percent of the applicable cases, with their fathers at least once a month in 50 percent of the applicable cases, and with their siblings at least once a month in 56 percent of the applicable cases.

Visitation frequency for children in foster care (during the period under review)	Visits with Mother	Visits with Father	Visits with Siblings in Foster Care
At least once a week	10 (37%)	8 (33%)	5 (28%)
Less than once a week but at least twice a month	1 (4%)	1 (4%)	3 (17%)
Less than twice a month but at least once a month	1 (4%)	3 (12.5%)	2 (11%)
Less than once a month	13 (48%)	9 (37.5%)	6 (33%)
Never	2 (7%)	3 (12.5%)	2 (11%)
Total cases for which item 13 was applicable	**27**	**24**	**18**

Rating Determination
Item 13 is assigned an overall rating of ANI. In 62 percent of the cases, reviewers determined that the agency had made concerted efforts to ensure that visitation was of sufficient frequency to meet the needs of the child and family. This percentage is less than the 90 percent or higher required for a rating of Strength. Item 13 also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, visitation with parents was addressed in a 2006 Stakeholder Survey of 140 parents. When asked if they were satisfied with the visitation schedule, 50 parents out of the 140 interviewed indicated that they were satisfied with the visitation schedule, while 82 parents indicated that they were not satisfied with the visitation schedule.

The Statewide Assessment reports that QA review data indicate that compliance with the requirements for visitation between parents and siblings varies throughout the State. The table presented in the Statewide Assessment shows that, for 2008, the Juneau and Mat-Su offices were in 100 percent compliance with this item; in Anchorage and Bethel compliance was about 80 percent; and in Fairbanks compliance was approximately 75 percent.

Stakeholder Interview Information
Some Anchorage stakeholders commenting on this item during the onsite CFSR indicated that when visits do not occur with parents it is usually due to the lack of supervised visitation services. They noted that there are not sufficient resources to coordinate and support visits.

Item 14. Preserving connections

____ Strength __X__ Area Needing Improvement

Case Review Findings

Item 14 was applicable for all 40 foster care cases. In assessing item 14, reviewers were to determine whether the agency had made, or was making, diligent efforts to preserve the child's connections to neighborhood, community, heritage, family, faith, and friends while the child was in foster care. This item is not rated on the basis of visits or contacts with parents or siblings in foster care. The results of the assessment are provided in the table below.

Item 14 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	15	8	8	31	77.5
Area Needing Improvement	5	2	2	9	22.5
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Item 14 was rated as a Strength in 75 percent of Anchorage cases and 80 percent of Bethel and Juneau cases. The item was rated as a Strength when reviewers determined that the agency made concerted efforts to preserve the child's connections with extended family members, religious or cultural heritage, schools, neighborhoods, and friends. Item 14 was rated as an ANI in nine cases when reviewers determined one or more of the following:

- The agency did not make concerted efforts to maintain the child's connections to extended family (eight cases). In seven of these cases, the lack of connection was with siblings who were not in foster care.
- The agency did not make concerted efforts to maintain the child's connections to his or her cultural heritage (three cases). In all three cases, the children were of Native American heritage.

Rating Determination

Item 14 is assigned an overall rating of ANI. In 77.5 percent of the cases, reviewers determined that the agency had made concerted efforts to maintain the child's connections with extended family, culture, religion, community, and school. This percentage is less than the 90 percent or higher required for a rating of Strength. Item 14 also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information

According to the table presented in the Statewide Assessment, the QA review for 2008 found that 100 percent of the cases reviewed in Anchorage, Juneau, and Bethel and about 81 percent of the cases reviewed in Fairbanks and Mat-Su were determined to have met the requirements of this item. However, the Statewide Assessment also reports that in a survey of 140 parents conducted in 2006, only 45 percent of the parents reported that their children were able to remain in the same school while in foster care, only 60 percent of the parents surveyed indicated that their children were able to maintain community activities while in out-of-home care, and only 65 percent of the parents reported that their children's cultural activities had been supported and maintained while in out-of-home placement.

Stakeholder Interview Information
Stakeholders commenting on this item during the onsite CFSR expressed different opinions with regard to notification of Tribes when Native children come into contact with the child welfare system. Several stakeholders indicated that in some areas of the State, caseworkers are not making concerted efforts to identify Native children and therefore are not providing timely notice to the Tribes. However, other stakeholders said that OCS does a good job in determining whether children have Native Alaskan heritage and are notifying the Tribes and seeking relative placements whenever possible. Anchorage stakeholders said that Native Alaskan children are not always placed with relatives because if the parents live in Anchorage the parents often do not want the child moved far away to a remote village.

A few Anchorage stakeholders reported that there are 62 languages spoken in the Anchorage schools and many more cultures than Native, and it was not clear whether any efforts were being made to address the cultural heritage of these children. A few Anchorage stakeholders also noted that when children are moved from foster homes or relative placements, no efforts are made to maintain the children's connections to these families.

Juneau stakeholders said that there is a cultural night activity held in that site for non-Native parents who are fostering Native children. They reported that this activity was well attended and perceived as helpful for foster parents and children.

Item 15. Relative placement

____ Strength __X__ Area Needing Improvement

Case Review Findings
Item 15 was applicable for 36 (90 percent) of the 40 foster care cases. Cases were not applicable if relative placement was not an option during the period under review because (1) the child was in an adoptive placement at the start of the time period or (2) the child entered foster care needing specialized services that could not be provided in a relative placement. In assessing this item, reviewers were to determine whether the agency had made diligent efforts to locate and assess relatives (both maternal and paternal relatives) as potential placement resources for children in foster care. The results of this assessment are presented in the table below.

Item 15 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	14	10	6	30	**83**
Area Needing Improvement	4	0	2	6	**17**
Total Applicable Foster Care Cases	**18**	**10**	**8**	**36**	[redacted]
Not Applicable Foster Care Case	2	0	2	4	[redacted]
Total Foster Care Cases	**20**	**10**	**10**	**40**	[redacted]

Item 15 was rated as a Strength in 78 percent of applicable Anchorage cases, 100 percent of Bethel cases, and 75 percent of applicable Juneau cases. The item was rated as a Strength when reviewers determined the following:

- The child was placed with relatives (20 cases).
- The child was not placed with relatives but the agency made diligent efforts to search for maternal and/or paternal relatives (10 cases).

Item 15 was rated as an ANI in six cases when reviewers determined one or both of the following:

- The agency had not made efforts to search for maternal relatives (five cases).
- The agency had not made efforts to search for paternal relatives (five cases).

Rating Determination

Item 15 is assigned an overall rating of ANI. In 83 percent of the cases, reviewers determined that the agency had made diligent efforts to locate and assess relatives as potential placement resources. This percentage is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, the QA case reviews for the 2008 period found that in 100 percent of the cases reviewed, concerted efforts were made to place the child with relatives, including paternal relatives, when appropriate. However, the Statewide Assessment also reports that in a 2007 survey of 130 Tribes, only 63 percent of respondents stated that they strongly agree or agree that OCS makes efforts to place children in an ICWA-preference placement setting with a relative or Tribal care provider and only 75 percent of the respondents stated that they strongly agree or agree that OCS involves the Tribes in relative searches for children in foster care.

Stakeholder Interview Information

Several Anchorage stakeholders indicated that TDMs in that location have been beneficial in promoting relative placements, particularly for Native children. Some stakeholders at this site also noted that the ICWA specialist raises the issue of the need for continued relative search at every 6-month review involving a Native child.

Although most stakeholders expressed the opinion that relatives often are sought, several noted that some relatives who are not licensed may not have the resources necessary to assume care of the children. A few stakeholders suggested that relatives are not always fully informed about their right to be licensed. Stakeholders also noted that while there might be some criminal background incident that prevents licensure, the children are still placed in the homes. In these situations, the relative caregivers do not get the financial support or other supports that would help them care for the children.

Item 16. Relationship of child in care with parents

____ Strength __X__ Area Needing Improvement

Case Review Findings

Item 16 was applicable for 30 (75 percent) of the 40 foster care cases. Cases were not applicable if (1) parental rights had been terminated prior to the period under review and parents were no longer involved with the child or (2) a relationship with the parents was considered to be not in the child's best interests throughout the period under review. In assessing this item, reviewers were to determine whether the agency had made diligent efforts to support or maintain the bond between children in foster care and their mothers and fathers through efforts other than arranging visitation. The results of this assessment are provided in the table below.

Item 16 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	6	5	3	14	**47**
Area Needing Improvement	7	5	4	16	**53**
Total Applicable Foster Care Cases	**13**	**10**	**7**	**30**	
Not Applicable Foster Care Cases	7	0	3	10	
Total Foster Care Cases	**20**	**10**	**10**	**40**	

Item 16 was rated as a Strength in 46 percent of applicable Anchorage cases, 50 percent of Bethel cases, and 43 percent of applicable Juneau cases. The item was rated as a Strength when reviewers determined that the agency made concerted efforts to support and/or strengthen the bond between parents and children. For the most part, this involved the agency encouraging the parent's participation in school activities and/or doctor's appointments.

Item 16 was rated as an ANI in 16 cases when reviewers determined one or both of the following:

- The agency did not make concerted efforts to support the relationship with the mother (12 out of 27 applicable cases).
- The agency did not make concerted efforts to support the relationship with the father (10 out of 24 applicable cases).

Rating Determination

Item 16 is assigned an overall rating of ANI. Reviewers determined that the agency had made concerted efforts to support the parent-child relationships of children in foster care in only 47 percent of the applicable cases. This percentage is less than the 90 percent or higher required for a rating of Strength. Item 16 also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, the QA reviews have found that the majority of field offices have been performing at or near 100 percent on this item across the State. However, the Statewide Assessment did not provide specific data pertaining to this item.

Stakeholder Interview Information
Stakeholders did not comment on this item during the onsite CFSR.

III. CHILD AND FAMILY WELL-BEING

Well-Being Outcome 1

Outcome WB1: Families have enhanced capacity to provide for their children's needs					
Number of cases reviewed by the site according to degree of outcome achievement					
Outcome Achievement	**Anchorage**	**Bethel**	**Juneau**	**Total**	**Percent**
Substantially Achieved	11	1	3	15	**23.1**
Partially Achieved	8	4	7	19	**29.2**
Not Achieved or Addressed	12	12	7	31	**47.7**
Total Cases	**31**	**17**	**17**	**65**	

Status of Well-Being Outcome 1

Alaska is not in substantial conformity with Well-Being Outcome 1. The outcome was determined to be substantially achieved in only 23.1 percent of the cases reviewed, which is less than the 95 percent or higher required for substantial conformity. The outcome was substantially achieved in 35 percent of Anchorage cases, 6 percent of Bethel cases, and 18 percent of Juneau cases. The outcome was substantially achieved in 35 percent (14 cases) of the 40 foster care cases compared with 4 percent (1 case) of the 25 in-home services cases. Alaska also was not in substantial conformity with this outcome in its 2002 CFSR and was required to address the outcome in its PIP.

Key Concerns From the 2002 CFSR

During the 2002 CFSR, all items assessed for this outcome were rated as ANIs. The key concerns identified in the 2002 CFSR were the following:

- In many cases, the service needs of children, parents, and foster parents were neither assessed nor addressed.

- The child welfare agency did not consistently involve parents and children in the case planning process.
- In the majority of cases reviewed, the frequency and quality of visitation with both children and parents was not adequate to meet the needs of the child or promote attainment of case goals.

To address the concerns identified in the 2002 CFSR, the State developed and implemented the following strategies:
- Enhanced policy and procedure for administrative review feedback to the child welfare agency administration (issued July 2005)
- Developed case planning protocols to identify required services
- Strengthened caseworker training in conducting initial assessments
- Developed the expectation that supervisors are to work with their staff regarding the assessment of child and family needs and the incorporation of these needs into a strengths-based case and service planning process
- Implemented statewide tracking of caseworker visits with children and parents

The State met its PIP target goals for this outcome by the end of its PIP implementation period.

Findings of the 2008 CFSR

The findings of the 2008 CFSR pertaining to the specific items assessed under Well-Being Outcome 1 are presented below.

Item 17. Needs and services of child, parents, foster parents

____ Strength __X__ Area Needing Improvement

Case Review Findings
Item 17 was applicable for all 65 cases. In assessing this item, reviewers were to determine whether the agency had (1) adequately assessed the needs of children, parents, and foster parents and (2) provided the services necessary to meet those needs. This item excludes the assessment of children's (but not parents') needs pertaining to educational, physical health, and mental health needs. These issues are addressed in later items. The case review results are presented in the table below.

Item 17 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	13	3	5	21	**32**
Area Needing Improvement	18	14	12	44	**68**
Total Cases	**31**	**17**	**17**	**65**	

Item 17 was rated as a Strength in 42 percent of Anchorage cases, 18 percent of Bethel cases, and 29 percent of Juneau cases. The item was rated as a Strength in 45 percent (18 cases) of the 40 foster care cases compared with 12 percent (3 cases) of the 25 in-home services cases.

Item 17 was rated as a Strength when reviewers determined that the needs of children, parents, and foster parents had been adequately assessed and that identified service needs had been met. Item 17 was rated as an ANI when reviewers determined that there was either inadequate assessment of needs or inadequate services to meet identified needs.

Specific case review findings for item 17 are shown in the table below. For the foster care cases, the data suggest that the agency was considerably less consistent in assessing and meeting service needs of mothers and fathers than it was in assessing and meeting the needs of the children, although the needs of children were adequately assessed in only 73 percent of the cases. However, for the in-home services cases, the needs of the children were assessed and met in only 44 percent of the cases. The agency was least consistent in assessing and meeting needs of the fathers in both types of cases, although the percentage was particularly low in the in-home services cases.

Item 17. Assessment and Services Summary

Target person for assessment and services	Foster Care Cases		In-Home Services Cases	
	Yes	Total Applicable Cases	Yes	Total Applicable Cases
Mother's needs assessed and met?	14 (52%)	27	10 (40%)	25
Father's needs assessed and met?	11 (46%)	24	3 (12.5%)	24
Foster parents' needs assessed and met?	25 (66%)	38	[redacted]	[redacted]
Child's needs assessed and met?	29 (72.5%)	40	11 (44%)	25

Rating Determination

Item 17 is assigned an overall rating of ANI. Reviewers determined that the State had adequately assessed and addressed the service needs of children, parents, and foster parents (when applicable) in only 32 percent of the cases, which is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, the QA reviews have indicated that Alaska's performance with regard to the adequate assessment of needs and services of child, parent, and foster parents has declined in most of the State since 2006. The data presented in the Statewide Assessment for 2008 indicate that slightly less than 60 percent of the cases reviewed in Anchorage, Bethel, and Fairbanks were rated as a Strength, slightly less than 80 percent of the cases reviewed in Juneau were rated as a Strength, and about 90

percent of the cases reviewed in Mat-Su were rated as a Strength. The Statewide Assessment reports that OCS speculates that staff turnover and the struggle with implementation of the safety decision-making model are significant contributing factors to the decline in performance. As noted in the Statewide Assessment, "Again, challenges do not seem to be limited to a specific area or group and are more the result of uncovered cases and cases with new or overworked caseworkers who falter in maintaining consistent contact and follow-through with the provision of needed services."

Stakeholder Interview Information

Several Anchorage stakeholders commenting on this item during the onsite CFSR indicated that there are not sufficient service supports for foster parents, children in residential treatment, and relative caregivers. A few Anchorage stakeholders also expressed concern about the agency not being proactive in engaging parents in services and instead just giving them a list of referrals.

Item 18. Child and family involvement in case planning

____ Strength __X__ Area Needing Improvement

Case Review Findings

Item 18 was applicable for 63 (97 percent) of the 65 cases. A case was not applicable if parental rights had been terminated prior to the period under review and parents were not involved with the child in any way and the child was too young or had cognitive delays or other conditions that were barriers to participation in case planning. In assessing this item, reviewers were to determine whether parents and children (if age-appropriate) had been involved in the case planning process, and if not, whether their involvement was contrary to the child's best interests. A determination of involvement in case planning required that a parent or child had actively participated in identifying the services and goals included in the case plan. This assessment produced the following findings:

Item 18 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	13	4	6	23	**37**
Area Needing Improvement	16	13	11	40	**63**
Total Applicable Cases	**29**	**17**	**17**	**63**	
Not Applicable Cases	2	0	0	2	
Total Cases	**31**	**17**	**17**	**65**	

Item 18 was rated as a Strength in 45 percent of applicable Anchorage cases, 24 percent of Bethel cases, and 35 percent of Juneau cases. The item was rated as a Strength in 58 percent (22 cases) of the 38 applicable foster care cases compared with 4 percent (1 case) of 25 in-home services cases. Item 18 was rated as a Strength when reviewers determined that all appropriate parties actively participated in case planning or that the agency had made concerted efforts to involve them in case planning. The item was rated as an

ANI when reviewers determined that the agency had not made concerted efforts to involve the mother, father, and/or child (when age appropriate) in case planning.

Key findings with regard to this item are presented in the table below. As shown in the table, the largest differences with regard to involving the mothers, fathers, and children in case planning occurred between foster care and in-home services cases. However, in the in-home services cases, the mothers were more likely to be involved in case planning than were the fathers or children.

Target person	Foster Care Cases		In-Home Services Cases	
	Yes	Total Applicable Cases	Yes	Total Applicable Cases
Mother involved in case planning?	18 (67%)	27	7 (28%)	25
Father involved in case planning?	14 (58%)	24	2 (8%)	24
Children involved in case planning?	14 (67%)	21	2 (14%)	14

Rating Determination
Item 18 is assigned an overall rating of ANI. Reviewers determined that the agency had made diligent efforts to involve parents and/or children in case planning in only 37 percent of the applicable cases. This percentage is less than the 90 percent or higher required for a rating of Strength. Item 18 also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, the results of the QA review in 2008 indicate that Alaska has room for improvement in the area of involving parents and children in case planning. As noted in the Statewide Assessment, in the QA review, only those cases that were determined to have successfully involved all parties in a meaningful way in the development of the case plan were rated as a Strength. The Statewide Assessment reports that in the State's 2008 QA review, a Strength rating was assigned to 52 percent of Anchorage cases, about 12 percent of Bethel cases, about 81 percent of Fairbanks cases, and about 58 percent of Juneau and Mat-Su cases. The Statewide Assessment notes that Bethel's low level of compliance in this area may be related to staffing and workload issues; in comparison, Fairbanks' performance, which is better for this item, may be attributed to its more stable work force.

Stakeholder Interview Information
Several Anchorage stakeholders commenting on this item indicated that children and families can express their opinions and perspectives during a TDM. However, other Anchorage stakeholders indicated that TDMs primarily focus on placement decisions and not on the services or the case plan.

Other comments on parent involvement in case planning are provided under item 25 in the Systemic Factors section of this report.

Item 19. Caseworker visits with child

____ Strength __X__ Area Needing Improvement

Case Review Findings
Item 19 was applicable for all 65 cases. In assessing this item, reviewers were to determine whether the frequency of visits between the caseworkers and children was sufficient to ensure adequate monitoring of the child's safety and well-being and whether visits focused on issues pertinent to case planning, service delivery, and goal attainment. The results of the assessment are presented in the table below:

Item 19 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	13	0	4	17	**26**
Area Needing Improvement	18	17	13	48	**74**
Total Cases	**31**	**17**	**17**	**65**	

Item 19 was rated as a Strength in 42 percent of Anchorage cases, 0 Bethel cases, and 24 percent of Juneau cases. The item was rated as a Strength in 40 percent (16 cases) of the 40 foster care cases compared to 4 percent (1 case) of the 25 in-home services cases.

Item 19 was rated as a Strength when reviewers determined that the frequency and quality of visits between caseworkers and children were sufficient to ensure adequate monitoring of the child's safety and well-being and promote attainment of case goals. Item 19 was rated as an ANI in 48 cases when reviewers determined the following:

- The frequency of caseworker visits was not sufficient to meet the needs of the child and when visits did occur, they did not focus on issues pertinent to case planning, service delivery, and goal attainment (33 cases).
- The frequency of caseworker visits with children was not sufficient to meet the needs of the child, although when visits did occur, they were substantive (four cases).
- The frequency of caseworker visits was sufficient, but the visits did not focus on issues pertinent to case planning, service delivery, and goal attainment (six cases).
- There were no visits with children during the period under review (five cases).

Specific information on the frequency of caseworker visits is presented in the table below. The data in the table indicate that caseworkers visited children less frequently than once a month in 55 percent of foster care cases and 84 percent of in-home services cases.

Typical frequency of caseworker visits with child (during the period under review)	Foster Care Cases	In-Home Services Cases
Visits occurred at least once a week	1 (2.5%)	0
Visits occurred less frequently than once a week but at least twice a month	2 (5%)	0
Visits occurred less frequently than twice a month but at least once a month	15 (37.5%)	4 (16%)
Visits occurred less frequently than once a month	22 (55%)	16 (64%)
There were no visits during the period under review	0	5 (20%)
Total cases	**40**	**25**

Rating Determination
Item 19 is assigned an overall rating of ANI. Reviewers determined that caseworker visits with children were of sufficient frequency and/or quality in only 26 percent of the cases. This percentage is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, OCS policy requires an OCS caseworker to have face-to-face contact at least once a month with any child with an open case who resides in Alaska and who is placed either in his or her own home or in an out-of-home placement. This contact must occur in the home in which the child resides at least once every other month. The Statewide Assessment also notes that policy requires that the contact must allow for discussion with the child regarding their current placement, activities on the case plan, and any safety or well being issues that have been identified.

The Statewide Assessment reports that the results of the State's QA reviews indicate that Alaska has difficulty conducting monthly caseworker visits. For the 2008 data, caseworker visits with children was rated as a Strength in only 28 percent of Anchorage cases, 18 percent of Fairbanks cases, 9 percent of Juneau cases, 25 percent of Mat-Su cases, and 0 Bethel cases.

The Statewide Assessment also notes that, according to ORCA data, the statewide percentage for caseworker visits for March 2008 for all regions and field offices was 18.9 percent for children in custody. The Statewide Assessment indicates that ORCA data does not include visits with children receiving in-home services, although the QA data includes this population.

Stakeholder Interview Information
Stakeholders commenting on this item during the onsite CFSR expressed different opinions regarding the frequency of caseworker visits with children. Some State-level stakeholders cited the State data regarding the lack of adequate contact between caseworkers and children and suggested that this may be due to a lack of skills on the part of the caseworkers and a lack of confidence in their

ability to engage children and families. Several Anchorage stakeholders, however, said that caseworkers have at least monthly contact and often weekly contact with the children on their caseloads, although they may not be documenting this appropriately. However, several Anchorage stakeholders also noted that contact varied across caseworkers, with some caseworkers doing a better job than others.

Item 20. Caseworker visits with parents

____ Strength __X__ Area Needing Improvement

Case Review Findings

Item 20 was applicable for 55 (85 percent) of the 65 cases. Cases were not applicable for this assessment if parental rights had been terminated prior to the period under review and parents were no longer involved in the lives of the children. All cases that were not applicable were foster care cases. In assessing this item, reviewers were to determine whether the caseworker's face-to-face contact with the children's mothers and fathers was of sufficient frequency and quality to promote attainment of case goals and/or ensure the children's safety and well-being. The results of this assessment are presented in the table below:

Item 20 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	6	1	4	11	**20**
Area Needing Improvement	18	16	10	44	**80**
Total Applicable Cases	**24**	**17**	**14**	**55**	[redacted]
Not Applicable Cases	7	0	3	10	[redacted]
Total Cases	**31**	**17**	**17**	**65**	[redacted]

Item 20 was rated as a Strength in 25 percent of applicable Anchorage cases, 6 percent of Bethel cases, and 29 percent of applicable Juneau cases. The item was rated as a Strength in 30 percent (9 cases) of the 30 applicable foster care cases compared with 8 percent (2 cases) of the 25 in-home services cases.

Item 20 was rated as a Strength when reviewers determined that visits occurred with sufficient frequency to meet the needs of parents and children and that visits focused on issues pertinent to case planning, service delivery, and goal attainment. Item 20 was rated as an ANI when reviewers determined the following with regard to visits with the mothers (52 applicable cases):

- The frequency of visits with mothers was not sufficient and, when visits did occur, the quality was not sufficient to meet the needs of the children or further achievement of case goals (24 cases).
- The frequency of visits with mothers was sufficient, but when visits did occur, the quality was not sufficient (two cases).

- The frequency of visits with mothers was not sufficient, but when visits did occur, the quality was sufficient (seven cases).
- There were no visits with the mother during the period under review (five cases).

Item 20 was rated as an ANI when reviewers determined the following with regard to visits with the fathers (48 applicable cases):

- The frequency of visits with fathers was not sufficient and, when visits did occur, the quality was not sufficient to meet the needs of the children or further achievement of case goals (20 cases).
- The frequency of visits with fathers was sufficient, but when visits did occur, the quality was not sufficient (one case).
- The frequency of visits with fathers was not sufficient, but when visits did occur, the quality was sufficient (three cases).
- There were no visits with fathers during the period under review (13 cases).

In one case, there were no visits with either the mother or the father during the period under review, but the case was rated as a Strength because reviewers determined that the agency had made concerted efforts to visit both the mother and the father.

Additional information on the frequency of caseworker visits with parents is provided in the table below. As shown in the table, the most typical frequency of visits with both mothers and fathers was less than once a month for both types of cases.

Typical frequency of caseworker visits with parents (during the period under review)	Foster Care Cases		In-Home Services Cases	
	Mother	Father	Mother	Father
At least once a week	0	0	0	0
Less than once a week but at least twice a month	2 (7%)	2 (8%)	1 (4%)	0
Less than twice a month but at least once a month	2 (7%)	4 (17%)	5 (20%)	3 (12.5%)
Less than once a month	20 (74%)	13 (54%)	16 (64%)	12 (50%)
Never	3 (11%)	5 (21%)	3 (12%)	9 (37.5%)
Total Applicable Cases	**27**	**24**	**25**	**24**

Rating Determination

Item 20 is assigned an overall rating of ANI. Reviewers determined that the frequency and quality of caseworker visits with parents were sufficient to monitor the safety and well-being of the child or promote attainment of case goals in only 20 percent of the applicable cases. This percentage is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, OCS policy requires that the assigned caseworker must have face-to-face contact with both of the parents, or Native custodian, with an open case at least once a month. This contact must occur in the home in which the parent(s)/Indian custodian reside(s) at least once every other month and may occur in an alternate setting every other month. The Statewide Assessment also reports that if the required contact standards cannot be met, the caseworker must document the reasons why in the ORCA case file.

As indicated in the Statewide Assessment, QA reviews found that visits with parents are not occurring in accordance with OCS policy. The data presented in the Statewide Assessment show that in the QA case reviews, visits with parents were rated as a Strength in only 17 percent of Anchorage cases, 20 percent of Fairbanks cases, and 0 cases in Bethel, Juneau, and Mat-Su.

Stakeholder Interview Information
Stakeholders did not comment on this item during the onsite CFSR.

Well-Being Outcome 2

Outcome WB2: Children receive appropriate services to meet their educational needs					
Number of cases reviewed by the team according to degree of outcome achievement					
Outcome Achievement	**Anchorage**	**Bethel**	**Juneau**	**Total**	**Percent**
Substantially Achieved	19	5	11	35	**76.1**
Partially Achieved	1	0	0	1	**2.2**
Not Achieved	1	7	2	10	**21.7**
Total Applicable Cases	**21**	**12**	**13**	**46**	
Not Applicable Cases	10	5	4	19	
Total Cases	**31**	**17**	**17**	**65**	

Status of Well-Being Outcome 2

Alaska is not in substantial conformity with Well-Being Outcome 2, which includes only one item—item 21: Educational needs of the child. Reviewers determined that the outcome was substantially achieved in 76.1 percent of the applicable cases, which is less than the 95 percent or higher required for substantial conformity. The outcome was substantially achieved in 90 percent of applicable Anchorage cases, 42 percent of applicable Bethel cases, and 85 percent of applicable Juneau cases. The outcome was substantially

achieved in 78 percent (29 cases) of the 37 applicable foster care cases and 67 percent (6 cases) of the 9 applicable in-home services cases. Alaska also was not in substantial conformity with this outcome in its 2002 CFSR and was required to address the outcome in its PIP.

Key Concerns From the 2002 CFSR

A key concern of the 2002 CFSR was that children in the in-home services cases had education-related issues to which the agency was not responding. To address this concern, the State implemented the following strategies in its PIP.

- Court orders were amended to authorize OCS to gather educational information about children in out-of-home care.
- An interdepartmental work group was established to ensure enhanced relationships between the agency and school administrators at the local level.
- Training was provided regarding a new policy requiring workers to assess, address, and document the educational needs of children who remain in their homes.

The State met its PIP target goals for this outcome by the end of its PIP implementation period.

Key Findings of the 2008 CFSR

The findings of the 2008 CFSR with regard to this outcome are presented below.

Item 21. Educational needs of the child

____ Strength __X__ Area Needing Improvement

Case Review Findings
Item 21 was applicable for 46 (71 percent) of the 65 cases reviewed. Cases were not applicable if any of the following applied: (1) children were not of school age; or (2) children in in-home cases did not have service needs pertaining to education-related issues. In assessing this item, reviewers were to determine whether children's educational needs were appropriately assessed and whether concerted efforts were made to meet those needs. The results of this assessment are provided below.

Item 21 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	19	5	11	35	**76**
Area Needing Improvement	2	7	2	11	**24**
Total Applicable Cases	**21**	**12**	**13**	**46**	
Not applicable	10	5	4	19	
Total Cases	**31**	**17**	**17**	**65**	

Item 21 was rated as a Strength when reviewers determined that the child's educational needs were appropriately assessed and concerted efforts were made to provide services, if necessary. Item 21 was rated as an ANI in 11 cases when reviewers determined the following:

- No efforts were made to assess the child's educational needs (seven cases).
- Educational needs were assessed or identified but no services were provided (four cases).

Rating Determination

Item 21 is assigned an overall rating of ANI. Reviewers determined that the agency had made diligent efforts to meet the educational needs of children in 76 percent of the applicable cases. This percentage is less than the 95 percent or higher required for this item to be rated as a Strength. A 95-percent standard is set for this item because it is the only item assessed for the outcome.

Statewide Assessment Information

According to the Statewide Assessment, OCS policy requires that the case plan address the goal of child and family well-being, which includes the outcome that children in custody will have their educational needs met. As indicated in the Statewide Assessment, when a child enters custody, the caseworker is required to obtain education information from the parents including whether or not the child has been determined eligible for services by the special education or infant learning programs. The caseworker is expected to use this information in developing case plans and placement plans. The Statewide Assessment reports that for 2008, QA case review findings were that educational needs were met in approximately 92 percent of Anchorage cases, 100 percent of Bethel cases, 88 percent of Fairbanks cases, 82 percent of Juneau cases, and 100 percent of Mat-Su cases.

Stakeholder Interview Information

Some Anchorage stakeholders commenting on this item said that the school system is using the McKinney-Vento Act to identify foster care children as homeless so that they can transport them to their "home" school if they are placed away from their communities. However, a few of these stakeholders expressed the opinion that OCS caseworkers often do not know about this transportation program, and other stakeholders suggested that caseworkers may not be accessing the program because foster parents may want children to attend their local schools.

Some stakeholders expressed the opinion that OCS caseworkers are not knowledgeable about education-related concerns. Bethel and Juneau stakeholders suggested that the agency is involved in the education of youth in foster care, but that youth often are forced to change schools when they enter placements.

Well-Being Outcome 3

Outcome WB3: Children receive adequate services to meet their physical and mental health needs					
Number of cases reviewed by the team according to degree of outcome achievement					
Outcome Achievement	**Anchorage**	**Bethel**	**Juneau**	**Total**	**Percent**
Substantially Achieved	19	2	10	31	**52.5**
Partially Achieved	3	3	3	9	**15.3**
Not Achieved or Addressed	5	11	3	19	**32.2**
Total Applicable Cases	**27**	**16**	**16**	**59**	
Not Applicable	4	1	1	6	
Total Cases	**31**	**17**	**17**	**65**	

Status of Well-Being Outcome 3

Alaska is not in substantial conformity with Well-Being Outcome 3. The outcome was determined to be substantially achieved in 52.5 percent of the applicable cases, which is less than the 95 percent required for substantial conformity. The outcome was substantially achieved in 70 percent of applicable Anchorage cases, 12.5 percent of applicable Bethel cases, and 62.5 percent of applicable Juneau cases. The outcome was substantially achieved in 62.5 percent (25 cases) of the 40 foster care cases compared with 32 percent (6 cases) of the 19 applicable in-home services cases. Alaska also was not in substantial conformity with Well-Being Outcome 3 in its 2002 CFSR and was required to address the outcome in its PIP.

Key Concerns From the 2002 CFSR

In the 2002 CFSR, both relevant items were rated as an ANI. The key concerns identified in the 2002 CFSR were the following:

- Agency performance was inconsistent with regard to providing health screenings for children at entry into foster care and providing foster parents with children's health records.
- Agency performance was inconsistent with regard to assessing children's mental health needs and providing the necessary mental health services.

To address these concerns, Alaska implemented the following strategies as part of its PIP:

- Training was provided to caseworkers regarding completing the EPSDT screening of children within State guidelines and using the health-care provider's recommendations as a guide for all health treatment decisions.
- Physical and mental health issues were added as a topic of discussion in the administrative review process.
- Policy was established to ensure that all children in foster care received mental health evaluations.

The State met its target goals for this outcome by the end of its PIP implementation period.

Key Findings of the 2008 CFSR

The findings for the 2008 CFSR pertaining to the specific items assessed under Well-Being Outcome 3 are presented and discussed below.

Item 22. Physical health of the child

____ Strength __X _ Area Needing Improvement

Case Review Findings
Item 22 was applicable for 49 (75 percent) of the 65 cases reviewed. Cases that were not applicable were in-home services cases in which physical health concerns were not an issue. In assessing this item, reviewers were to determine whether (1) children's physical health needs (including dental needs) had been appropriately assessed, and (2) the services designed to meet those needs had been, or were being, provided. The findings of this assessment are presented in the table below:

Item 22 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	20	5	10	35	**71**
Area Needing Improvement	4	8	2	14	**29**
Total Applicable Cases	**24**	**13**	**12**	**49**	
Not Applicable Cases	7	4	5	16	
Total Cases	**31**	**17**	**17**	**65**	

Item 22 was rated as a Strength in 83 percent of applicable Anchorage cases, 38 percent of applicable Bethel cases, and 83 percent of applicable Juneau cases. The item was rated as a Strength in 80 percent (32 cases) of the 40 foster care cases and 33 percent (3 cases) of the 9 applicable in-home services cases.

Item 22 was rated as a Strength when reviewers determined that children's health needs (medical and dental) were routinely assessed and services provided as needed. The item was rated as an ANI when reviewers determined one or more of the following:

- Physical health needs were not assessed or addressed (eight cases).
- Dental health needs were not assessed or addressed (eight cases).
- Physical health needs were assessed but identified needs were not addressed (four cases).

Rating Determination

Item 22 was assigned an overall rating of ANI. In 71 percent of the applicable cases, reviewers determined that the agency adequately addressed the health needs of children in both the foster care and in-home services cases. This percentage is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, the State QA case review findings for 2008 indicate that meeting the physical health needs of children was a Strength in 73 percent of the Anchorage, Bethel, and Fairbanks cases and 100 percent of the Juneau and Mat-Su cases.

Stakeholder Interview Information

Some stakeholders in Anchorage expressed concern about the need for children in foster care to have parental consent for any medical procedure unless there has been a TPR for both parents. This problem was noted to be critical in emergency situations. Stakeholders also indicated that there are other barriers with regard to children to receiving medical care. These barriers include a lack of dentists who will accept Medicaid, the fact that the agency does not supply either foster parents or children with a list of doctors who accept Medicaid, and the need to have proof of Native Alaskan blood to receive services from Alaska Native Health Care.

Item 23. Mental health of the child

____ Strength __X_ Area Needing Improvement

Case Review Findings

Item 23 was applicable for 44 (68 percent) of the 65 cases reviewed. Cases were not applicable if the child was too young for an assessment of mental health needs, or if there were no mental health concerns. In assessing this item, reviewers were to determine whether (1) mental health needs had been appropriately assessed and (2) appropriate services to address those needs had been offered or provided. The findings of this assessment are presented in the table below.

Item 23 Ratings	Anchorage	Bethel	Juneau	Total	Percent
Strength	15	2	7	24	**55**
Area Needing Improvement	5	10	5	20	**45**
Total Applicable Cases	**20**	**12**	**12**	**44**	
Not Applicable Cases	11	5	5	21	
Total Cases	**31**	**17**	**17**	**65**	

Item 23 was rated as a Strength in 75 percent of the applicable Anchorage cases, 17 percent of applicable Bethel cases, and 58 percent of applicable Juneau cases. The item was rated as a Strength in 62 percent (18 cases) of the 29 applicable foster care cases and 40 percent (6 cases) of the 15 applicable in-home services cases.

Item 23 was rated as a Strength when reviewers determined that children's mental health needs were appropriately assessed and the identified mental health needs were addressed. Item 23 was rated as an ANI in 20 cases when reviewers determined the following:

- Mental health needs were not assessed nor addressed (15 cases, 7 foster care, and 8 in-home services cases).
- Mental health needs were assessed but services were not provided to address identified needs (four cases, all foster care cases).
- Mental health needs were assessed for some of the children in the family and services provided, but there was no assessment or service provision for the other children in the family (one in-home services case)

Ratings Determination

Item 23 is assigned an overall rating of ANI. Reviewers determined that the agency had made concerted efforts to address the mental health needs of children in 55 percent of the cases reviewed, which is less than the 90 percent or higher required for a rating of Strength. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, the State QA case review for 2008 found that children's mental health needs were adequately assessed and addressed in approximately 68 percent of Anchorage cases, 38 percent of Bethel cases, 75 percent of Fairbanks cases, 80 percent of Juneau cases, and 50 percent of Mat-Su cases.

Stakeholder Interview Information

A few Anchorage stakeholders expressed the opinion that youth in foster care sometimes are medicated when they do not need to be and are placed in residential treatment when they do not need to be there. Some Juneau stakeholders indicated that in that location there are a limited number of mental health service providers, which results in waiting lists for mental health services. They also noted that some providers there are not of the highest quality.

SECTION B: SYSTEMIC FACTORS

This section of the CFSR Final Report provides information on Alaska's substantial conformity with the seven systemic factors examined during the CFSR. Information on the items included under each systemic factor comes from the Statewide Assessment and from interviews with stakeholders conducted during the onsite CFSR. It should be noted that ratings for the systemic factors are not based on single comments from an individual stakeholder; however, these comments are included in the report when they provide important insights or clarification regarding the State's performance on a particular systemic factor.

The scoring categories for the systemic factors are "Not in Substantial Conformity" or "In Substantial Conformity." The assessment for substantial conformity pertains to the requirements of the Child and Family Services Plan (CFSP) that States are required to submit to CB. Numerical scores of 3 and 4 represent substantial conformity. Scores of 1 or 2 mean that a State is not in substantial conformity with the requirements of the systemic factor. If a State is not in substantial conformity with a specific systemic factor, then that factor must be addressed in the State's PIP. Specific information regarding the scoring of systemic factors is provided in the table below.

Rating the Systemic Factor			
Not in Substantial Conformity		**In Substantial Conformity**	
1	2	3	4
None of the CFSP or program requirements are in place.	Some or all of the CFSP or program requirements are in place, but more than one of the requirements fail to function as described in each requirement.	All of the CFSP or program requirements are in place, and no more than one of the requirements fails to function as described in each requirement.	All of the CFSP or program requirements are in place and functioning as described in each requirement.

Information is provided in this section regarding the State's performance on each systemic factor and on each of the items incorporated in a systemic factor. Information also is provided about the State's performance on each systemic factor during the State's 2002 CFSR. If the systemic factor was part of the State's PIP, the key concerns addressed in the PIP and the strategies for assessing those concerns are presented.

I. STATEWIDE INFORMATION SYSTEM

Rating of Review Team Regarding Substantial Conformity				
	Not in Substantial Conformity		Substantial Conformity	
Rating	1	2	3X	4

Status of Statewide Information System

Alaska is in substantial conformity with the systemic factor of Statewide Information System. The State was in substantial conformity with this systemic factor during its 2002 CFSR and, therefore, was not required to address the factor in its PIP. Findings of the 2008 CFSR are presented below.

Item 24. The State is operating a statewide information system that, at a minimum, can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care

___X___ Strength _____Area Needing Improvement

Item 24 is rated as a Strength because the State is operating a Statewide Information System called ORCA from which staff can readily identify the legal status, demographic characteristics, location, and goals for each child in foster care. Stakeholders expressed the opinion that information in ORCA with regard to these data elements is current and reliable. This item was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, ORCA is used to track the location of every child in foster care and maintains information regarding each child's legal and placement status (including pre-adoptive placements, type of custody, and trial home visits); permanency goals (if the child is in out-of-home care); and characteristics such as age, gender, ethnicity, and Tribal affiliation. The Statewide Assessment reports that in the majority of cases, information regarding placement information and child characteristics is entered in a timely manner, although there may be a few cases in rural areas where there is a delay in data entry due to connectivity and bandwidth issues. The Statewide Assessment also reports that ORCA supports intake, investigation, case management, adoption, and provider management. ORCA also is the system of record for eligibility determination, payment processing, and personnel functions.

The Statewide Assessment notes that ORCA is a relatively new data system for Alaska. In January 2008, using ORCA, Alaska was able to produce data sufficient for the CB to generate a State Data Profile in preparation for the September 2008 CFSR.

Stakeholder Interview Information
Most stakeholders commenting on this item during the onsite CFSR expressed the opinion that the State's management information system (ORCA) can identify the location of children in foster care, their demographic characteristics, and their case goals. Stakeholders in all sites also indicated that managers and supervisors have access to a variety of managerial reports and that, despite several problems with the system, ORCA is an improvement over the previous legacy system. However, there were some differences of opinion regarding how up-to-date the location information is at any given point in time. While some stakeholders indicated that ORCA information is current, others suggested that the currency of the information varies by caseworker. Several stakeholders also suggested that ORCA is not user-friendly and Bethel stakeholders noted that in some of the more rural locations in the State, there are connectivity problems that often frustrate caseworkers and contribute to delays in data entry.

Some stakeholders suggested that there is variation across caseworkers with regard to entering data into ORCA correctly and in a timely manner and that this may be attributed to the lack of access to consistent ongoing training on ORCA, particularly for caseworkers who are not in the Anchorage area. Juneau stakeholders, for example, expressed concern that sometimes the information that caseworkers enter is not showing up in ORCA because the caseworkers did not enter it correctly, but the system does not alert them to the data entry error. However, it was noted that this problem does not pertain to basic information regarding the children's demographic characteristics, case plan, or location.

II. CASE REVIEW SYSTEM

Rating of Review Team Regarding Substantial Conformity				
	Not in Substantial Conformity		Substantial Conformity	
Rating	1	2X	3	4

Status of Case Review System

Alaska is not in substantial conformity with the systemic factor of Case Review System. Alaska was not in substantial conformity with this factor during its 2002 CFSR and was required to address the factor in its PIP.

Key Concerns From the 2002 CFSR

In the 2002 review, items 25 (case planning process), 27 (permanency hearings), and 29 (notice to foster parents and other caregivers) were rated as ANIs. The following key concerns were identified:

- There was lack of goal-oriented case plans (item 25).
- The system did not consistently involve parents and children (when appropriate) in case planning (item 25).
- Permanency hearings were not consistently held in a timely manner (item 27).
- Foster parents and other caregivers were not consistently notified regarding permanency hearings nor were they provided with an opportunity to be heard at the hearings (item 29).

The following key strategies were implemented in Alaska's PIP to address these concerns:

- The State developed and implemented policy and procedure changes to strengthen and enhance the use of case plans, to ensure that case plans are developed in conjunction with parents and children (when appropriate), and to incorporate case planning for in-home services cases.
- The State implemented, in collaboration with the Court Improvement Project (CIP), a court data system called Court View to enable the court to track court hearings. (This system currently is in operation in only a few jurisdictions.)
- In conjunction with the Attorney General's office, developed a new protocol for notification of foster parents of court hearings. In 2005, Alaska statutes were changed to require that notification of all court hearings in a child's case be provided to the child, each parent, the Tribe, foster parent, or other out-of-home care provider, guardian, and guardian *ad litem*. In some circumstances, written notice of all court hearings in a child's case must be provided to a grandparent of the child.

Alaska met its target goals for this systemic factor by the end of the PIP implementation period.

Key Findings of the 2008 CFSR

The specific findings of the 2008 CFSR are presented below.

Item 25. The State provides a process that ensures that each child has a written case plan to be developed jointly with the child's parent(s) that includes the required provisions

____ Strength __X___ Area Needing Improvement

Item 25 is rated as an ANI because, as noted in the Statewide Assessment, a statewide survey of parents found that although parents are familiar with their case plans, their input is not consistently sought in developing the plans. The Statewide Assessment also notes that stakeholders expressed similar concerns about the case planning process and said that caseworker training does not focus adequately on involving parents in developing the case plan. In addition, in the CFSR onsite case reviews, item 18, which assesses the involvement of parents and children in case planning, was rated as a Strength in only 37 percent of the cases. Item 25 also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, although OCS has enhanced policy and procedure to improve case planning, the concerns outlined in the previous CFSR continue to exist. The Statewide Assessment reports that in a consumer survey conducted by OCS, parents indicated that they are familiar with their case plan and that they receive copies of their plan, but that their input is not sought in developing the case plan. The Statewide Assessment also reports that stakeholders expressed similar concerns about the case planning process and said that caseworker training does not focus adequately on involving parents in developing the case plan.

The Statewide Assessment identifies the following as potential reasons why parents and children are not being involved in case planning:

- OCS does not have a structured process for working with parents, youth, or children in the development of the family's case plan.
- Caseworkers do not always understand the importance of case planning with regard to reunifying children with their parents in a timely manner.
- New caseworkers lack training on the purpose, value, development, and maintenance of well-defined, measurable case plans that parents can understand and follow.

The Statewide Assessment reports that the agency QA team looks comprehensively at case plans and how they are developed and has found that performance is inconsistent across the State. The QA findings for FY 2007 indicate that case planning met Federal guidelines in 50 percent of Anchorage cases, slightly more than 80 percent of Fairbanks case, fewer than 30 percent of Juneau cases, and about 58 percent of Mat-Su cases.

Stakeholder Interview Information
Stakeholders in the three sites included in the CFSR expressed a wide range of opinions regarding both the timeliness of the written case plan, the quality of the case plan, and the involvement of parents and children (when appropriate) in case planning. However, there was general agreement among stakeholders that the ORCA case plan is difficult to understand and not family-friendly. Some stakeholders indicated that ORCA-generated case plans are not considered useful in the court process because of their complexity and volume. Several stakeholders made strongly negative comments about the ORCA case plan, such as "Everybody hates it." A few Bethel and Juneau stakeholders expressed concern that the initial case plan is not routinely or consistently updated. The lack of updated case plans was attributed to the caseload burden of caseworkers, turnover in the caseworker positions, and the difficulty of updating case plans in ORCA. Stakeholders also noted that the quality of case plans varies considerably across caseworkers.

Stakeholders expressed different opinions about the involvement of parents in case planning. Most stakeholders suggested that the involvement of parents in case planning varies depending on the skill level of the caseworker. A few Bethel stakeholders suggested that parent involvement is particularly problematic in ICWA cases. However, a few stakeholders indicated that there is a process for involving parents when the caseworker meets with the family initially and conducts a social history interview, followed by a case planning conference. These stakeholders noted that there is ample opportunity for parent input into the case plan during the case planning conference.

Several stakeholders reported that Tribal caseworkers rarely are involved in case planning and often do not see the case plan until just before the 6-month review. These stakeholders suggested that OCS caseworkers often do not respond to Tribal efforts to be involved in case planning.

Item 26. The State provides a process for the periodic review of the status of each child no less frequently than once every 6 months either by a court or by administrative review

___X__ Strength ____Area Needing Improvement

Item 26 is rated as a Strength. Although data are not available for this item, there was general agreement among stakeholders interviewed during the onsite CFSR that the State is conducting timely and meaningful 6-month administrative reviews for all children in foster care. This item was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, OCS policy requires that a Child and Family Conference, which is an administrative review process, must be held every 6 months for all children in custody. The Statewide Assessment notes that reviews always are held before an established panel no later than 6 months from the date of the most recent removal from the home and/or no later than 6 months from the

date of the last administrative review. It is written in policy that administrative reviews must continue every 6 months until the child returns home, or until the child is in a finalized guardianship or adoption.

The Statewide Assessment reports that stakeholders interviewed during the development of the Statewide Assessment expressed the opinion that most case reviews, but particularly the 6-month administrative reviews, are occurring consistently, and that many case participants, including the public defenders and guardians *ad litem*, are regularly invited.

As indicated in the Statewide Assessment, youth surveyed during the Statewide Assessment process reported that often they were not given sufficient notification of the administrative reviews and that reviews were scheduled at times when they (the youth) were not able to attend. The Statewide Assessment reports that recently regions have been making efforts to schedule an administrative review at the end of the school day when the review involves a youth. Although youth agreed that they are encouraged to attend reviews, they said that they do not always understand the process nor do they think their opinions or concerns are acknowledged.

Stakeholder Interview Information
Almost all stakeholders commenting on this item during the onsite CFSR expressed the opinion that administrative case reviews are held at least every 6 months and that the reviews are effective in moving a case toward permanency. They noted that policy requires that the first review be held after 3 months in foster care and then every 6 months after that.

Stakeholders also reported that there have been improvements in the number of people attending the reviews and that the reviews currently are very detailed and comprehensive. A few Anchorage stakeholders expressed concern about a new agency policy to reduce the time for the reviews from 1 hour to 45 minutes. Stakeholders indicated that 45 minutes was not sufficient to cover the issues necessary to ensure that the reviews are meaningful.

Some stakeholders also expressed concern that although the reviews result in recommendations regarding case plan changes, these changes do not consistently happen and there is no accountability to ensure that they occur.

Item 27. The State provides a process that ensures that each child in foster care under the supervision of the State has a permanency hearing in a qualified court or administrative body no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter

__X__ Strength _____Area Needing Improvement

Item 27 is rated as a Strength. Although the Statewide Assessment did not provide data with regard to the timeliness of permanency hearings or whether the hearings are substantive, most stakeholders reported that the hearings are held in a timely manner and that they focus on achieving permanency for children. Item 27 was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, permanency hearings are occurring for every child and youth who has been in foster care for 12 months. The Statewide Assessment reports that the Alaska Court System analyzed the timeliness of permanency hearings in the Anchorage, Fairbanks, and Palmer courts during 2006 and found that, for all three communities, the average number of days from probable cause to permanency hearing "did not support a concern that permanency hearings are untimely." The Statewide Assessment also reports, however, that in approximately 16 to 31 percent of the cases, findings were not made in a timely manner due to continuances.

As reported in the Statewide Assessment, input from judges indicated that for permanency hearings they will most often grant continuances for reasons related to the parties' due process rights—e.g., because a required report was late or missing, or because a party could not attend the hearing. The Statewide Assessment reports that an investigation found a correlation between late reports and continued hearings. Specifically, in the two court locations with the longest time between probable cause and the permanency hearing, approximately 36 percent of reports were filed late. In the court with the shortest time between probable cause and the permanency hearing, only 23 percent of reports were late.

The Statewide Assessment indicates that, in an effort to improve timely submission of reports needed for the permanency hearing, OCS issued a Program Instruction in Spring 2008 that mandated the timeframe for submitting permanency reports to the court. The Department of Law reported in May 2008 that timely submissions of permanency reports are occurring in Anchorage, Southeast, and Northern regions, but that challenges for filing timely permanency reports continue in the Southcentral region and could be due to the diverse geographical location of the region, staff turnover, and the number of vacancies in the child welfare agency.

Stakeholder Interview Information
Most stakeholders commenting on this item during the onsite CFSR expressed the opinion that Permanency Hearings are held at least every 12 months for every child in foster care. Stakeholders noted that the date for each subsequent hearing is set at the current hearing so that the date is entered early on court dockets. Stakeholders reported that often the permanency hearing dates are scheduled for 10 months to allow for unforeseen circumstances that may delay the hearing. Stakeholders said that continuances are possible, but that they do not occur often. Several stakeholders acknowledged that continuances have been more of a problem in the past and when they occur now, they are most frequently due to late reports from the caseworkers. This was attributed to the excessive caseloads carried by the caseworkers.

Most stakeholders also indicated that permanency hearings are substantive and are effective in moving the case forward. However, a few stakeholders expressed concern about the lack of judicial support in some courts for the agency establishing concurrent goals. In addition, some Bethel stakeholders questioned the efficacy of the permanency hearings.

Item 28. The State provides a process for termination of parental rights proceedings in accordance with the provisions of the Adoption and Safe Families Act

_____Strength __X__ Area Needing Improvement

Item 28 is rated as an ANI. As noted in the Statewide Assessment, OCS does not track the percentage of cases in which TPR petitions are filed on time and, consequently, no data are available to support timely filing. In addition, most stakeholders interviewed during the onsite CFSR expressed the opinion that TPR petitions are not filed in a timely manner. Finally, the data from the CFSR onsite case review indicate that ASFA requirements regarding petitioning for TPR were met in only 72 percent of the applicable cases. This item was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, Alaska has a process for filing TPR petitions in accordance with ASFA. The Statewide Assessment reports that ". . . it is the view of the practitioners that, generally, petitions for TPR are filed in a timely manner unless compelling reasons exist." No data were provided to support this statement. The Statewide Assessment also reports that OCS does not track the percentage of cases for which petitions are filed in a timely manner or whether compelling reasons are documented when a petition is not filed.

Stakeholder Interview Information
Most stakeholders commenting on this item during the onsite CFSR said that OCS has established a process for filing a TPR petition within the timeframes required by the ASFA and a process for documenting compelling reasons if the decision is made not to petition for TPR. Although a few stakeholders expressed the opinion that OCS usually files for TPR in a timely manner, most stakeholders expressed the opinion that sometimes caseworkers are not implementing the OCS procedural requirements pertaining to filing TPR petitions in accordance with ASFA timeframes or documenting compelling reasons when a TPR petition is not filed.

Some stakeholders noted that often a case goal is changed to adoption but no TPR petition is filed. Several Anchorage stakeholders attributed this to the requirement in that location that caseworkers instead of the agency attorneys must complete the TPR petition, which is a time-consuming and difficult process, particularly given their caseload demands and the frequent turnover among caseworkers.

Stakeholders also noted that in some cases, the child will have been in foster care for 15 of the most recent 22 months, but the caseworker and supervisor do not want to change a goal to adoption and want to continue to work with parents toward reunification. Stakeholders noted that this situation is most likely to occur when there is a new caseworker or supervisor assigned to the case who wants to "start over" with the family.

With regard to documentation of compelling reasons, many stakeholders said that the issue of compelling reasons is frequently discussed in the permanency conference held at 9 months, as well as during the permanency review. However, several stakeholders questioned whether compelling reasons are being documented in the case file or in ORCA. They suggested that in some situations compelling reasons may be presented at the court hearing but not documented in ORCA

One concern identified by stakeholders is that there is no automated system in place to alert caseworkers when a case is due for a TPR filing and the "month count" usually has to be done by the caseworker or supervisor. Stakeholders also expressed concern that there are no statewide data to track TPR filings or outcomes.

Item 29. The State provides a process for foster parents, pre-adoptive parents, and relative caregivers of children in foster care to be notified of, and have an opportunity to be heard in, any review or hearing held with respect to the child

_____ Strength _X___ Area Needing Improvement

This item is rated as an ANI. According to the Statewide Assessment and stakeholders interviewed during the onsite CFSR, although OCS caseworkers are responsible for notifying caregivers, notification is not occurring consistently across the State. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, OCS policy and Alaska State statutes outline notification procedures for all parties for court hearings and case conferences for each child in out-of-home care. When there is a court hearing, the Attorney General's Office is responsible for notifying the legal parties to the case, and OCS caseworkers are responsible for notifying the foster parents and relative caregivers. When there is an administrative review or permanency planning conference, all notifications are sent out by OCS staff 30 days prior to the administrative review or permanency planning conference. The Statewide Assessment reports that although the notifications to the legal parties of the case are made consistently by the Attorney General's (AG) Office, the notifications that the OCS caseworkers are responsible for (foster parents, grandparents, and other relative caregivers) are not occurring consistently. The Statewide Assessment also reports that data are not available to document how well OCS is complying with notification to foster parents, grandparents, and other relative caregivers.

Stakeholder Interview Information

All stakeholders who commented on this item during the onsite CFSR expressed the opinion that foster parents are notified of administrative reviews and that they are given ample opportunity to be heard during those reviews. However, stakeholders expressed different opinions regarding notification and participation of foster parents in court hearings. Most Anchorage stakeholders indicated that foster parents are not routinely notified of court hearings in that location. They suggested that this may be due to the confusion regarding the responsibility for notification. That is, according to stakeholders, the agency believes it is the AG's responsibility to notify foster parents and other caregivers of court reviews, but the AG's Office believes it is the responsibility of the OCS caseworker to make the notification. In contrast, stakeholders in Bethel and Juneau indicated that foster parents are routinely notified about court hearings and are given opportunities to be heard when they attend.

III. QUALITY ASSURANCE SYSTEM

Rating of Review Team Regarding Substantial Conformity				
	Not in Substantial Conformity		Substantial Conformity	
Rating	1	2X	3	4

Status of Quality Assurance System

Alaska is not in substantial conformity with the systemic factor of QA System. Alaska was not in substantial conformity with this systemic factor in its 2002 CFSR and was required to address the factor in its PIP.

Key Concerns From the 2002 CFSR

In the 2002 CFSR, although item 30 was rated as a Strength, item 31 was rated as an ANI. The key concern identified in the 2002 CFSR was that Alaska did not have a statewide QA process and had no formal process for clients or stakeholders to evaluate agency performance.

To address this concern through its PIP, the State developed and implemented a comprehensive QA system that incorporates both case reviews and interviews with case-related stakeholders. In addition, the PIP focused on ongoing improvement of supervisory case reviews and administrative reviews.

Alaska met its target goals for this systemic factor by the end of its PIP implementation period.

Key Findings of the 2008 CFSR

The findings of the 2008 CFSR with regard to the items assessed for this systemic factor are presented below.

Item 30. The State has developed and implemented standards to ensure that children in foster care are provided quality services that protect the safety and health of the children

_____Strength ___X__ Area Needing Improvement

Item 30 is rated as an ANI. Although the State has developed standards to ensure quality services that protect the safety and health of children, many of the standards are not being implemented on a consistent basis and, at the time of the onsite CFSR, many were not fully operational. This item was rated as a Strength in the 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, OCS has revised policy and procedures to ensure that children in foster care receive quality services to protect their safety and health. It was noted that OCS policy is readily available online and easy to access for caseworkers and stakeholders. Each caseworker also has a hardcopy binder that is updated as new or revised policies are issued. The Statewide Assessment reports that OCS has made concerted efforts to ensure that policies are written in a manner that is clear and easily understood by all staff. The Statewide Assessment also reports that OCS managers and caseworkers have indicated that the newly written sections of the policy are easier to follow and provide better guidance to workers.

Stakeholder Interview Information
Most stakeholders commenting on this item during the onsite CFSR expressed the opinion that some of the standards that have been established by OCS are not being implemented. Stakeholders noted, for example, that although OCS has established a safety-related standard requiring caseworkers to have once-a-month contact with each foster child in the home, this requirement is not being met. Anchorage stakeholders expressed concern about the ability of the agency to meet safety standards pertaining to timeliness of investigations because of the considerable backlog of child maltreatment allegations requiring investigation. Stakeholders also indicated that the safety model is not fully implemented. Stakeholders in Juneau noted that while the safety model process is being used at the beginning of a case, it is not being used throughout the life of the case.

Item 31. The State is operating an identifiable quality assurance system that is in place in the jurisdictions where the services included in the Child and Family Services Plan are provided, evaluates the quality of services, identifies strengths and needs of the service delivery system, provides relevant reports, and evaluates program improvement measures implemented

____Strength _X__ Area Needing Improvement

Item 31 is rated as an ANI. Although the State has a QA system in place, the QA system does not incorporate a process for evaluating program improvement measures that are implemented. For example, there is no process for following up on QA findings with the field offices to determine whether program improvements have been implemented in response to findings and/or the effectiveness of program improvement efforts. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, over the past 5 years, the State has developed a QA system that provides for ongoing consistent measurement of the quality of practice, incorporates stakeholder input, and includes a system of data dissemination to the agency staff and public. The Statewide Assessment reports that the current QA system is able to evaluate practice and generate outcome information that is disseminated to caseworkers and supervisory staff as well as managers. The system also has a feedback loop that provides the field offices with an opportunity to respond and make changes in practice to improve outcomes. As indicated in the Statewide Assessment, the findings from all QA activities are compiled into reports for use by field staff and managers. These data are used to examine programs and practice and make changes to improve outcomes.

The Statewide Assessment describes the QA system as including a review of a random sample of approximately 250 cases per year and interviews with case-related stakeholders. In addition, the QA system conducts various surveys to gain additional information from families served by the system and from Tribal and community partners. The Statewide Assessment reports that the QA unit conducts approximately 10 surveys per review year either by mail, telephone, or electronically and that survey findings and focus group information are compiled into reports that are provided to managers, supervisors, staff, and the public. The reports are available online at the OCS website.

The Statewide Assessment reports that a continuing challenge in Alaska with regard to ongoing QA is the size of the State, the number of field offices (26), and the ability of the QA program to adequately serve each office. As noted in the Statewide Assessment, approximately 20 field offices are reviewed per year, with other field offices rotated for review on alternate years. The Anchorage Field Office is reviewed at least twice yearly because approximately 41 percent of the State's caseload is in that field office. Twelve cases are reviewed in each field office; half are in-home and half are out-of-home cases. The Statewide Assessment notes that there are difficulties in some field offices in identifying a sufficient number of in-home cases to fit the ratio of in-home to out-of-home cases.

The Statewide Assessment also notes that, in addition to the activities of the QA team, each region has a Continuous Quality Improvement Committee composed of representatives from the community. The committees meet on a regular basis and review information and data from the QA case reviews, information gained from stakeholder surveys, and other data reports through the SACWIS system. As indicated in the Statewide Assessment, the committees assist regional management in planning and in responding to agency issues and provide a community perspective that can directly affect practice.

Stakeholder Interview Information

Stakeholders commenting on this item during the onsite CFSR indicated that there is a statewide QA system in place that is very similar to the CFSR case review process and uses the CFSR Onsite Review instrument (with some additional questions specific to Alaska). Several stakeholders noted that input from community stakeholders is obtained through surveys of foster parents, providers, and other relevant groups. However, a key concern expressed by stakeholders at the State level and in all three sites was that although OCS shares information with local offices about the QA review findings, the State does not have a formal program improvement process or requirement of the field offices to address identified concerns. In addition, OCS has no process in place to monitor whether changes are being made. Stakeholders in one site, for example, noted that the local child welfare office will hold discussions about the QA findings and possible improvement efforts, but there is no State requirement to report on these discussions or to implement program improvement efforts. Some stakeholders suggested that the lack of accountability results in little change actually being made.

State-level stakeholders indicated that there is a need to formalize the feedback loop to ensure that caseworkers, supervisors, and managers are getting the information that they need. Some stakeholders suggested that it would be useful if caseworkers had a better understanding of the QA process, although they noted that the high level of turnover makes this difficult.

Local level stakeholders also identified other forms of QA including a manager's retreat held once per quarter, a self-evaluation workgroup started in Anchorage through the Family-to-Family initiative, individual unit meetings to review cases, and weekly office staff meetings. Stakeholders also said that ORCA reports are used to monitor and evaluate the performance of caseworkers and to identify areas of concern.

IV. TRAINING

Rating of Review Team Regarding Substantial Conformity				
	Not in Substantial Conformity		Substantial Conformity	
Rating	1	2X	3	4

Status of Training

Alaska is not in substantial conformity with the systemic factor of Training. Alaska was in substantial conformity with this systemic factor in its 2002 CFSR and therefore was not required to address the factor in its PIP. The findings for the 2008 CFSR with regard to the specific items assessed for this factor are presented below.

Item 32. The State is operating a staff development and training program that supports the goals and objectives in the CFSP, addresses services provided under titles IV-B and IV-E, and provides initial training for all staff who deliver these services

_____Strength __X____ Area Needing Improvement

Item 32 is rated as an ANI because the initial training that is provided to staff is not sufficient to prepare them to carry out their responsibilities. This item was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, OCS partners with the University of Alaska Anchorage, Family and Youth Services Training Academy (FYSTA) to provide the Training and Orientation of New Employees (TONE) program. TONE is the initial orientation and training offered to all new line staff and licensing workers. It is a 10-day training that must be completed before a caseload is assigned to a new employee. The Statewide Assessment reports that even after a new employee is assigned a caseload, training continues throughout the first 12 months of employment for a total of 20.5 days.

The Statewide Assessment also notes that in response to concerns about the adequacy of cultural training, the TONE curriculum was revised in 2006 to improve the cross-cultural training component and issues in child protection. In addition, as indicated in the Statewide Assessment, Tribal-State collaboration members, in partnership with FYSTA, are revising the ICWA curriculum to better serve workers.

The Statewide Assessment reports that the Anchorage region has recently implemented a 2-week New Employee Orientation for Anchorage regional employees, which immediately follows each TONE training. This additional training is a part of the initial training that focuses on specific programs in the Anchorage region such as Family-to-Family. The training is provided to support administrative staff as well as front-line caseworkers.

As indicated in the Statewide Assessment, at the completion of each course, FYSTA conducts an evaluation of the training. FYSTA also conducted a survey about the training in January 2008. The Statewide Assessment reports that over 90 percent of trainees saw the

training as useful (the child abuse and neglect training was the most well-received by staff, while the court/legal training was rated lower). However, the Statewide Assessment also reports the following survey or evaluation findings with regard to TONE:

- Almost all respondents wanted to see additional trainings in the following topics: interviewing/information gathering; family assessment; ICWA; legal issues; and cultural awareness beyond Alaska Native cultures.
- After 6 months of employment, the majority of training attendees reported that TONE was useful but was not sufficient to cover all aspects of CPS work.
- Survey respondents consistently mentioned wanting more support in making the transition from the classroom or theory aspect of training to the field. This included the opportunity to shadow workers in a variety of OCS positions and to have mentors who assist new employees.

The Statewide Assessment reports that although licensing workers are required to complete the TONE training as their initial training, the initial training for licensing workers currently does not provide a focus on the statutory and regulatory processes for licensing foster homes, foster group homes, and child placement agencies. Instead, training on the statutory and regulatory requirements for licensing has been provided annually through the State of Alaska Department of Law to all licensing staff. Licensing staff do not routinely receive training in the licensing process before being assigned a caseload.

Stakeholder Interview Information

Most stakeholders commenting on this item during the onsite CFSR expressed the opinion that caseworkers generally complete the initial 10-day TONE training before being assigned a caseload. However, most stakeholders also expressed the opinion that the current (at the time of the onsite CFSR) initial training (TONE) does not adequately prepare caseworkers for their jobs and that the entire initial training program is under revision, with the new version to be piloted in January 2009. Anchorage stakeholders indicated that an additional 2-week training program is provided to new caseworkers in the Anchorage office because the State training is not sufficient. Anchorage stakeholders reported that new caseworkers in that office must complete the additional 2-week training before they are assigned a caseload.

The following are some key concerns noted by various stakeholders with regard to the existing TONE initial training:

- There is a "disconnect" between what is offered in training and what is actually going on in the field. As a result, current workers and supervisors must fill in the gaps through on-the-job training, but there is no formalized system for them to do that. Stakeholders noted that existing caseworkers become overwhelmed when they are given the responsibility of training new caseworkers but are not paid for that task or given the time to do it correctly.
- The current training that must be completed before assuming a caseload tends to emphasize investigations and safety, so caseworkers who are not going to be investigators are not prepared for their jobs after the initial 10-day training. This was seen as particularly problematic because not all new caseworkers have social work backgrounds or degrees in that field.

- Although there is a post-training test, there is no evaluation of how caseworkers are doing in the field after training. Stakeholders noted that most caseworkers feel they have not received adequate training.
- ORCA training is not provided in the initial training and sometimes is not accessible until 4 to 12 weeks after employment. This means that new caseworkers are working on cases without training on how to manage the case through ORCA. Stakeholders noted that it is an addition burden for supervisors or other caseworkers to have to train new caseworkers on how to use ORCA. Although web-based training is available, most stakeholders said that it is just an introductory training, and most caseworkers do not access it.
- Although improvements have been made in focusing the training on cultural competency, that component of the training is still not adequate to prepare caseworkers for working with Native Alaskan families.

Stakeholders' recommendations regarding initial training included the following:
- New caseworkers should shadow experienced caseworkers before they attend TONE training.
- Supervisors should go out in the field with new caseworkers to see how they are interacting with clients.

Item 33. The State provides for ongoing training for staff that addresses the skills and knowledge base needed to carry out their duties with regard to the services included in the CFSP

_____Strength __X__ Area Needing Improvement

Item 33 is rated as an ANI. The State does not require caseworkers or supervisors to receive ongoing training as part of their job requirements. In addition, the training opportunities that are available for caseworkers and supervisors are limited, particularly outside of Anchorage. As noted in the Statewide Assessment, agency staff often cannot access training either because of workload responsibilities or lack of transportation. This item was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment
According to the Statewide Assessment, although on-going training opportunities are available to all OCS caseworkers and licensing staff, on-going training varies from region to region and is based on availability of funds. Stakeholders and OCS agree that caseload demands and high staff turnover impact the time workers have to attend trainings. The Statewide Assessment identifies the following as additional factors that affect the ability of the State to deliver ongoing training on a consistent basis.
- There are constraints on the training budget that limit the provision of ongoing training to all caseworkers throughout the State. Often, field offices outside of Anchorage must make choices to send new caseworkers to the initial training instead of existing caseworkers to on-going training due to these budget constraints.
- Training is not readily accessible to all caseworkers statewide. Scheduled trainings in OCS service regions outside of Anchorage occur when FYSTA sends staff to other locations to provide trainings. However, if trainings do not have enough trainee

participants, they are cancelled. This scarcity of training opportunities makes it difficult for caseworkers to receive the required ongoing training hours.

- Staff turnover and burnout limits the opportunities for expanded training options for tenured employees, as much of the training time is spent on the provision of initial trainings.
- The lack of caseworker availability to attend training limits the numbers of trainings that can be offered by FYSTA.

The Statewide Assessment also reports that ongoing, in-service training for supervisors is limited to two courses through FYSTA trainings and is not mandated, although it is strongly encouraged. In addition, as noted in the Statewide Assessment, OCS has recognized that expanded training to supervisors is needed to meet the needs of OCS staff. The Statewide Assessment reports that supervisors new to OCS are required to complete the initial 10-day TONE training as well as two courses specific to supervision of child protection workers, which total 6 hours. Both of the supervisory training courses are offered within the first year of a supervisor's employment. The Statewide Assessment also reports that the State of Alaska through the Department of Personnel provides a week-long Academy for Supervisors specific to Human Resource matters within the State system generally and that OCS supervisors are encouraged to attend these trainings.

The Statewide Assessment reports that OCS received increased funding for staff training from the legislature in July 2007 and OCS is expanding TONE training from 2 weeks to 4 weeks and developing a mandatory new supervisory curriculum.

The Statewide Assessment notes that a stipend program is available to current OCS staff interested in pursuing continued education to obtain a Bachelor or Master of Social Work degree.

Stakeholder Interview Information

All stakeholders commenting on this item during the onsite CFSR indicated that there is a training requirement for new caseworkers during the first year of employment, but there are no requirements for ongoing training beyond the first 12 months of employment. Stakeholders in Bethel and Juneau said that caseworkers in those communities have difficulty even accessing the required training during the first 12 months of employment, although they are able to access the initial 10-hour TONE training.

Stakeholders indicated that, for the most part, caseworkers are not receiving the training support that they need after their first year on the job. Stakeholders suggested that training is needed in domestic violence, substance abuse, interviewing, adoption (particularly how to have a conversation with families about TPR), and other critical areas.

Stakeholders also noted that OCS will not fund training for caseworkers to maintain their licenses. It was noted that in order to maintain a license, caseworkers must have 45 hours of Continuing Education Units (CEUs) each year, but many caseworkers are unable to obtain the required credits because the agency will not pay for the training and because they often cannot leave their

caseloads unattended in order to access training. Stakeholders indicated that the lack of ongoing continuing education opportunities is one reason why many of the caseworkers do not become licensed social workers. A few stakeholders in Anchorage indicated that some, but not all, caseworkers in that office are able to meet their CEU requirements for licensure. They noted that a training is offered by the Anchorage office every Tuesday. Juneau stakeholders reported that although agency trainers are supposed to come to that location to offer training, they usually do not.

Stakeholders also expressed concern about the lack of training for new supervisors and of ongoing training for supervisors. A few stakeholders noted that the State is developing new training for supervisors that will focus on the role of the supervisor as a coach and consultant and the need for supervisors to set expectations for work quality. One stakeholder noted that there used to be statewide supervisory meetings but that these were stopped in 2005.

Stakeholders reported that while ongoing training on ORCA is available in Anchorage, it is not available in the other field offices and caseworkers have to go to Anchorage to access the training.

Item 34. The State provides training for current or prospective foster parents, adoptive parents, and staff of State licensed or approved facilities that care for children receiving foster care or adoption assistance under title IV-E that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children

____Strength __X___ Area Needing Improvement

Item 34 is rated as an ANI because foster parents are not receiving sufficient training to carry out their responsibilities. The Statewide Assessment and stakeholders interviewed as part of the onsite CFSR process indicated that initial CORE training for foster parents is available but is not required. In addition, although there is a requirement for annual training (10 to 15 hours), the Statewide Assessment reports that in 2008, 23 percent of foster parents did not complete these requirements. This item also was rated as an ANI in the 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, State statutes and regulations outline foster parent orientation and training requirements. OCS provides resource families with a 2-hour orientation session covering basic information on becoming a resource family. All resource families are encouraged (but not required) to complete the orientation process before placement of a child in their home. In emergency placement situations, training is initiated at the beginning of placement.

The Statewide Assessment also describes a resource family training that consists of an 8-week initial CORE curriculum, as well as specialized training for all resource families. As indicated in the Statewide Assessment, new resource families are strongly encouraged

to complete the 8-week CORE curriculum before placement, or within the first year of licensure. Specialized trainings are offered to resource families to assist them in meeting specific needs of the children in their care.

Although there are no mandatory training requirements for foster parents prior to placement of a child in their home, there are requirements for training after a child is placed in the home. The Statewide Assessment reports that State statutes and regulations require that foster parents complete 10-15 hours of resource family training per year: 10 hours for a single-parent family; and 15 hours for a two-parent family, with each parent completing at least 5 hours of training. As noted in the Statewide Assessment, OCS encourages foster parents to access trainings that are held in the foster parents' community and the Alaska Center for Resource Families works with foster parents to identify available trainings within the community that can be used to fulfill the required training hours. Despite efforts to ensure that foster parents can access training, the Statewide Assessment reports that in 2008, about 23 percent of resource homes statewide had not met the training requirement. Due to an increased focus on compliance with training standards by regional licensing staff and management, OCS has been able to demonstrate incremental improvements on meeting training requirements in three of the four OCS service regions.

According to the Statewide Assessment, training for State-licensed or State-approved residential facilities is provided through a grant with Alaska Children's Services. Initial training primarily consists of behavioral intervention strategies and building rapport with children and families. Ongoing training is provided according to the facilities' self assessment of their needs and based on staff skills and client profiles.

Stakeholder Interview Information

Stakeholders commenting on this item during the onsite CFSR indicated that there is an orientation session (the 2-hour initial session) that is mandatory, but the core training for foster parents, which consists of six sessions, is not mandatory, although it is strongly encouraged. However, most stakeholders noted that foster parents do not have to complete the core training to have a child placed in their home. They said that many foster parents participating in the core training already have children placed in their homes.

Stakeholders also noted that foster parents must complete 10 hours (for a single parent) to 15 hours (for a couple) of ongoing training each year to maintain their licensure. However, when foster parents do not meet training requirements, they may still be issued a new license, although the license will indicate that not all conditions have been met. Many stakeholders said that foster parents do not always meet the ongoing training requirements. While several stakeholders noted that ongoing training is available on the Internet and in a number of distance learning formats, a few stakeholders expressed the opinion that if a foster parent's primary language is not English, it is difficult for them to take advantage of many of the training opportunities.

Stakeholders reported that there are no training requirements for relative caregivers who are not licensed.

V. SERVICE ARRAY

Rating of Review Team Regarding Substantial Conformity				
	Not in Substantial Conformity		Substantial Conformity	
Rating	1	2X	3	4

Status of Service Array

Alaska is not in substantial conformity with the systemic factor of Service Array. The State was not in substantial conformity with this systemic factor in its 2002 CFSR and, therefore, was required to address this factor in its PIP.

Key Concerns From the 2002 CFSR

The key concerns identified in the 2002 CFSR were the following:

- Key services were not available in sufficient quantity in either rural or urban communities (item 35).
- Many critical services were not available in all communities in the State (item 36).
- In many situations, the types of services provided to children and families were more likely to be influenced by what was available rather than by what was needed to meet their particular needs (item 37).

To address these concerns in its PIP, OCS implemented the following strategies:

- Conducted an assessment of strengths and service gaps using a collaborative approach with community providers and stakeholders
- Collaborated with other State agencies and departments to ensure the efficient use of available resources for shared populations
- Used Tribal, paraprofessional, and village-based resources to assist in case planning
- Developed grant programs to expand services and worked with grantees to develop a baseline of current services and identify changes that are needed to evaluate services, including post-adoption services

Alaska met its target goals for this systemic factor by the end of the PIP implementation period.

Key Findings of the 2008 CFSR

Findings from the 2008 CFSR for the specific items assessed for this factor are presented below.

Item 35. The State has in place an array of services that assess the strengths and needs of children and families and determine other service needs, address the needs of families in addition to individual children in order to create a safe home environment, enable children to remain safely with their parents when reasonable, and help children in foster and adoptive placements achieve permanency

_____Strength __X___ Area Needing Improvement

Item 35 is rated as an ANI. The Statewide Assessment and stakeholders interviewed during the onsite CFSR reported that statewide, substance abuse and mental health treatment services are not sufficient to meet the needs of children and families. Stakeholders also identified the lack of in-home family preservation services and basic case-management services, and the statewide shortage of foster homes (particularly Native Alaskan foster homes) as key service gaps. This item also was rated as an ANI in the 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, in January 2005, OCS modified the grantee process for grants funded by title IV-B that resulted in an improvement in the availability of family support services; family preservation services, which are prioritized for families with an open in-home case; family preservation visitation centers; time-limited reunification services; the differential response program; adoption support services; and Child Advocacy Centers.

The Statewide Assessment also identifies the following services as part of the service array for children in the Alaska child welfare system:

- Early Intervention and Infant Learning services are available for families with infants and toddlers (birth to age 3).
- Resource Family Training and Support Services are available to all OCS foster families providing initial and ongoing training to assist with meeting the individualized and unique needs of children.
- The Alaska Children's Trust's grantees provide a hotline for parents to obtain services to improve knowledge, skills and understanding about child development, age-appropriate expectations, and roles and responsibilities. Services also include professional counseling, parenting classes, and education.
- The Bring the Kids Home program was established within the DHSS across the Division of Behavioral Health, Division of Juvenile Justice (DJJ), and OCS with funding partners at the Mental Health Trust, Denali Commission, and the Department of Education. The focus of this project is to decrease the number of children placed in out-of-State residential treatment facilities and increase capacity to serve Alaska's children at home.
- The Rural Social Services program provides grants to three Tribal organizations to provide services such as child abuse prevention, support services to families at risk of entering into OCS custody, coordinated case management services, and placement support for children who are involved in the OCS system.

Despite these services, the Statewide Assessment notes that substance abuse treatment services and mental health services are not sufficient to meet the needs of children and families in any areas of the State. With regard to mental health services, the Statewide Assessment reports that staff shortages, low pay, and demanding job duties within provider agencies add to the lack of services available. Also, as indicated in the Statewide Assessment, although collaboration to deliver behavioral health services exists among community providers statewide, the focus often is on crisis care rather than on long-term therapies that are crucial to parents and children on the path to reunification. In addition, the Statewide Assessment indicates that OCS recognizes that allocations of funding for mental health services continue to be a challenge due to the fact that residential placements consume the majority of limited funds that are available to OCS; OCS would like to shift funding to serve children in less restrictive environments.

With regard to substance abuse treatment services, the Statewide Assessment notes that most, if not all, substance abuse treatment programs have waiting lists and that many clients must wait an average of 2 to 3 months before they are accepted into an in-patient treatment program. As noted in the Statewide Assessment, this waiting period diminishes the likelihood of the parent actually enrolling in the in-patient program. The Statewide Assessment also reports that only three programs in the State allow children to reside with parents during the course of treatment. This means that many parents attending programs far from their homes have little or no contact with their children during the course of treatment.

Stakeholder Interview Information

Almost all stakeholders commenting on this item during the onsite CFSR expressed the opinion that the current service array in the State is not sufficient to meet the needs of children and families regardless of their locations. The most frequently mentioned service gaps pertained to mental health and substance abuse services, particularly in-patient substance abuse treatment services. Stakeholders also reported that a lack of sufficient in-patient substance abuse treatment for youth was a statewide concern and that there are no detoxification services available for parents and children.

A few stakeholders indicated that substance abuse assessments can be done quickly, but other stakeholders said that the assessment process often involves a long waiting period, sometimes 2 to 3 months. Some stakeholders noted that because of a scarcity of substance abuse treatment services, even when assessments are done in a timely manner, parents may not be able to access treatment for several months, at which time the assessment may be out-of-date and a new one required by the court.

With regard to mental health services, Stakeholders said that there are clinics available throughout the State that will provide short-term, crisis-related mental health services, but that there is a lack of longer-term services. Stakeholders reported that many therapists will not accept Medicaid, and OCS will not pay for services from anyone who does not accept Medicaid.

Another key service gap identified by stakeholders in all sites pertained to in-home services and placement prevention services. Many stakeholders spoke about the disappearance of these services over the past few years as budget cuts have eliminated funding for them.

Stakeholders suggested that as a result, children who are being removed from their homes could have remained at home if services were available. Stakeholders also expressed concern about the lack of services statewide for parents and children with FASDs. In particular, stakeholders noted that parents with FASD experience numerous difficulties parenting and need ongoing support, which is not readily available.

A third key service gap identified by stakeholders pertained to the lack of foster and adoptive homes throughout the State. In particular, stakeholders expressed concern about the insufficient number of Native Alaskan foster and adoptive homes to meet the needs of these children who are in foster care.

Finally, most stakeholders said that even the basic case management services are not being provided consistently. They attributed this lack of basic case management services to insufficient staffing of OCS offices and insufficient support for OCS caseworkers.

Other key services gaps identified by various stakeholders were the following:

- Housing for youth who are in custody and after leaving custody
- Visitation services to ensure sufficient and high quality visitation between children and parents
- Domestic violence services for both victims and perpetrators
- Family support services for foster parents, particularly respite services
- Parenting classes
- Pre- and post-adoption support services
- Sex offender treatment services, including treatment for youth who are perpetrators
- Methadone clinics

Despite these concerns, most stakeholders praised the State's IL program, although a few noted that it is difficult to extend this program to youth living in the very remote villages. Stakeholders also noted that youth are referred to the IL program even if they do not have a case plan goal of OPPLA and can be served as young as 14 years of age. Anchorage stakeholders identified the local trauma program, positive parenting program, and Father's Journey program as exemplary services available in that location. Other stakeholders praised the Programs for Infants and Children and the Anchorage Child Advocacy Center.

Item 36. The services in item 35 are accessible to families and children in all political jurisdictions covered in the State's CFSP

_____Strength __X__ Area Needing Improvement

Item 36 is rated as an ANI. As indicated in the Statewide Assessment and by stakeholders interviewed during the onsite CFSR, the agency is not effective in ensuring that resources are available in all political jurisdictions. Although the Statewide Assessment

attributes this lack of available services to the remoteness of some of Alaska's communities and the resultant transportation difficulties, stakeholders indicated that there also is a lack of State effort to ensure that local offices have the resources necessary to adequately serve those populations residing in remote areas. These stakeholders said that even basic child protective and case management services are limited in these areas due in large part to insufficient child welfare staff in the offices that serve these areas. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, Alaska continues to struggle to provide all services in all political jurisdictions of the State. The lack of available services was attributed to the size of the State, the fact that the population is spread out among numerous villages, and the lack of a road system in many areas of the State. The Statewide Assessment notes that OCS is divided into four regions: Anchorage, Northern, Southcentral, and Southeast. As indicated in the Statewide Assessment, key resources such as family support, family preservation, time limited reunification, early intervention/infant learning program, Child Advocacy Centers, residential treatment, and post-adoption services are available in all regions. However, the Statewide Assessment also notes that although these services are available in each region, they may not be available from each field office location and access to services may require plane, boat, or snow machines.

According to the Statewide Assessment, QA team members have reported that in some cases children and families receive all required services regardless of their geographic location, while in other cases, they do not.

The Statewide Assessment reports that although residential treatment facilities are available in all regions, psychiatric services for the most complex children and adults are located only in Anchorage, Fairbanks, and Juneau. Family Preservation Supervised Visitation is available only in Anchorage, while the Differential Response program is available only in Anchorage, Wasilla, and Nome.

Stakeholder Interview Information
Stakeholders commenting on this item during the onsite CFSR expressed the opinion that key services are not available to children and families in all jurisdictions covered by the CFSP. For the most part, stakeholders attributed the differential availability of services to the fact that some of the families served in Alaska live in remote areas that have few if any services. They noted that most of these areas do not have funds to pay for families to come to the more urban areas to access services.

Some stakeholders also noted that many children in rural areas are not being protected and are not safe. They expressed the opinion that the lack of safeguards for children is due to the fact that OCS offices that serve these areas are understaffed because OCS staffing plans do not take into account the large distances that caseworkers have to travel and the potential for bad weather. As a result, even basic child protective services and case management services are not available to many children and families.

Item 37. The services in item 35 can be individualized to meet the unique needs of children and families served by the agency

_____Strength ___X_ Area Needing Improvement

Item 37 is rated as an ANI. Although there are flexible funding resources and culturally appropriate services in the State, they are not sufficient to meet the needs of the children and families requiring individualized services. This item also was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information

According to the Statewide Assessment, Alaska has worked on providing individualized services to children and families through the use of individualized service funds, which are intended to keep children in their home communities. However, the Statewide Assessment also notes that these funds are limited and approval must be provided through the State office. The Statewide Assessment reports that the special needs funds that are available support individualized service needs because they allow caseworkers to pay for services that are not available under Medicaid, not covered by the foster care base rate, and/or not attainable by the family. Examples of these services include bus passes, entry fees for camps/activities, individual counseling services, drug screening, and genetic testing for paternity.

The Statewide Assessment says that to individualize services for children and families, caseworkers must be creative and collaborate with local resources to ensure that these services are provided. One example noted in the Statewide Assessment is that in many rural communities there are ICWA workers who provide services to families in an effort to keep them together. These services include transportation, food, shelter, heating fuel, parenting skills development, anger management classes, and respite care.

The Statewide Assessment reports that OCS recognizes that it is critical to understand the cultural differences among families in Alaska to be able to address individual needs of Alaska Native children and families. Although all caseworkers are required to take the ICWA training offered through TONE, it can be difficult for local child welfare agencies to consistently be staffed by caseworkers who are aware of the cultural issues of children from diverse villages and Alaskan Native cultures primarily due to high staff turnover and limited training opportunities. The Tribal State Collaboration Group (TSCG) is working on development of culturally appropriate training for all State employees. Additionally, OCS is working with Tribes to include cultural training requirements for OCS grantees.

The Statewide Assessment also notes that the populations of Hispanic, Asian, and African Americans varies across the State with a greater number of these ethnic and racial groups located in Anchorage, Juneau, and Fairbanks. There has been a higher rate of immigration to the State of Hispanics and Asians in the past few years. Resources are accessed from leaders in the Asian and Hispanic communities for services such as interpreters and culturally based services.

Stakeholder Interview Information
Stakeholders commenting on this item during the onsite CFSR acknowledged that the general lack of services makes it difficult for caseworkers to address the individual needs of children and families. Many stakeholders identified the scarcity of OCS caseworker staff as a key problem in ensuring that cases are treated individually. However, a few stakeholders noted that because of the lack of services, some good caseworkers and service providers get creative about working with families and advocate for the families to meet their unique needs.

Many stakeholders spoke about the lack of culturally appropriate services for Native Alaskan children and families. A few stakeholders noted that there is a need for proven traditional Native services to be accepted by the general culture as effective in resolving some of the problems experienced by children and families. They noted, for example, that if a family goes to a traditional healer, that is not counted for the case plan. Some stakeholders suggested that although the OCS caseworkers are supposed to work with Tribal caseworkers on case planning for Native children, often the Tribal caseworker receives the case plan just before the 6-month administrative review without having had any input into the plan.

Stakeholders also noted that there are few culturally appropriate resources for the Korean and Hmong communities in Anchorage.

VI. AGENCY RESPONSIVENESS TO THE COMMUNITY

Rating of Review Team Regarding Substantial Conformity				
	Not in Substantial Conformity		Substantial Conformity	
Rating	1	2X	3	4

Status of Agency Responsiveness to the Community

Alaska is not in substantial conformity with the systemic factor of Agency Responsiveness to the Community. The State was found to be in substantial conformity with this systemic factor in its 2002 CFSR and therefore did not address this factor in its PIP. Findings with regard to the 2008 CFSR are presented below.

Item 38. In implementing the provisions of the CFSP, the State engages in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals and objectives of the CFSP

_____Strength ___X__ Area Needing Improvement

Item 38 is rated as an ANI because OCS does not have a process to consistently seek input from and engage stakeholders, including local child welfare agency directors and staff, in the development of its goals and objectives for the State child and family services programs. This item was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, the goals and objectives of the Alaska CFSP reflect input from individuals who represent a wide range of agencies and community partners throughout the State. These include the following: TSCG; CIP; Department of Law; Alaska Citizen Review Panel; Facing Foster Care in Alaska; OCS grantees; Alaska Association of Homes for Children; and State office administrators, managers, program staff, regional managers, and supervisors.
As indicated in the Statewide Assessment, although OCS may not facilitate regularly scheduled "formal" CFSP meetings, the regular contact and collaboration with the partners listed above provides a rich ongoing exchange of information and allows for an evaluation of CFSP progress and services.

In addition, Facing Foster Care in Alaska, a foster care youth group that was established in 2003, meets quarterly with the OCS IL Coordinator and the statewide IL Specialists to discuss challenges facing youth as they prepare for adulthood. Membership comprises youth currently in the system as well as alumni. Members also have participated in other child welfare conferences and public forums.

Stakeholder Interview Information
Most stakeholders commenting on this item during the onsite CFSR reported that there is no formal child welfare advisory group in the State that provides input to the State's 5-year plan or CFSP, or that is consulted on a formal and routine way when making decisions regarding the child welfare system. In addition, stakeholders at the local sites indicated that even local-level agency supervisors and administrators often are not engaged in the development of the State plan, and there is no mechanism in place for seeking or using their input. Stakeholders also noted that Tribal input with regard to new child welfare program initiatives often is sought after OCS has decided to develop a particular initiative and not during the early decision-making stages. Tribes are asked to assist with implementation but not the development of the initiative. One stakeholder noted that there is a new effort to have one person from OCS focus on Tribal input, and that effort may help this situation.

A few stakeholders reported that some members of the Citizen's Review Panel participated in the development of the last 5-year plan. Some stakeholders also indicated that recently representatives of various departments, including the Department of Education, participated on a State Assessment Team, which was a group of about 45 people who were given the task of determining how to improve the State child welfare system.

Item 39. The agency develops, in consultation with these representatives, Annual Progress and Services Reports (APSRs) delivered pursuant to the CFSP

_X___ Strength _X _Area Needing Improvement

Item 39 is rated as an ANI because OCS does not have a formal process for engaging stakeholders in developing annual progress and services reports. This item was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment
According to the Statewide Assessment, OCS is actively involved with all representatives that contribute to the CFSP and works with them to evaluate CFSP goals and strategies on an informal basis. If necessary, goals and strategies are modified to support the direction of the agency and its partners. Information for the plan is regularly obtained from the collaboration with these groups and is integrated into the APSR, which is developed once a year. The APSR is shared with community partners and is available on the OCS website.

Stakeholder Interview Information
Several stakeholders reported that they participate in a variety of meetings and workgroups designed to affect practice and the direction of the child welfare agency. Stakeholders noted for example that the TSCG is used to work together on identified statewide issues such as disproportionality. However, several stakeholders also noted that, although in past years Tribal groups have had a chance to comment on the APSR, in the past year, they were not provided with the report for comment. Other stakeholders noted that community stakeholders may have seen the report, but most expressed the opinion that they have not had much opportunity for input into the annual report although they believe that they have input into agency planning and programs.

Item 40. The State's services under the CFSP are coordinated with services or benefits of other Federal or Federally-assisted programs serving the same population

_X_Strength _____Area Needing Improvement

Item 40 is rated as a Strength because the State's services are coordinated with services or benefits of other Federal or Federally-assisted programs serving the same population. This item also was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, coordination efforts are ongoing with the Division of Behavioral Health—mental health and substance abuse, DJJ, Child Advocacy Centers, Alaska Children's Trust, CIP, Division of Public Assistance—TANF and Child Care, Department of Revenue—Child Support, Faith Based Programs (FLAME), Department of Education—Individual Service Plans and Head Start, Division of Public Health, Division of Senior and Developmental Disabilities, Department of Public Safety, Social Security Administration, Department of Law, Department of Labor—Workforce Investment Act, and the Bureau of Vital Statistics.

In addition, as reported in the Statewide Assessment, OCS has memoranda of agreement with the Department of Education, Department of Public Safety, Department of Revenue, and numerous Tribes/Tribal Entities that outline the agency interchanges and responsibilities for children under the purview of Alaska's Child Welfare System.

The Statewide Assessment also reports that the DHSS Leadership Team includes all Division Directors within the Department and works cooperatively to resolve departmental issues that arise. In May 2008, the Department published its five top priorities: substance abuse, vulnerable Alaskans; health and wellness; health-care reform; and long term care. The Children's Policy Team meets bimonthly and includes representatives from DHSS Commissioner's Office, Behavioral Health, Public Assistance, OCS, Public Health, Medicaid, and Senior and Developmental Disabilities to coordinate services and programs among divisions within the department.

Stakeholder interview information
Stakeholders commenting on this item during the onsite CFSR identified the following efforts to coordinate services among Federal or Federally-assisted programs serving the same population:

- OCS and the courts are working together to develop meaningful visitation plans for parents and children.
- OCS, DJJ, and Division of Behavioral Health (DBH) agencies work together to ensure that children do not get lost when they transition from Juvenile Justice to OCS.
- OCS, DBH, and the courts collaborate on developing the Shields program for residential substance abuse treatment for mothers and children.
- OCS and TANF work together to ensure integrated services to families through the Families First! initiative.
- There is preliminary matching of families who are served by OCS, DJJ, TANF, and DBH at the same time.
- OCS and TANF work together to ensure support for relative caregivers not licensed foster parents.

- OCS participates in a system of care effort with TANF, Tribes, and other divisions of DHSS.
- The Bring the Kids Home program is a joint effort of DBH, OCS, and other agencies.
- OCS works with Tribal groups and other agencies on disproportionality issues.

VII. FOSTER AND ADOPTIVE PARENT LICENSING, RECRUITMENT, AND RETENTION

Rating of Review Team Regarding Substantial Conformity				
	Not in Substantial Conformity		Substantial Conformity	
Rating	1	2X	3	4

Status of Foster and Adoptive Parent Licensing, Recruitment, and Retention

Alaska is not in substantial conformity with the systemic factor of Foster and Adoptive Parent Licensing, Recruitment, and Retention. Alaska also was not in substantial conformity with this factor in its 2002 CFSR and, therefore, was required to address the factor in its PIP.

Key Concerns From the 2002 CFSR

The 2002 CFSR identified the following key concerns with regard to this factor:

- The State granted variances to the licensing standards with the result that full licensing standards are not equally applied to all foster homes.
- The State did not have an effective recruitment plan for recruiting foster and adoptive parents who meet the needs of the children in foster care.

To address these concerns, the State implemented the following strategies in its PIP:

- Implemented efforts to improve the licensing process, particularly with regard to the use of variances
- Developed a statewide foster care recruitment plan with the assistance of the National Resource Center for Foster Care and Permanency
- Increased recruitment of Native Alaskan foster parents through increased collaboration with Tribes

Alaska met its target goals for this systemic factor by the end of the PIP implementation period.

Key Findings of the 2008 CFSR

Findings of the 2008 CFSR for this factor are provided below.

Item 41. The State has implemented standards for foster family homes and child care institutions which are reasonably in accord with recommended national standards

_____Strength ___X __ Area Needing Improvement

Item 41 is rated as an ANI because while there are licensing standards established, many licensed homes with ongoing placements do not meet the full licensing standards. This item was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, Alaska's new licensing standards provide adequate protection to the health and safety of children and require monitoring and home visits as part of the renewal process. The initial provisional license is issued for a period of 1 year. The provisional license can be fully licensed or not fully licensed; at the end of 1 year the license changes to a biannual license. If at any time, the license does not meet all "fully" licensed standards, the worker will change the status of the license from "fully" licensed to "not fully" licensed.

The Statewide Assessment also reports that many homes in rural communities do not meet all of the standard-by-standard home environmental licensure requirements, especially with regard to the "physical plant" of the home. In these cases, a variance may be requested and approved in order to accommodate children's special needs, or the best interest of children, such as placement of a sibling group. The variance process allows a particular standard to be varied if an alternate way of meeting the standard can be identified and implemented while ensuring the child's safety. The two most common reasons that variances are utilized are the following: (1) the physical plant of the foster home does not meet necessary fire and safety codes, and (2) the number of children in the home exceeds the standard in order to accommodate large sibling groups. OCS does not use variances for safety equipment requirements such as fire extinguishers, smoke detectors, and carbon monoxide detectors. In cases of foster home capacity, variances are approved whenever possible to ensure that children are placed with a relative and/or that siblings are placed together.

Stakeholder Interview Information
Stakeholders commenting on this item during the onsite CFSR identified the following types of foster parent licenses:

- Provisional license: Foster parents who meet all of the requirements for a licensed foster home and have had a complete background check with fingerprints are given a provisional license for a 12-month period.

- 2-year license: Foster parents who complete the first year as foster parents, and for whom no problems have been identified, are then issued a license for a 2-year period.

While there are licensing standards established, many licensed homes with ongoing placements do not meet the full licensing standards.

Anchorage stakeholders reported that in that location, licensing caseworkers conduct the home assessments for all applicants, including relatives, and explore whether they can be licensed and then give the information to the placement caseworker who makes the final placement decision. These stakeholders also indicated that licensing caseworkers investigate licensing violations and if there is a child abuse or neglect allegation, the licensing caseworker goes out to investigate with the CPS investigator.

Stakeholders also indicated that variances often are made to licensing standards and regulations. It was noted that these variances can apply to the number of children who can be placed in the home (this is not limited to sibling groups), whether there is a criminal record indicating a "barrier" crime, and for the physical aspects of the home, such as windows that are narrow. Stakeholders in Anchorage noted that many caseworkers have children in foster families that have variances that permit more children in the home. This situation may be because foster families in Alaska generally are licensed for a maximum of only three children. Stakeholders noted that with variances, this maximum often is increased to six children, even if the children are young. In addition to variances, some stakeholders noted that some families, in order to have more children in the home, will be licensed as group home facilities rather than be given a variance, which allows them to care for six or more children.

Some stakeholders expressed concern about the licensing process and about licensing workers having little contact with foster homes except for the 6-month assessments. However, other stakeholders reported that licensing caseworkers have frequent interaction with foster homes and provide support and assistance to foster parents that caseworkers cannot provide because of their caseloads.

A few stakeholders commented on Native Alaskan foster homes and noted that in some places a Tribe can license their own homes, but State funds cannot be used for payment in these homes. Some stakeholders indicated that State-licensed Native foster homes often are pushed to capacity.

Item 42. The standards are applied to all licensed or approved foster family homes or child care institutions receiving title IV-E or IV-B funds

___X___ Strength _____Area Needing Improvement

Item 42 is rated as a Strength because the Statewide Assessment and stakeholders both stated that Alaska claims title IV-E funds only for children placed in foster homes that are fully licensed. This item was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment
According to the Statewide Assessment, all licensed foster homes, relative and non-relative, are required to comply with the same set of standards. Relatives are provided a choice of whether to be licensed or not. If relatives are not licensed, OCS requires a criminal and child protection background check and a physical check of the home surroundings. Unlicensed relatives do not receive reimbursement from OCS; however, unlicensed relatives can receive TANF funding through the Division of Public Assistance to assist with the support of the children in their homes.

As indicated in the Statewide Assessment, variances are requested and approved through regional variance committees. In every case, OCS is utilizing the variance process to make sure that each standard for licensure is applied equally and that each home meets the safety requirements outlined in the licensing regulations. In the event that a variance is denied, OCS may use State funding and title IV-E reimbursement to make necessary physical modifications to the home so that a child can be placed in the home.

Stakeholder Interview Information
Stakeholders commenting on this item expressed the opinion that the standards for foster home licensing are applied equally to all licensed homes that receive title IV-E funds. Stakeholders noted that the State does not claim title IV-E funds if the foster parents are missing training, fingerprints, criminal history check, background information forms, references, or if they are not in compliance with key licensing issues. However, a few stakeholders indicated that many families often are not in compliance with the training requirements, particularly families in the rural areas, and it is not clear whether or not these homes continue to have full licenses.

Stakeholders noted that relatives are required to meet the same licensing standards as other foster homes. However, they can choose not to be licensed and still provide care to children.

Item 43. The State complies with Federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children

_X__Strength ____ Area Needing Improvement

Item 43 is rated as a Strength because the State complies with Federal requirements and completes criminal records checks on all licensed foster, adoptive, and relative placement homes. This item also was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, criminal background clearances are required for all foster parents, unlicensed relatives and pre-adoptive or adoptive homes. The Federal barrier crime regulations apply to unlicensed relatives and foster and adoptive families. The State barrier crime statutes and regulations only apply to licensed foster homes and facilities within the DHSS and are more restrictive. The Statewide Assessment also reports that Alaska has faced challenges in the timeliness of receiving fingerprint results, but is actively working to improve these outcomes through the use of fingerprint scanners. It is anticipated that the electronic transfer of fingerprints and results will significantly reduce the timelines for foster care licensing and adoption home study approvals.

Stakeholder Interview Information
Stakeholders commenting on this item during the onsite CFSR expressed the opinion that the State conducts criminal background clearances, including fingerprint checks, in the process of licensing foster care placements and approving relative placements. However, many stakeholders expressed concern regarding the length of time required to get fingerprint information, which ranged from 3 to 6 months.

Item 44. The State has in place a process for ensuring the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed

____Strength __X__ Area Needing Improvement

Item 44 is rated as an ANI because numerous stakeholders reported that Alaska does not have a statewide process in place to recruit foster homes despite significant shortages of all types of foster homes. Stakeholders reported that local offices do not have recruitment plans, recruitment resources are limited across the State, and efforts to recruit foster homes are insufficient. This item was rated as an ANI in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, over the past 5 years, Alaska has invested many resources into recruiting and retaining foster and adoptive parents. However, the Statewide Assessment notes that better tracking of these efforts is needed to determine their effectiveness with regard to the outcomes for children. The Statewide Assessment also notes that the development of a multi-year recruitment plan will better synthesize the various local and regional recruitment and retention efforts.

The Statewide Assessment identifies the following activities as part of Alaska's recruitment and retention efforts:

- Technical assistance was received from 2003 to 2005 from the National Resource Center on Foster Care and Permanency Planning to develop a recruitment and retention plan for OCS. (The Statewide Assessment indicates that this recruitment and retention plan was never formalized within OCS; however, a smaller recruitment effort was developed to address the need for additional Native foster families in rural Alaska.)
- The Native Rural Recruitment Team (NRRT) was developed in 2006 in response to the need for more Alaska Native and rural resource family homes to prevent Alaska Native rural children from being removed from their community and placed in urban areas of Alaska. This approach has increased the number of homes in rural villages available to children in need. To date, 37 foster homes in remote, village communities have been identified and licensed through the NRRT community teams.
- The Annie E. Casey Foundation's Family-to-Family Initiative has been implemented in the Anchorage region since 2004.
- As a part of the National Adoption Awareness month in 2006 and 2007, OCS funded a statewide media campaign that focused on the adoption of older youth in foster care. These media ads (radio and television) ran from November through May.
- Other recruitment strategies have occurred such as advertising signs on city buses, interviews with newspapers and radio stations, as well as print media. National Foster Care month activities have included foster parent appreciation events in all of the OCS service regions.
- Adoption days were implemented in the Anchorage, Palmer, Fairbanks, and Juneau courts over the past 3 years.
- The DHSS Office of Faith-Based Initiatives brought together the faith-based community in the Anchorage region to create a support network for resource families. This group has been meeting for more than a year and has developed a support plan that was finalized in March 2008; however, the plan is not yet implemented.
- In 2007, the OCS became a grantee of the Dave Thomas Foundation's Wendy's Wonderful Kids program. Through this program, Wendy's Wonderful Kids funds a half-time position for a child-specific recruiter in the Anchorage region to actively focus on six children a year who have been in foster care for the longest period of time and are legally free for adoption. In early 2008, this position was expanded by OCS to a full-time position through State funding resources to provide recruitment efforts focused on adoption and guardianship in the Anchorage region.

The Statewide Assessment notes that, despite efforts by OCS, Tribally licensed foster homes have not been established in Alaska due to various legal barriers. As indicated in the Statewide Assessment, OCS remains committed to working with the Tribal partners on the establishment of licensed foster home standards for Alaska Native families and children in foster care, should legal impediments be resolved.

Stakeholder Interview Information

All stakeholders commenting on this item expressed the opinion that there is a considerable need for foster homes, particularly for Native Alaskan children. Stakeholders indicated that at present, there is no systematic agency plan for recruiting Native Alaskan foster homes either at the State or local levels.

Stakeholders also noted that homes are needed for older children who often must seek their own placements or end up living in a shelter for 6 months or longer until they turn 18 because there is no place for them to go. Stakeholders indicated that families are needed for children with special needs, but when those families are found, they do not receive the support they need from the agency, and as a result, they drop out. Stakeholders generally viewed the lack of support for foster parents as problematic. Many stakeholders indicated that it is difficult to ask current foster parents to recruit other families to be foster parents because so little support is given to the foster parents. Several stakeholders indicated that, as a result, attention is being given more to retaining existing foster parents rather than recruitment. Some stakeholders said that licensing staff are trying to provide more of the support services to foster families because they realize that caseworkers are overwhelmed and do not have the time to assist foster parents with their concerns.

All stakeholders commenting on this item also expressed the opinion that there is no statewide recruitment plan. It was noted that local offices do their own recruitment, but have few resources; it was noted that even at the local levels, there is no systematic recruitment plan. Anchorage stakeholders reported that licensing caseworkers are responsible for recruiting foster homes but that they do not have a systematic recruitment plan and there is no budget set aside for recruitment.

The general recruitment strategies identified by stakeholders included recruitment picnics, ads, posters, word-of-mouth, and child-specific recruitment through the Heart Gallery.

Item 45. The State has in place a process for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children

_X___ Strength ____Area Needing Improvement

Item 45 is rated as a Strength because the State is effective in using cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children. This item was rated as a Strength in the State's 2002 CFSR.

Statewide Assessment Information
According to the Statewide Assessment, in 2007, the Alaska Adoption Exchange was established as a service within the Adoption program of the OCS State Office. The listing of a child on the Alaska Adoption Exchange automatically means that the child will be listed on the Northwest Exchange and the AdoptUsKids exchange. The Statewide Assessment notes that since the Alaska Adoption Exchange was established within OCS, 32 children have been listed on the exchange. One of the successes of the exchange has been to connect families from various locations in Alaska with waiting children statewide.

Stakeholder Interview Information
Stakeholders commenting on this item identified the following as cross-jurisdictional resources to facilitate adoptive or permanent placements for children:

- Placement of the child on the Alaska Adoption exchange, which leads to automatic placement on AdoptUsKids, and the Northwest Adoption Exchange
- The Heart Gallery

Stakeholders noted that the greatest barrier to out-of-State placement is the Interstate Compact for the Placement of Children process, which can result in considerable delays.

2/3/10 PRESENTA-TION: UNITED WAY 2-1-1 PROJECT

2-1-1 | Help starts here.

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- ... refer constituents to Alaska 2-1-1 or www.alaska211.org when they come to you with health and social services needs.
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This frees up legislative aide time that is usually spent researching and seeking out resources.

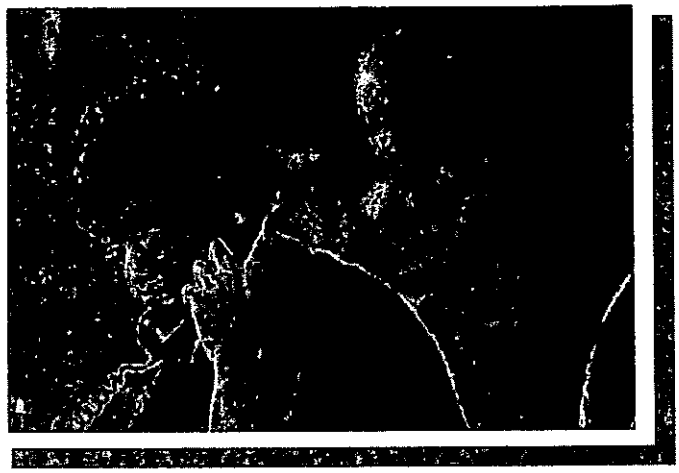
■ ■ ■

Alaska 2-1-1 is an efficient, confidential, easy-to-remember and free communications infrastructure and a statewide resource. Alaska 2-1-1 is operated by United Way of Anchorage. The Regulatory Commission of Alaska granted United Way of Anchorage the use of the designated three-digit entity for information referral services for the State of Alaska.

Alaska 2-1-1 is accessible by most phones in Alaska, and those communities that can't reach 2-1-1 directly can use the free (800) number, 1-800-478-2221.

Alaska 2-1-1 has already resulted in a reduction of non-emergency calls to 9-1-1.

Alaska 2-1-1 plays a critical role in responding to disaster. Alaskans face natural and manmade disasters, and Alaska 2-1-1 has become tool for disaster response and can be used as a central communications point for disaster relief and recovery. Recently, Alaska 2-1-1 was involved in assisting during Juneau Unplugged.

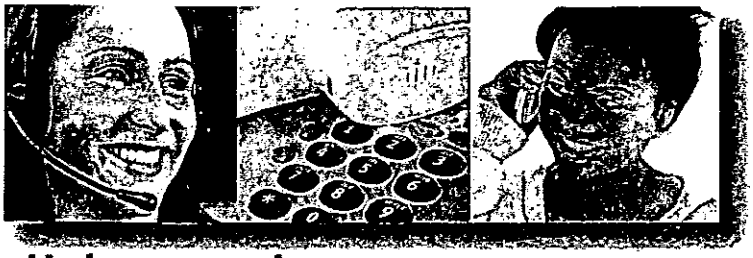


Help your constituents

find the resources they need by referring them to Alaska 2-1-1 via phone (2-1-1) or on the web (www.alaska211.org).

Help all Alaskans

discover this valuable service by spreading the word about Alaska 2-1-1. We can supply links for your website and widgets (below) for your newsletters.



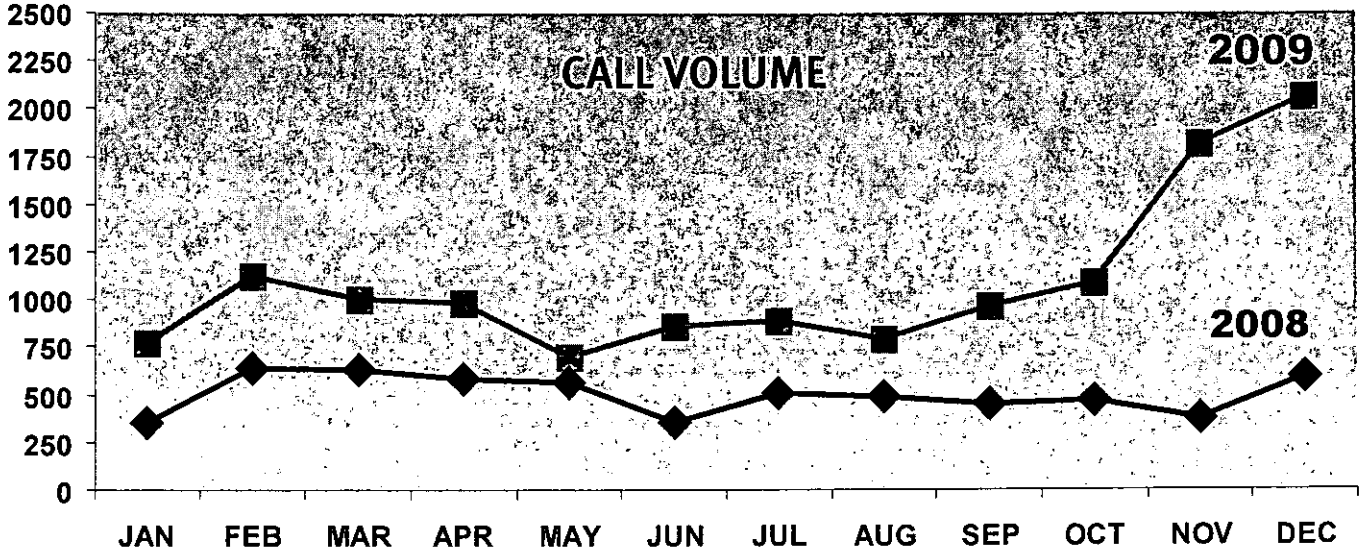
Alaska 2-1-1™ Get Connected. Get Answers.

United Way Alaska United Ways

Help starts here.

ALASKA 2-1-1 SERVICE SNAPSHOT 2009

13,060 CALLS FOR HELP answered by trained information and referral specialists



Top Three Caller Needs

Basic Needs 50%
Getting help to make ends meet was the top need in 2009. Calls for temporary supports and financial assistance – especially housing, food and utilities – doubled from 2008.

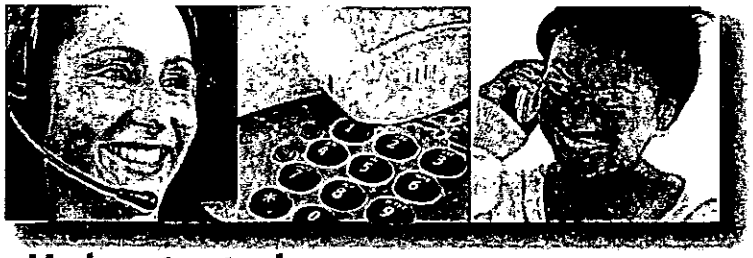
Employment & Income Boosts 27%
Alaskans actively looked for help to find employment opportunities and training. They also wanted to maximize their tax refunds through assisted tax preparation.

Health 15%
One in seven callers to Alaska 2-1-1 needed help finding health information and care like access to general and speciality services, dental, mental health, women's health and medications.

Calls by Region

Aleutians/Kodiak	2%
Fairbanks NSB	3%
Kenai Peninsula	5%
Mat-Su Borough	10%
North Slope	5%
Northwest Arctic (Nome)	7%
Southcentral (Anchorage)	51%
Southeast	5%
YK Delta/Bristol Bay	5%
Other	7%

Online Searches



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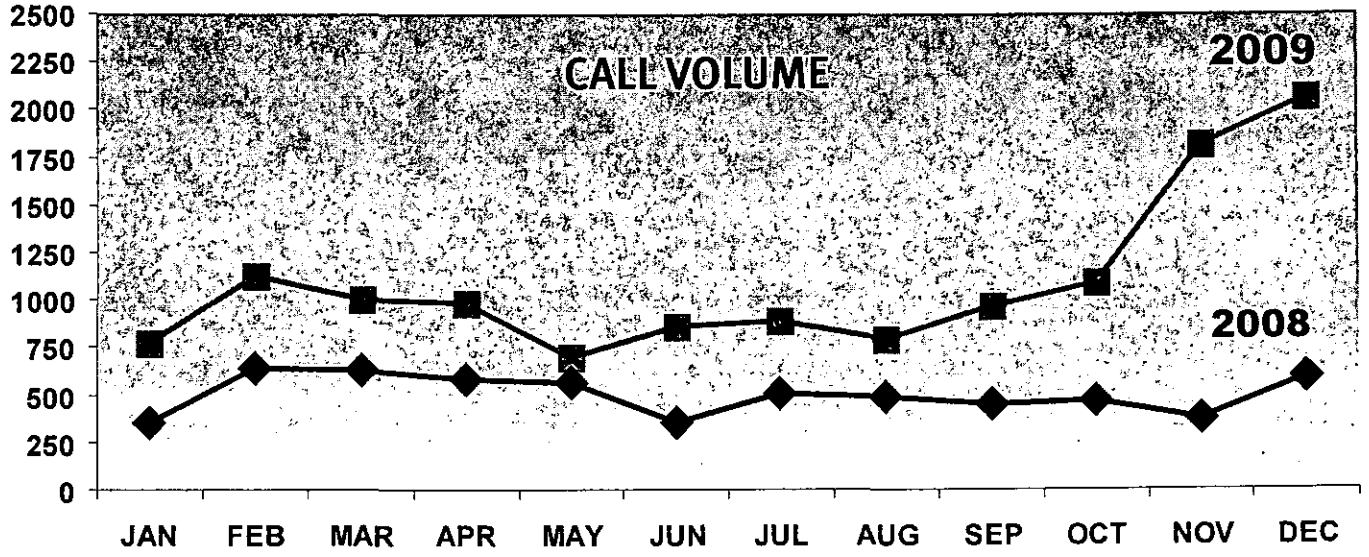

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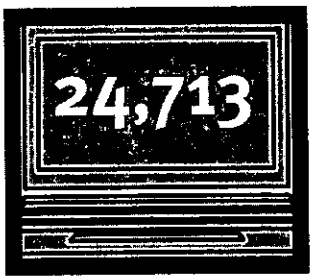


2/3/10 REPORT: ALASKA HEALTH CARE COMMIS-SION

Transforming Health Care in Alaska

Alaska Health Care Commission

2009 Report & 2010-2014 Strategic Plan

Presentation to

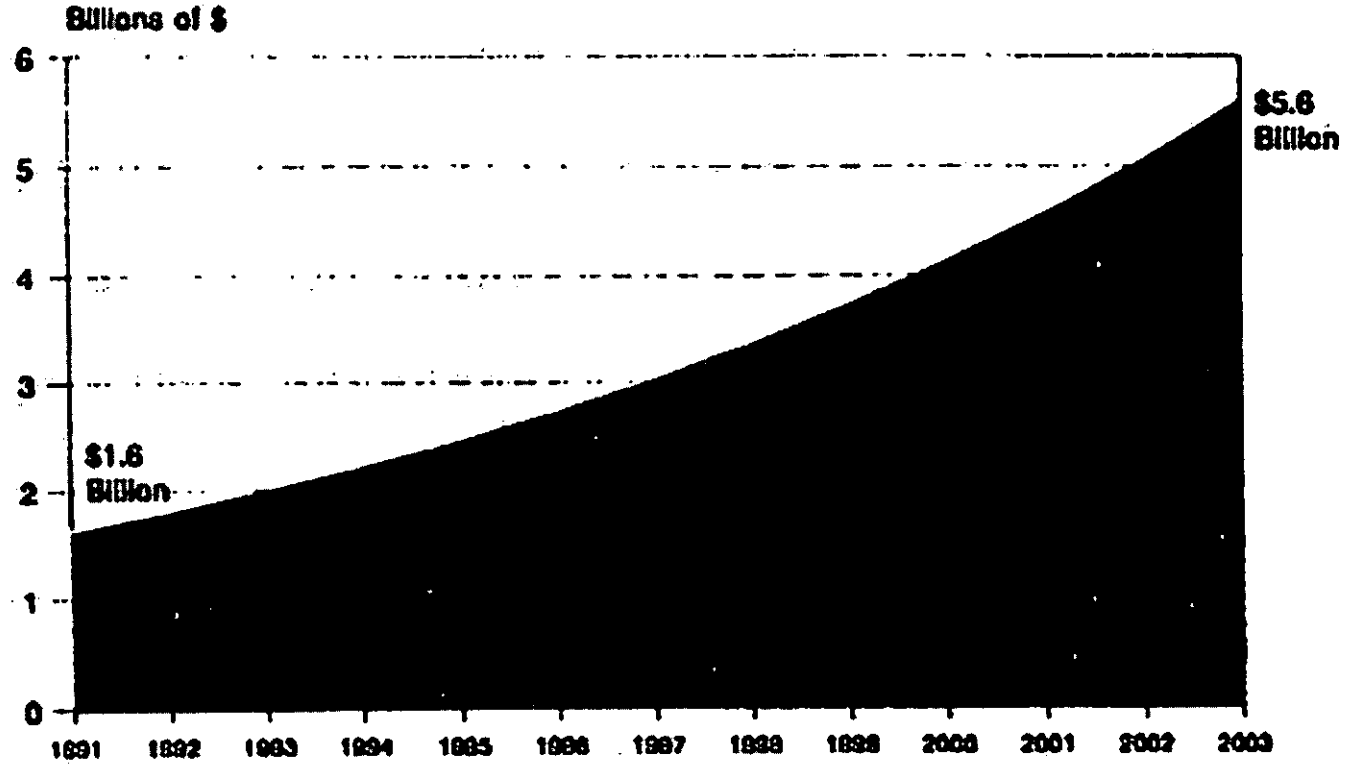
House and Senate Health & Social Services Committees

February 3, 2010

A Brief History...

1987-1988	Governor's Interim Health Care Commission
1991-1993	Health Resources and Access Task Force
2003-2005	CWN Alaska Health Care Roundtable
2007	AK Health Strategies Planning Council

Figure 2-1
Projections of Health Care Expenditures in Alaska under the Current System, 1991-2003



Source: Health Systems Research, Inc.

From Health Resources and Access Task Force 1993 Report

And Today...

with AK Health Care Expenditures over $6 Billion

Health Care Costs Pose a Significant Threat to Alaska's Economy and the Sustainability of State Government

The Alaska Health Care Commission

- Created by Gov. Palin under Administrative Order 246
- Members appointed January 2009
- Purpose: Foster development of statewide plan to address quality and accessibility of health care

Commission Members

- Dr. Ward Hurlburt, Chair – DHSS CMO
- Valerie Davidson – Tribal Health System
- Jeffrey Davis – Insurance Industry
- Keith Campbell – Consumer
- Ryan Smith – ASHNHA
- Wayne Stevens – Chamber of Commerce
- Dr. Lawrence Stinson – Health Care Provider
- Ex-Officio
  - Senator Donny Olson
  - Representative Wes Keller
  - Linda Hall – State Insurance Commissioner

Alaska Health Care Commission

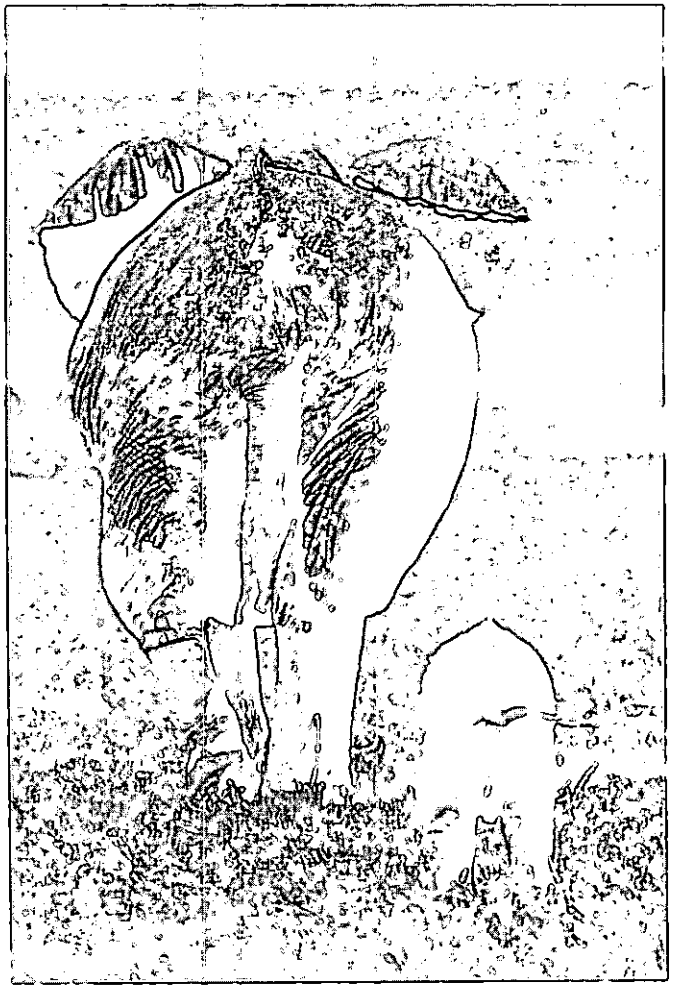
Duties

1. State health planning and coordinating body

2. Foster development of a:
   - Comprehensive statewide health care policy
   - Strategy for improving the health of Alaskans

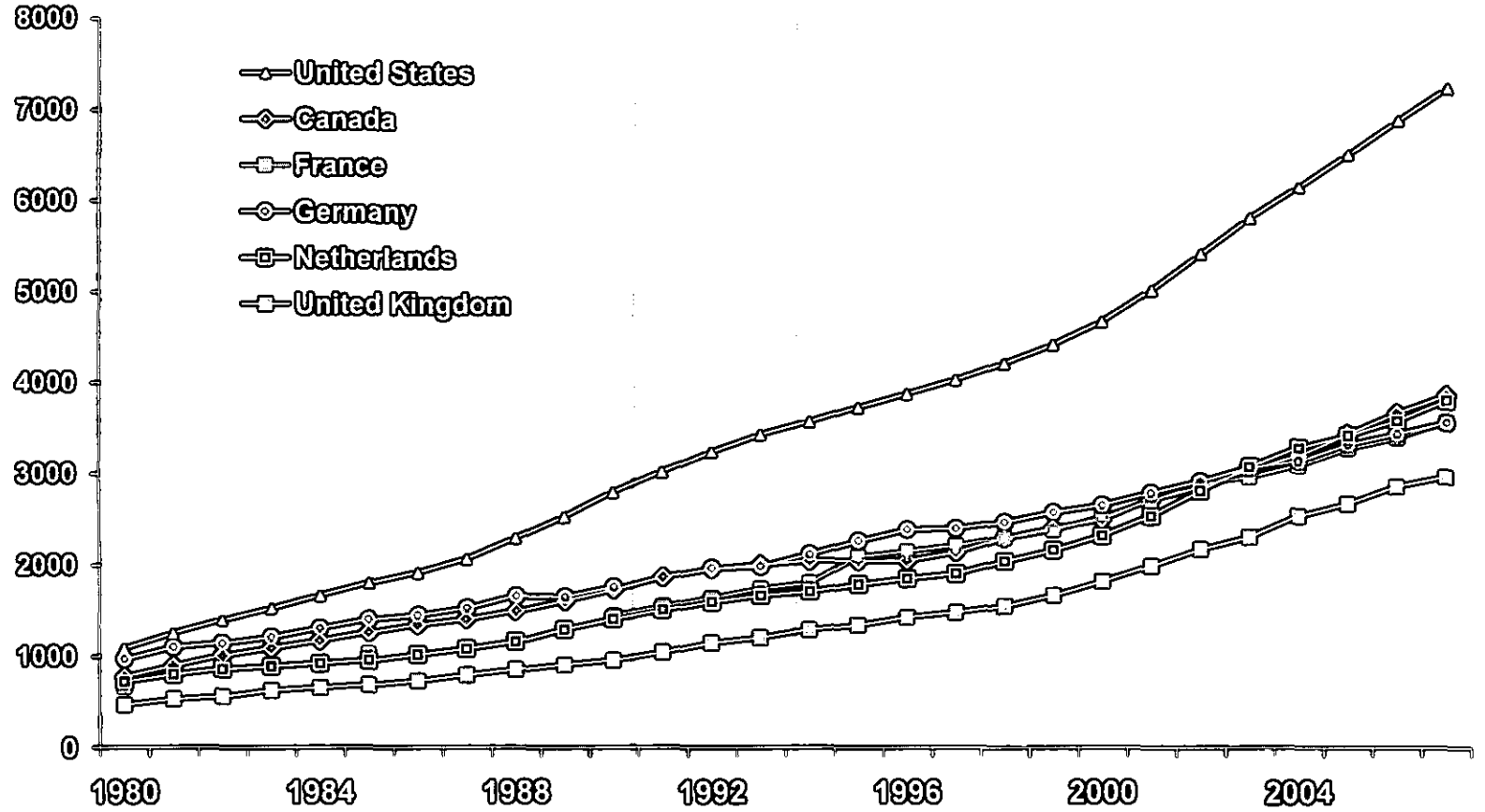
3. Report due to Governor and Legislature January 15, 2010

The Elephant in the Room



National Health Expenditures per Capita, 1980-2007

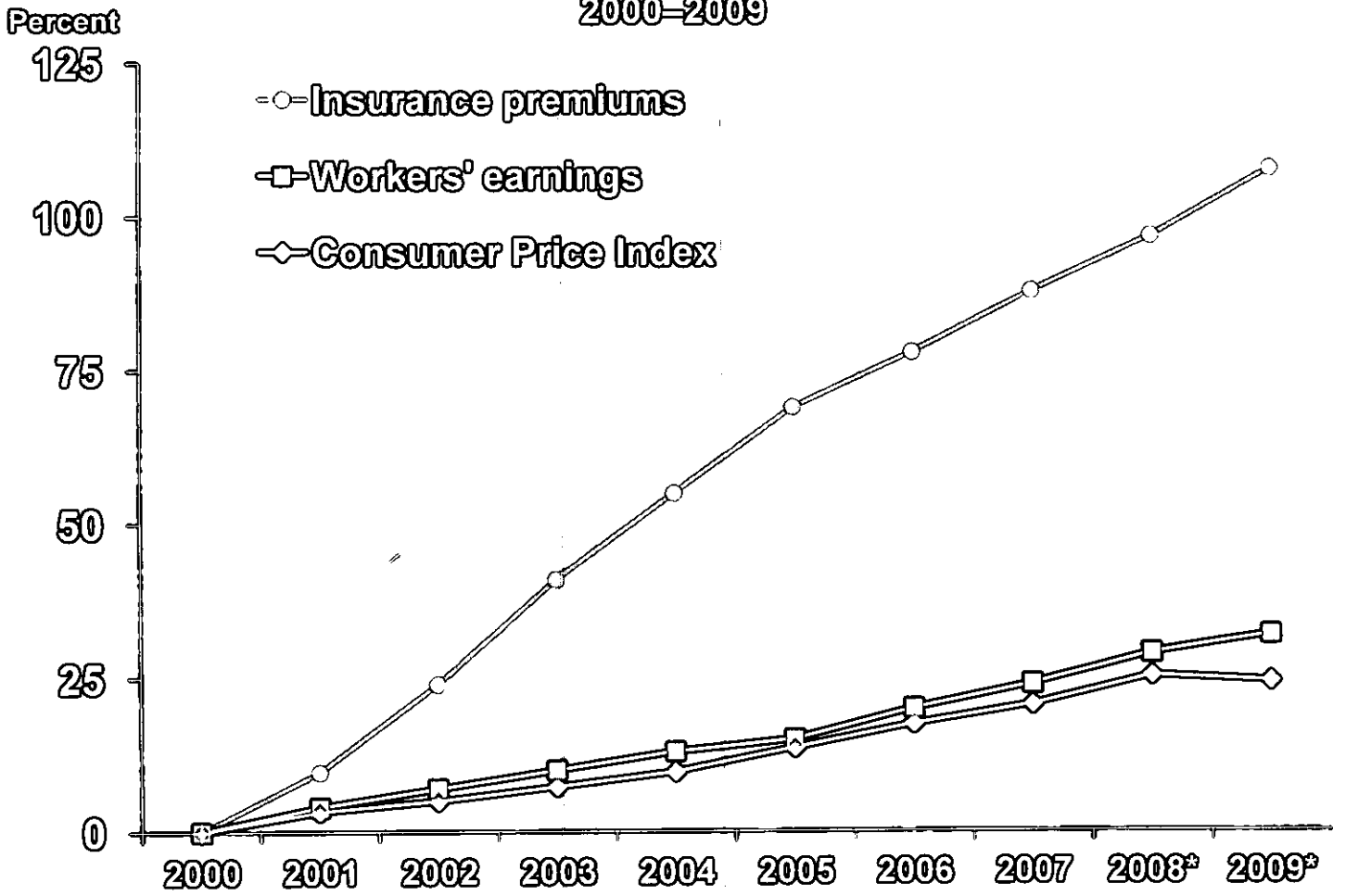
Average spending on health per capita ($US PPP)



Data: OECD Health Data 2009 (June 2009); from the Commonwealth Fund (Nov 2009)

Premiums Rising Faster than Wages and Inflation

Cumulative Changes in Components of U.S. National Health Expenditures and Workers' Earnings, 2000–2009



The High Cost of Care in Alaska

- Alaska has the highest annual Medicaid expenditure level per enrollee in the nation at $10,417 (2004)
- Alaska has ranked first in the nation for cost of Workers' Comp premium rates since 2005
  - Alaska has the highest Worker's Comp medical fee schedule rates in the nation – on average 3.5 times higher than the state with the lowest rates (2006)
  - Medical costs make up 72% of total Worker's Comp benefit claims in Alaska, compared to the national average of 58% (2008)
  - Alaska's average medical cost per Workers' Comp claim is $40K per injury compared to the national average of $26K (2008)
- The average cost per hospital stay in Alaska is $27,171 compared to the national average of $15,455 (2007)
- The price for medical care in Anchorage doubled between 1991 and 2005, while the Anchorage CPI for all items increased 38% during that same period

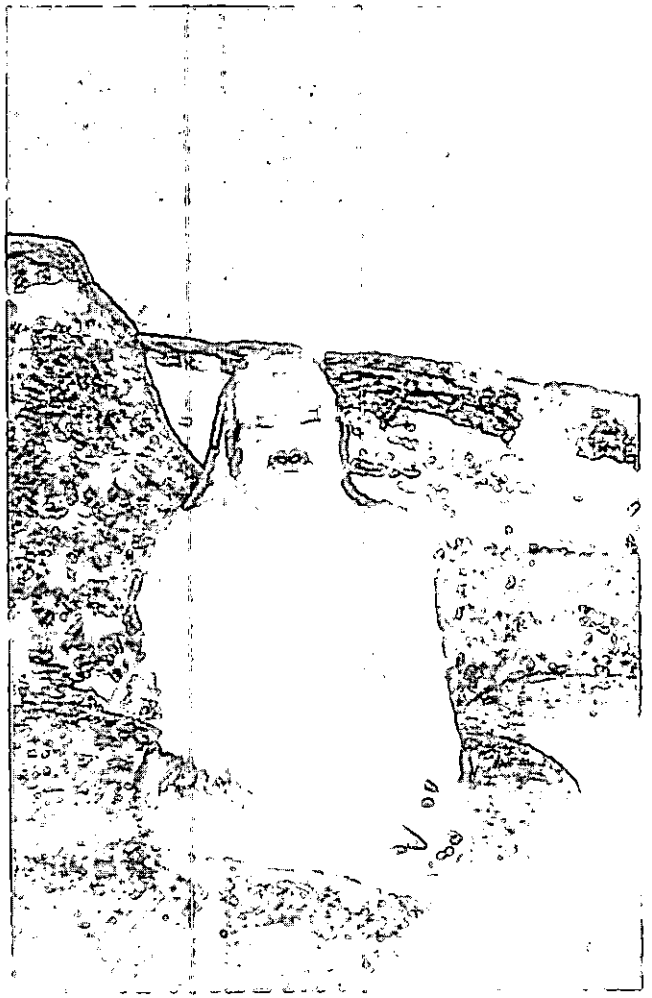
Differences in Medicaid Fees, 2009

Description	Code	AK Fee	WA Fee	% Difference
Outpatient Office Visit – Lower Level	99212	$62.46	$22.69	175%
Outpatient Office Visit – Highest Level	99215	$221.58	$76.00	192%
Emergency Department Visit	99283	$109.14	$37.48	191%
Knee Arthroscopy/Surgery	29881	$976.77	$358.08	173%
Gall Bladder Removal, Laparoscopic	47563	$1,175.10	$412.29	185%
Cataract Surgery w/Lens Implant	66984	$1,141.23	$394.44	189%

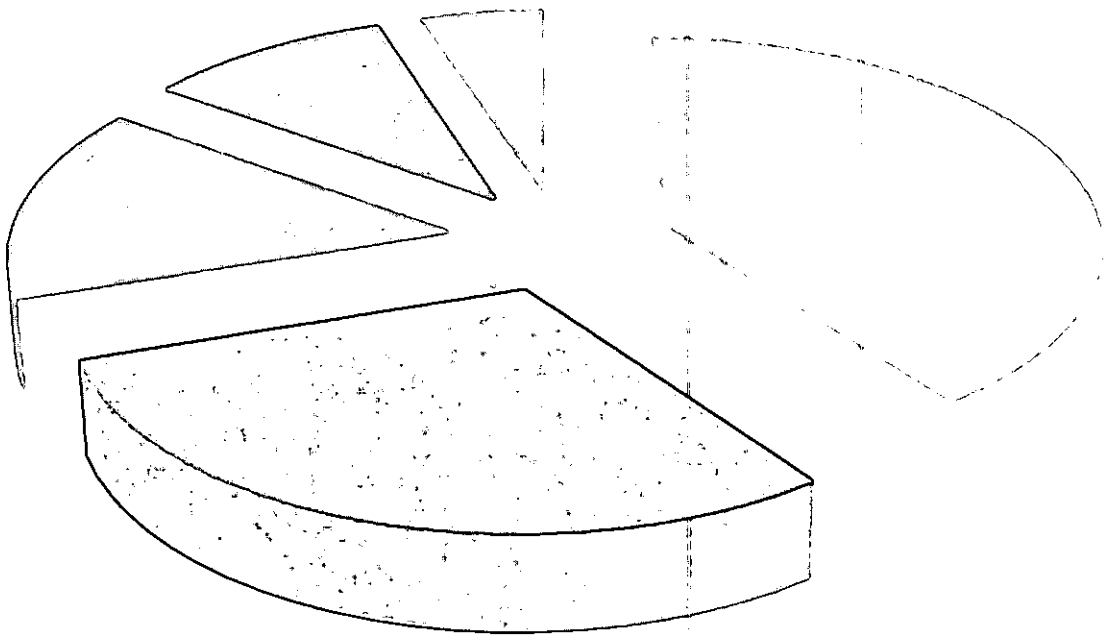
Differences in Workers' Comp Fees, 2006

Description	Code	AK Fee	WA Fee	HI Fee
Outpatient Office Visit – Mid Level	99213	$127.00	$76.00	$61.00
Radiology (MRI, spinal canal cervical)	72141	$2,339.00	$769.00	$634.00
General Medicine (nerve conduction)	95904	$219.00	$81.00	$66.00
Knee Arthroscopy/Surgery	29881	$4,181.00	$869.00	$693.00
Physical Medicine (therapeutic proc)	97110	$83.00	$40.00	$32.00

The 800 lb. Gorilla



Determinants of Health

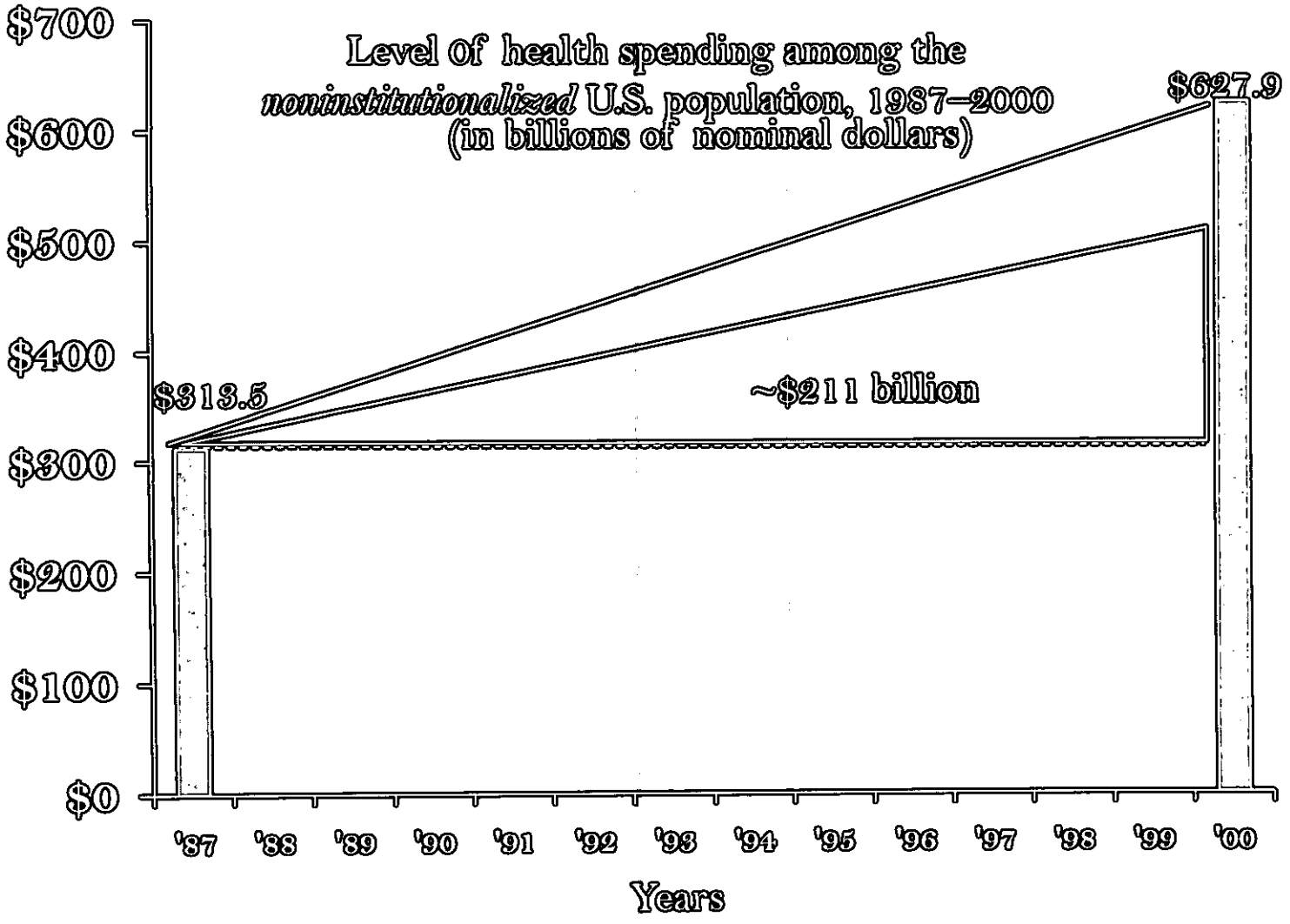


- 40% Behavior
- 30% Genetics
- 15% Social Circumstances
- 10% Health Care
- 5% Environment

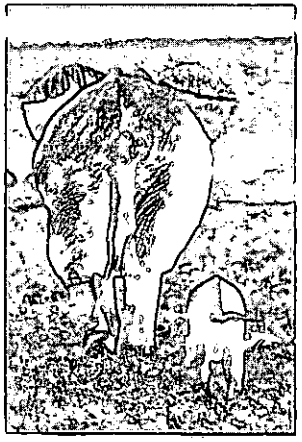
Chronic Disease accounts for

- 70% of all deaths in the U.S.
- 4 of the 5 leading causes of death in AK
- 75% of all health care expenditures

Health Expenditure Increase Due to Chronic Disease

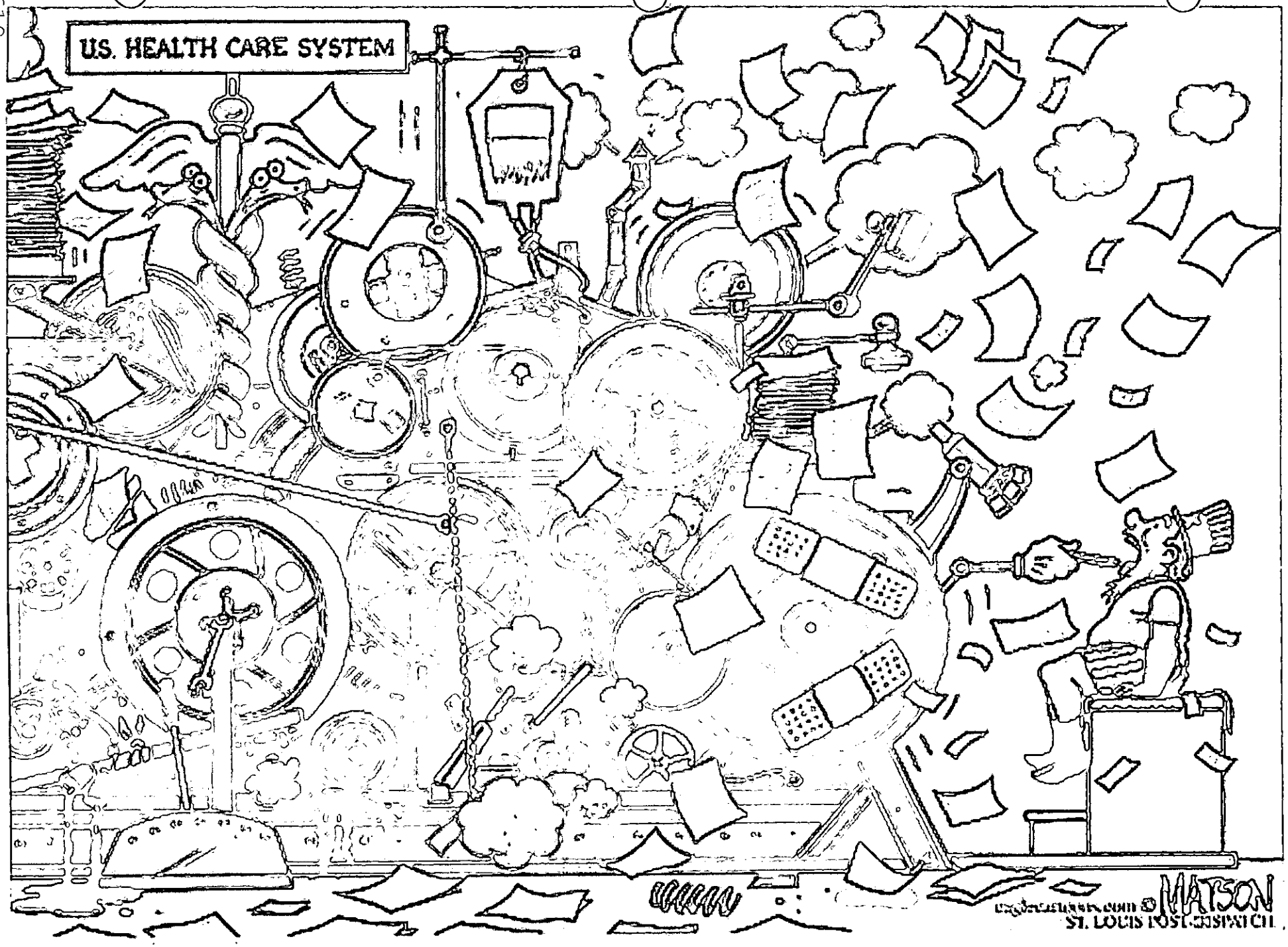


COST =



Price x Utilization

Thank you Mr. Foster


U.S. HEALTH CARE SYSTEM
MATSON
ST. LOUIS POST-DISPATCH

Diagnosis of Alaska's Health Care System

- Costs are unaffordably high and continue to climb
- The delivery of health care services is fragmented
- Financing and payment mechanisms are complex
- Many Alaskans lack health insurance
- Some Alaskans cannot find a doctor to care for them
- There are high vacancy rates in Alaska's health care workforce
- Levels and variations in quality of care are not well understood
- Consumers and health care providers are frustrated
- The system as currently designed is not sustainable

Commission's Strategic Plan

- 5-Year Planning Framework
  - I. Develop Vision
  - II. Accurately Describe Current System
  - III. Build the Foundation
  - IV. Design Transformation Elements
  - V. Measure Progress
  - VI. Engage Public & Stakeholders
- Action Plan for 2009 Recommendations
- 2010 Commission Work Plan

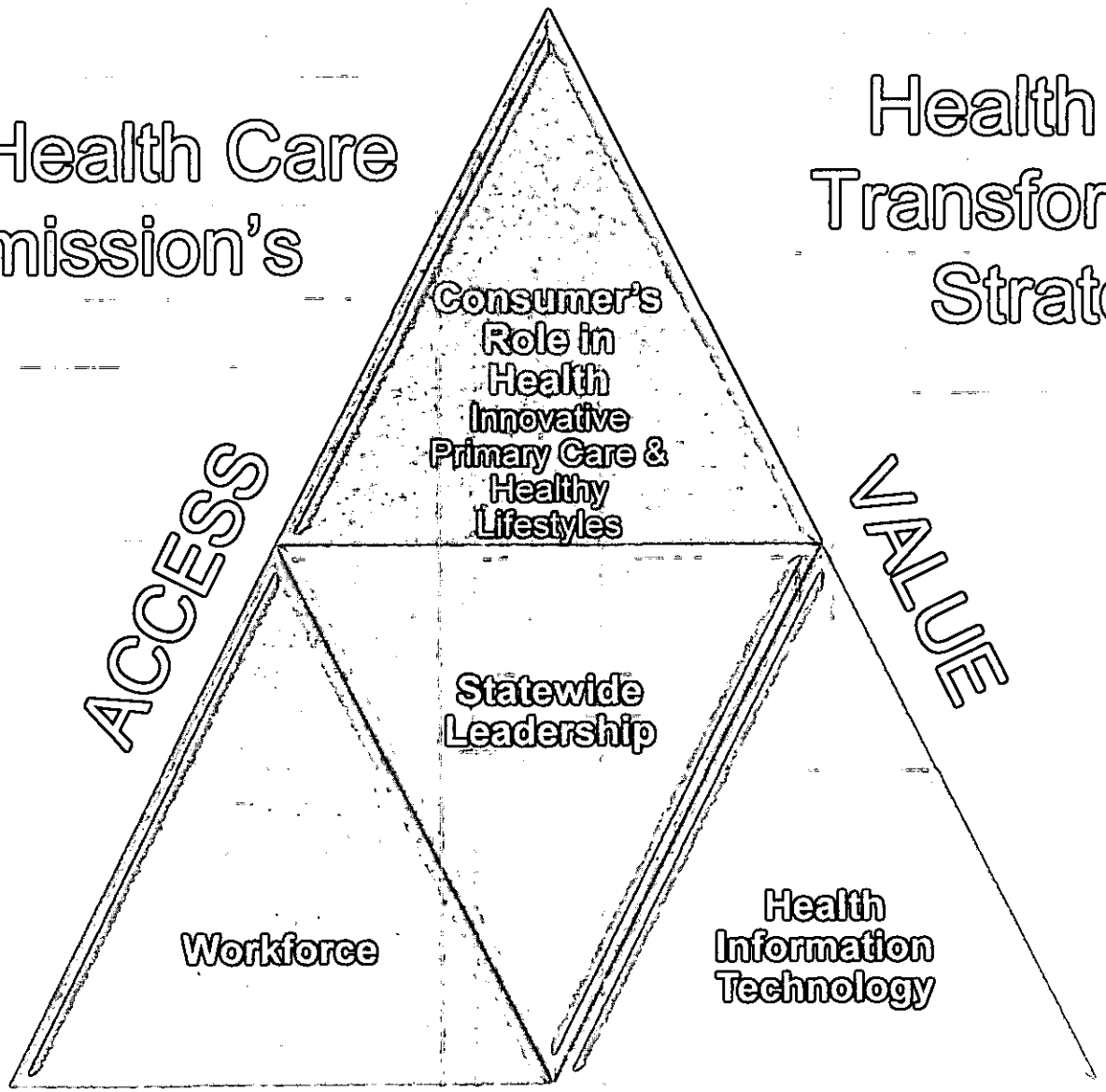
Vision & Values

- Vision
  - *Alaska's health care system produces improved health status, provides value for Alaskans' health care dollar, delivers consumer and provider satisfaction, and is sustainable.*
- Reform Goals
  - Improved Access
  - Controlled Costs
  - Improved Quality
  - Prevention-Based
- Values
  - Sustainability
  - Efficiency
  - Effectiveness
  - Individual Choice
  - Personal Engagement

Year 1 Priorities

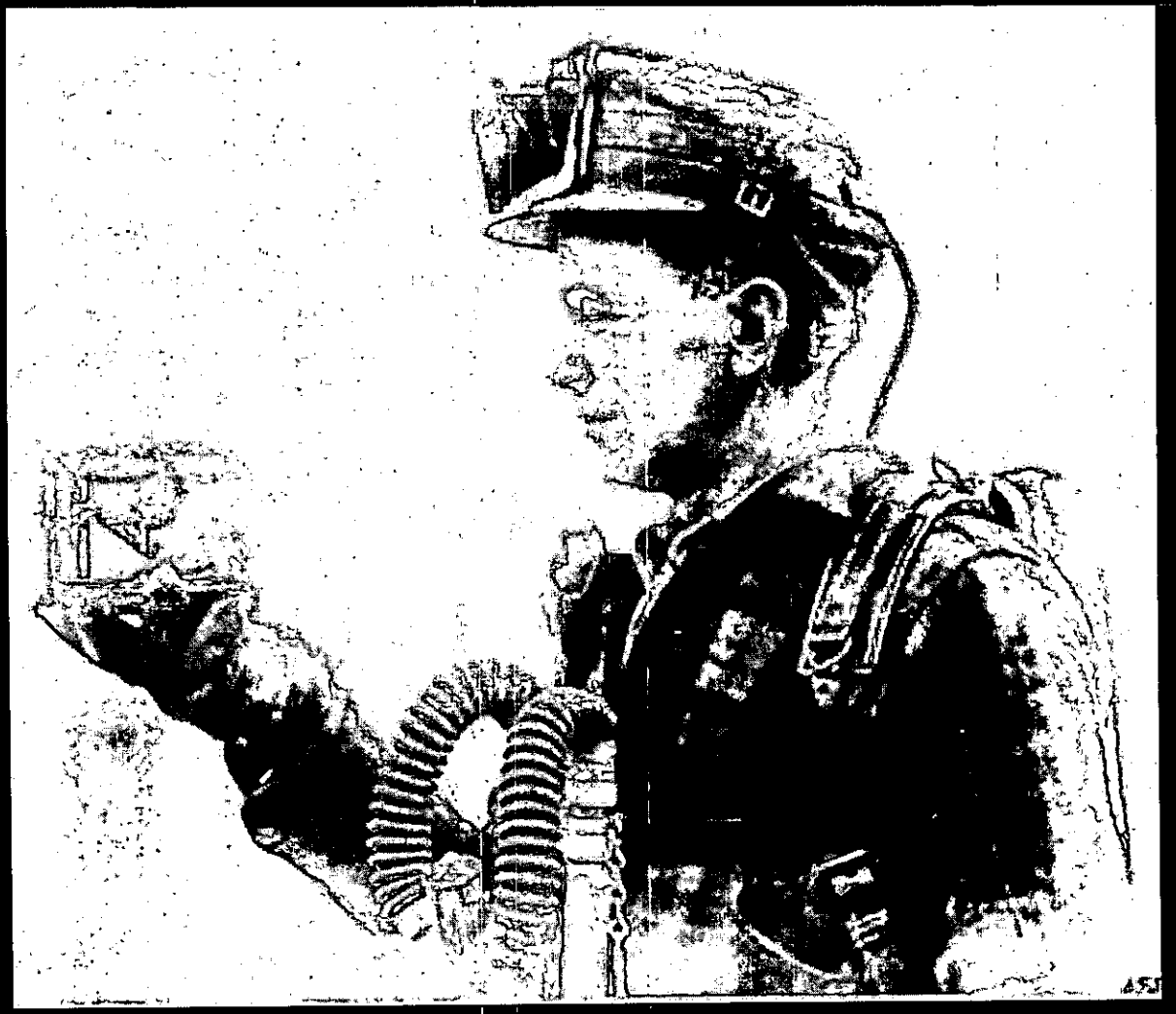
- Consumer's Role in Health Care
  - Healthy Lifestyles
  - Innovative Primary Care
- Statewide Leadership
  - Response to National Health Reform
  - Permanent State Health Planning Board
- Health Care Workforce Development
  - Physician Supply and Distribution
- Health Information Technology
  - Health Information Exchange/EHR
  - Telemedicine
- Primary Care Access for Medicare Enrollees

Alaska Health Care Commission's Health Care Transformation Strategy



PREVENTION-BASED

Medicare Access Problem - The Canary in the Coal Mine?



Recommendations

Strengthen Consumer's Role

- Support Healthy Lifestyles and Create Culture of Wellness
- Develop Patient-Centered Primary Care Model
  - Payment Reform
  - Removal of Statutory/Regulatory Barriers
  - Pilot Projects

Recommendations

Foster Statewide Leadership

- Invest in Health Policy Infrastructure to Respond to National Reform

- Permanent State Health Planning Board

Recommendations

Develop Health Care Workforce

- Priority for Health Care Reform and Economic Development Agendas
- Strengthen the Workforce "Pipeline"
- Innovation and Adaptation
- Coordinated Planning
- Target Physician Development $s to Primary Care
  - Loan Repayment & Financial Incentives for R&R
  - WWAMI Expansion as Resources Allow
  - GME for Peds, Psych, and Primary Care Internal Medicine

Recommendations

Deploy Health Information Technology

- Support HIT Adoption and Utilization
- Ensure Privacy and Security
- Broadband Telecom Infrastructure Access
- Reimbursement for Telemedicine

Recommendations

Improve Medicare Access

- Increase Supply of Primary Care Providers
  - Loan Repayment & Financial Incentives for R&R
  - WWAMI Expansion
  - GME for Primary Care Internal Medicine
  - Mid-Level Practitioners
- Support FQHCs and RHCs
- Request Relief from Federal Reimbursement Inequities and Administrative Burden
- Develop PACE Program

Transformation Elements

I. Access to Care

- Health Insurance Coverage
- Health Care Workforce Development
- Physical Health Care Services
- Behavioral Health & Long Term Care

Transformation Elements

II. Cost & Quality (VALUE)

- Analyze Cost of Care in Alaska
- Foster Primary Care Innovation
- Move to Value Driven Purchasing
  - Leverage State Purchasing Power
  - Transparency – Cost and Quality
  - Evidence-Based Medicine
  - Pay-for-Performance
  - Bundled Payment Systems
  - Medical Error and Infections Reporting & Non-Payment
- Fraud & Abuse Control
- Tort Reform
- Support Process & Quality Improvement Mgmt Strategies

Transformation Elements

III. Prevention

- Public Health & Community-Based Prevention
- Safe Water & Sanitation Systems
- Employee Health Risk Management

Commission's Future

- A.O. 246 expires 04/30/10 if not extended

- Creation of Commission in Statute
  - Bills Pending – 2010 Legislative Session
    - SB 172 Olson
    - HB 25 Hawker
    - HB 75 Cissna

Thank You

For more information please visit the Commission's web site at:

http://hss.state.ak.us/healthcommission/

Question? Comments?

2/24/10 PRESENTATION: BEST BEGINNINGS EARLY CHILDHOOD

2636

Investing in Alaska's Young Children

Alaska Early Care and Education: Public Policy Priorities for 2010

Denali Kid Care: Increase the income eligibility guidelines for Denali Kid Care (DKC) from 175% to a minimum of 200% of Alaska's federal poverty level (FPL). This change would restore eligibility to 1,300 children and 225 pregnant women. Children with access to preventative health care and developmental screenings have better outcomes for health and learning abilities throughout their lives.

Head Start: Increase State investment in Head Start to: expand services, address critical infrastructure needs, and keep existing slots from being reduced to due to rising costs. Provide workforce development funds to enable Alaskan Head Start staff to meet federal teacher qualification requirements.

Home Visiting: Establish research-based voluntary early childhood home visiting programs in Alaska, such as *Parents as Teachers*, with universal access for families with children prenatal up to kindergarten entry. Such programs increase parent knowledge of child development, improve parenting practices, promote early literacy experiences, provide early detection of developmental delays and health issues, and increase children's school readiness and school success. Through these preventative programs, future costs such as special education and remedial education have been shown to be reduced.

Best Beginnings: Support community-based **Early Childhood Partnerships** and **Imagination Library**. This leverages funding from the private sector and helps support the public-private partnership working to create and sustain a comprehensive statewide early childhood system. **Early Childhood Partnerships** provide a statewide coordinated network and structure necessary to move decisions closer to those being served, pinpoint actual needs, respond to cultural considerations, and ensure the best outcomes for young children in every community. **Imagination Library** mails a book per month to Alaska children from birth to age 5. Research shows that children who have not developed some basic literacy skills by the time they enter school are three to four times more likely to drop out in later years. Too many Alaska children, about 40%, are entering kindergarten without those skills. This program makes a difference by bringing quality books into the home, engaging young children and their families in early literacy activities.

Access to Quality Child Care: Increase child care reimbursement rates to the 75th percentile. This allows low-income children the opportunity to access higher quality programs, resulting in outcomes such as increased school readiness. Increase family eligibility to 85% of the state median income. This will enable the state to quantify and respond to support for families to enter or remain in the workforce.

Quality Rating and Improvement System (QRIS): Implement phase one of QRIS in Alaska. A QRIS is an organized method to assess, improve, and communicate the level of quality in early care and education settings outside the home. The system would provide a roadmap for individual early learning programs to improve their quality of care, thereby increasing parent access to a larger supply of quality options. The system would provide greater accountability for policy makers who govern public investments in Alaska's early care and education system and would ensure that publicly funded Pre-K services can be delivered through a variety of delivery systems that meet the needs of parents.

Professional Development and Retention of Early Educators: Provide funding to thread, **Alaska's Child Care Resource and Referral Network**, to increase the current Individual Reimbursement Awards (IRF's) for college child development courses, and reinstate the ROOTS (Retaining Our Outstanding Teacher) Awards to recognize and incentivize teachers with credentials in early education. There is a direct relationship between teacher preparation and quality of early care and education for children. It is difficult for individuals working full-time and earning low wages to afford the cost of education. In addition, due to low wages and lack of recognition, the teacher turnover rate in Alaska in early care and education programs is approximately 46%. By providing these incentives, the early care and education field would be able to recruit and retain a more qualified and stable workforce.

These priorities are recommendations articulated in no particular order. The recommendations are meant to assist public policy leaders in developing a system of early learning to promote school readiness, strong families, and a strong workforce. These are advanced by a coalition of early childhood advocates working together to support young children.

thread connecting early care & education to alaska

The Alaska Child Care Resource and Referral Network, thread, has a mission to advance the quality of early education and child development by empowering parents, educating child care professionals and collaborating with our communities.

www.threadalaska.com

BEST BEGINNINGS
Alaska's Early Childhood Investment

Best Beginnings is a public-private partnership that mobilizes people and resources to ensure all Alaska children begin school ready to succeed through support from businesses, foundations, nonprofits, government, and individuals.

www.bestbeginningsalaska.org

Alaska AEYC

The Alaska Association for the Education of Young Children's mission is to lead, facilitate, and support the effort of those working in the Early Care and Education profession throughout Alaska.

www.akaeyc.org

Alaska Head Start Association
Parents · Staff · Directors · Friends
Support Brings Success!

The Alaska Head Start Association is a membership organization providing a united voice of advocacy and leadership on issues affecting Alaska's Head Start children and families.

www.akheadstart.org

AILPA

The Alaska Infant Learning Professional Association-AILPA is a member organization to advocate for and support high quality early interventions services for infants and toddlers with special needs and their families.

BEST BEGINNINGS

Alaska's Early Childhood Investment

Early Childhood Partnerships

Request

- $1 million FY11 to support early childhood partnerships
- Funds would pay for grants to partnerships established in FY10, enabling them to begin work on locally identified priorities and their two-year strategic plans. Funding would also support technical assistance and start up of three to four new partnerships.

Rationale

- Current services and programs are like a jigsaw puzzle with mismatched pieces. There are gaps, overlap, and lack of coordination. People at the local level are in the best position to identify problems, design solutions, and improve coordination to meet local needs.
- Effective local organizations have been recognized in state and national studies as essential to building effective statewide systems.

Accomplished to date

- In July 2009, Best Beginnings awarded one-year grants to nine communities to form early childhood partnerships or support partnerships already established.
- Communities represented in the partnerships are home to 39,000 children under age 5. That's about 78% of all children birth to age 5 in Alaska.
- Partnerships create opportunities for local people from varied interests and backgrounds to improve services and resources for young children.
- Core funding from the state and private sector has been leveraged in local communities, resulting in $133,000 in cash and in-kind contributions.
- Partnerships are assessing needs and assets in their communities, developing priorities, and building strategic plans. The results will be improved coordination of services, better access for families, and communities that are very engaged in meeting the needs of young children.

Longer term goals

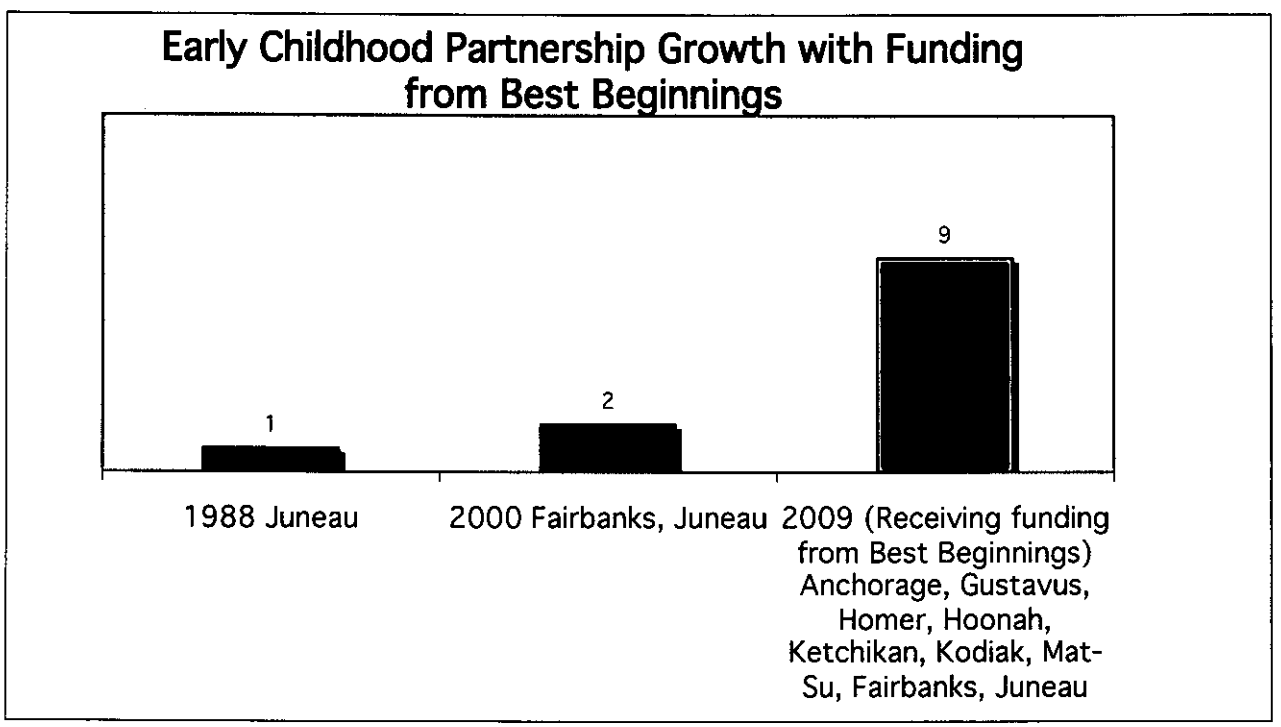
- Organize and mobilize early childhood partnerships all over Alaska.
- Develop a coordinated system of early childhood programs and services.
- "Delegate" to people in communities responsibility for identifying programs and systems that work well, where gaps exist, and how best to respond to local needs.
- Form a network of effective community and regional organizations that support comprehensive early childhood services. Such networks and a comprehensive systems-wide approach have been strongly recommended by state and national studies as key to meeting the needs of babies and young children.
- Children begin school prepared to succeed.

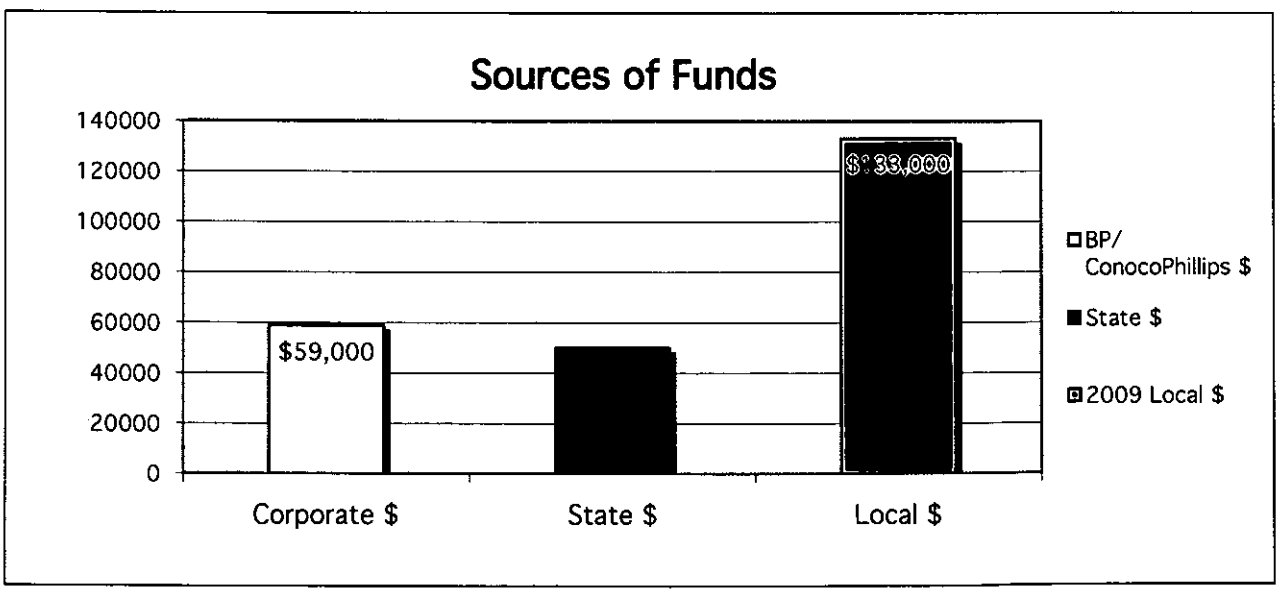
3350 Commercial Drive, Suite 104A • Anchorage, Alaska 99501
t. 907.297.3300 • f. 907.297.3304 • BestBeginningsAlaska.org

BEST BEGINNINGS

Alaska's Early Childhood Investment

BEST BEGINNINGS EARLY CHILDHOOD PARTNERSHIPS





BEST BEGINNINGS

Alaska's Early Childhood Investment

Imagination Library

Request

- $400,000 for FY11 to expand Imagination Library, which mails a free book every month to enrolled children, birth to age 5.
- Requested funds would expand the program to cover at least 14,000 Alaska children, about 28% of all children under 5. Leveraged local and private funding would increase the number of children served.

Rationale

- About 40% of Alaska children begin school unprepared to succeed. Alaska's dropout rate is among the highest in the nation.
- Early literacy is a key indicator of how a child will fare in school and in life. Children who have not developed some basic literacy skills *by the time they enter school* are three to four times more likely to drop out in later years.
- Imagination Library helps children develop the literacy skills they'll need to succeed … in their own homes, with their families.
- Imagination Library in Alaska has grown by leaps and bounds since Best Beginnings became involved. Best Beginnings provides technical assistance and funds to launch Imagination Library in new communities and to continue and expand the program in communities already participating.

Accomplished to date

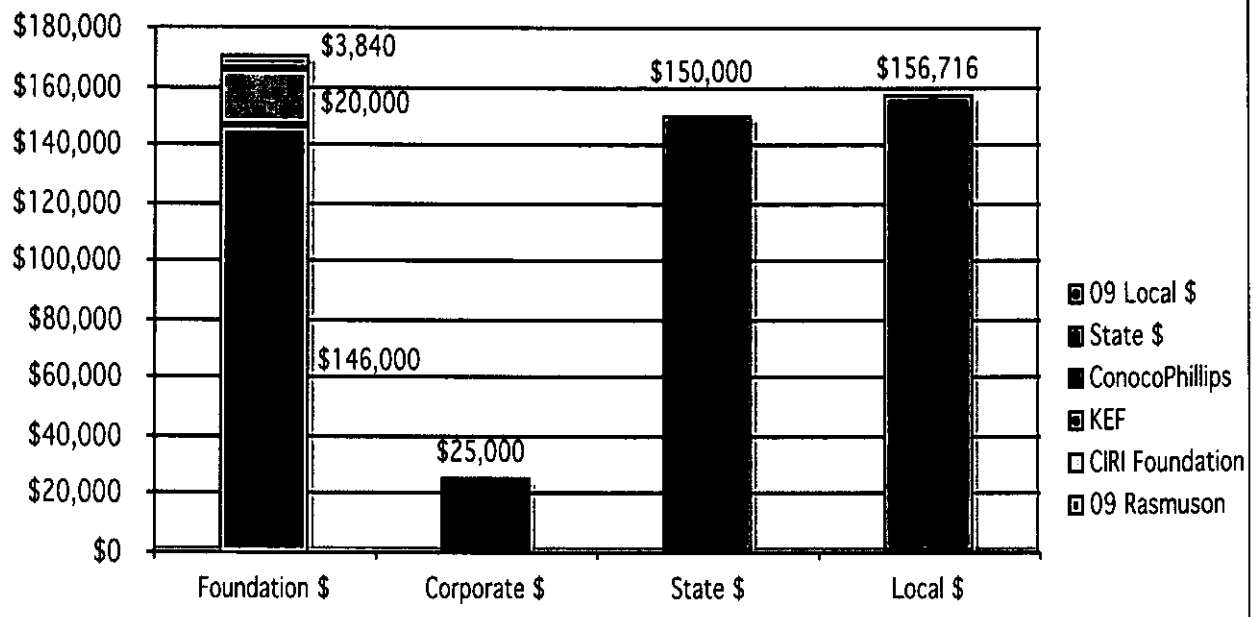
- Children impacted: Through the efforts of Best Beginnings and its partners, funds have been allocated to enroll 10,192 children in 32 communities. More than 1,500 additional children have graduated from the program when they turned 5.
- Private and local support: In most communities, volunteers raise funds locally to match grants from Best Beginnings. Best Beginnings has received major grants for Imagination Library from the private sector, foundations, and the Alaska Department of Education & Early Development. To date, $471,130 has been contributed in private and local support. The total will rise further later this year when local contributions begin matching a second Rasmuson Foundation grant (for 2010 and 2011) of $150,000.

Longer term goals

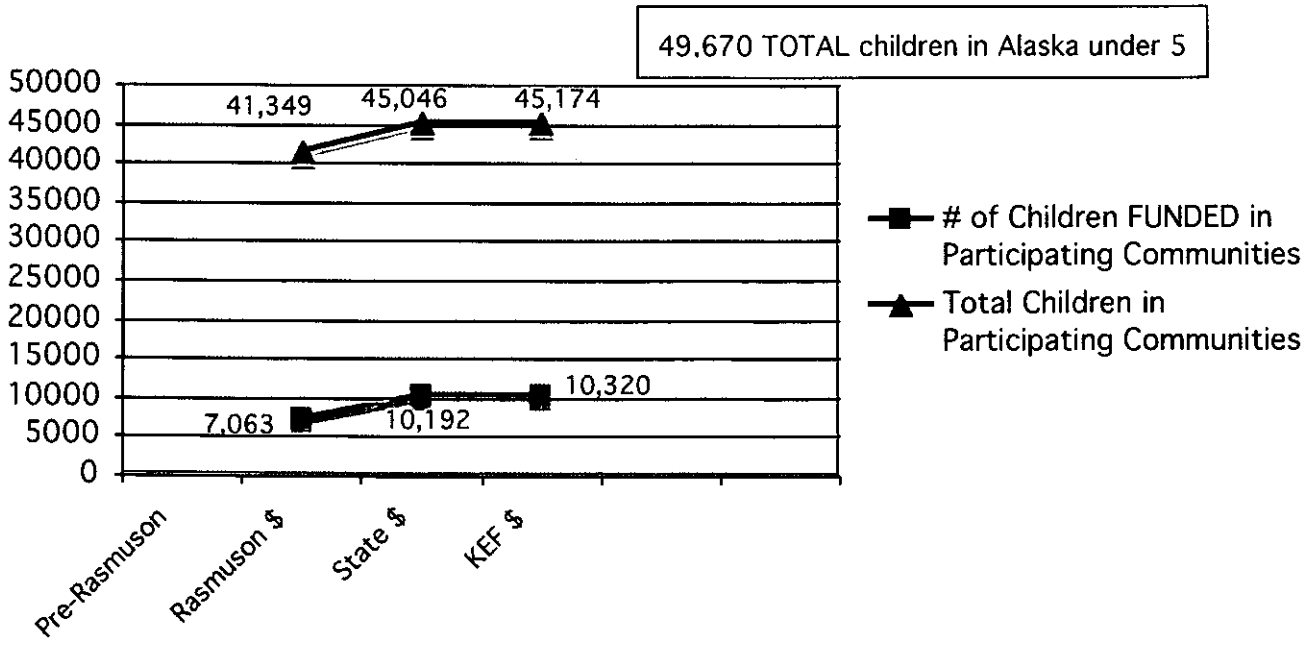
- Fully subsidize Imagination Library in communities with very limited resources.
- Enroll at least 80% of the children under age 5 in the current Imagination Library communities.
- Expand to additional communities so that every Alaska child, birth to age 5, would be eligible for Imagination Library.

3350 Commercial Drive, Suite 104A • Anchorage, Alaska 99501
t. 907.297.3300 • f. 907.297.3304 • BestBeginningsAlaska.org

SOURCES OF FUNDS & DOLLARS LEVERAGED

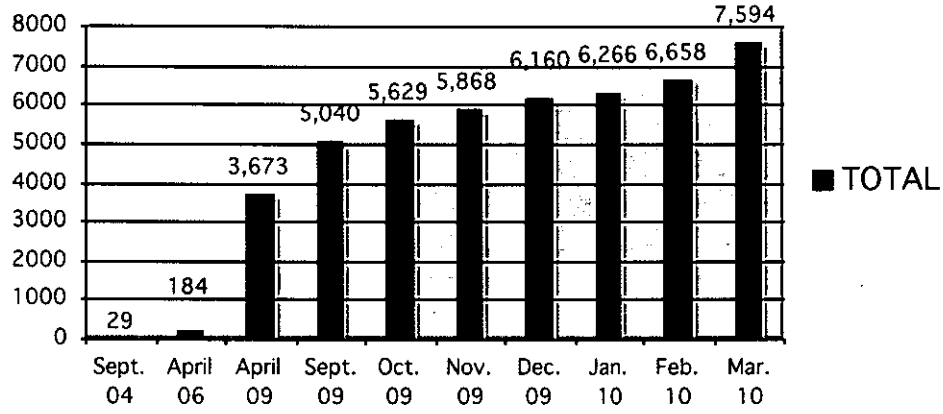


NUMBERS OF CHILDREN FUNDED vs TOTAL CHILDREN

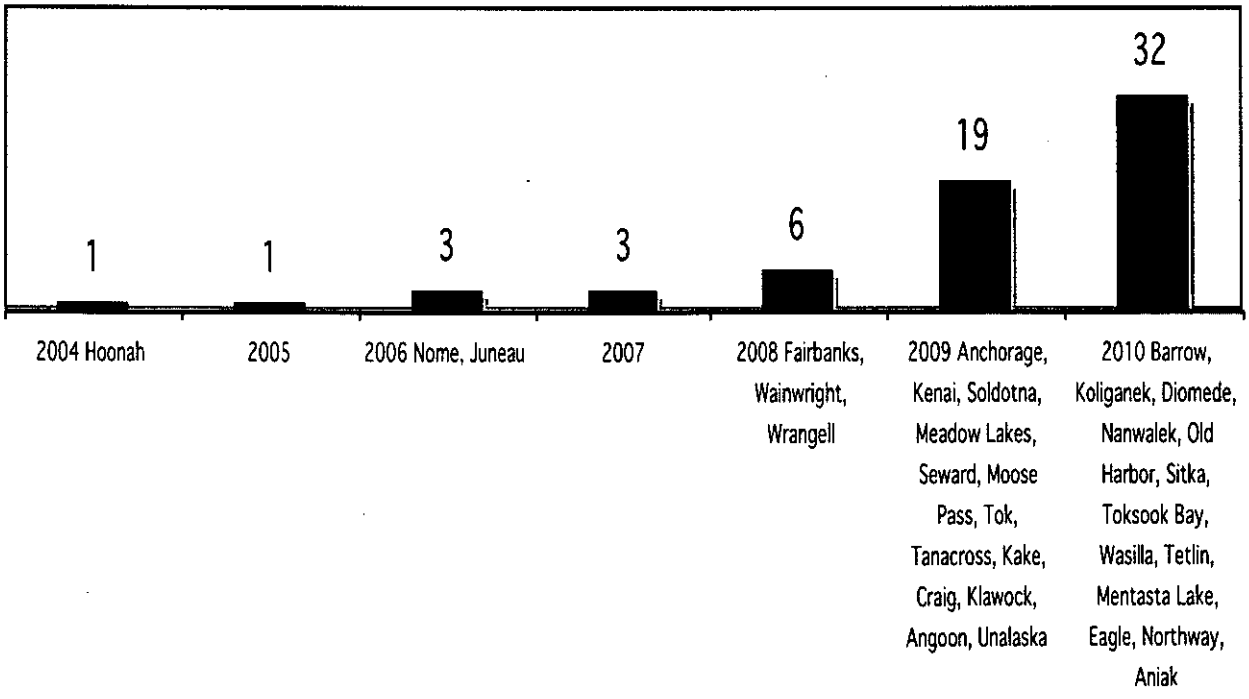


Imagination Library Enrollments (# of Children)

Affiliate	Apr 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10
Anchorage		834	1,105	1,304	1,514	1,600	1,818	2,340
Fairbanks	2,738	2,824	2,951	2,962	2,986	2,974	2,957	2,942
Juneau	800	977	1,003	1,000	1,024	1,029	1,038	1,056
Kenai		--	106	105	104	120	213	198
Koliganek								17
Kuskokwim								31
Mat-Su		44	70	82	88	88	166	502
Nome	135	160	160	158	171	174	171	184
Old Harbor							15	15
Seward		112	145	165	175	175	176	181
Tok		54	51	55	61	65	65	92
Unalaska		35	38	37	37	41	39	36
Total	**3,673**	**5,040**	**5,629**	**5,868**	**6,160**	**6,266**	**6,658**	**7,594**



Communities Adding Imagination Libraries



rev 2/22/10

Investing in Alaska's Young Children

Alaska Early Care and Education: Public Policy Priorities for 2010

A Collaborative Effort

- Abbe Hensley, Executive Director, Best Beginnings
- Melissa Pickle, Director, RurAL CAP Parents as Teachers
- Candace Winkler, CEO, thread
- Joy Lyon, Alaska Association for the Education of Young Children (AK AEYC)
- Other Partners: Alaska Head Start Association (AHSA), Alaska Infant Learning Programs Association (AILPA)

Alaska Facts

- 49,670 children under 5
- 1 out of 5 living below the federal poverty level
- Most likely to be poor – youngest children

Alaska's Early Childhood Legislative Priorities 2010

- Denali Kid Care
- Head Start
- Home Visiting
- Early Childhood Partnerships
- Imagination Library
- Access to Quality Child Care
- Quality Rating and Improvement System
- Professional Development and Retention of Early Educators

Early Childhood System

- Comprehensive early childhood system, not just separate, individual programs
  - Early learning
  - Health, mental health, and nutrition
  - Family support
  - Special needs/early intervention

Legislative Priority

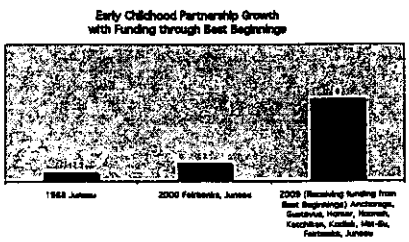
- Early childhood partnerships
  - Move decisions closer to those being served
  - Bring people together to solve problems
  - Pinpoint actual needs
  - Respond to cultural considerations
  - Focus on solutions, not turf
  - Ensure the best outcomes in each community for young children
  - A network of effective community and regional organizations that support comprehensive early childhood services called for by ECCS, Ready to Read, Ready to Learn, and Governor's Summit on Early Learning

Legislative Priority

- Early childhood partnerships 2009-10
  - Nine communities, with about 78% of Alaska children 0-5
  - Conducted needs and assets assessments
  - Identified priorities
  - Developing strategic plans
  - Taking action!

7

Legislative Priority



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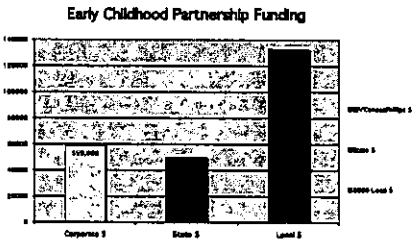
Legislative Priority



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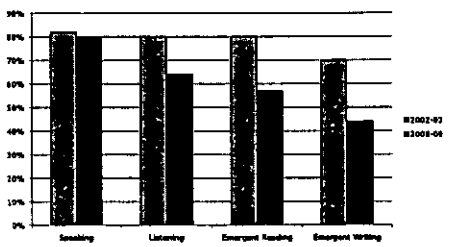
Alaska Kindergarten Developmental Profile Results



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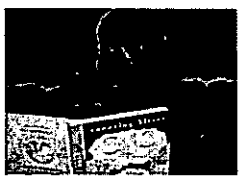
Legislative Priority

- Dolly Parton's Imagination Library in Alaska



11

Legislative Priority

- Imagination Library 2009-10
  - 32 communities participating
  - **7,594** children enrolled March 2010
  - Funds allocated for 10,192 children
  - 1,500 children have already "graduated"
  - Kuskokwim Educational Foundation funding books in all 10 villages
  - Funding from Rasmuson Foundation, Dept. of Education & Early Development, ConocoPhillips, The CIRI Foundation, multitude of individuals and local businesses
  - 49,670 Alaska children under 5

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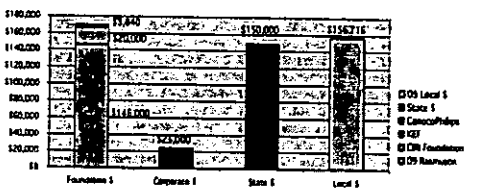
Legislative Priority

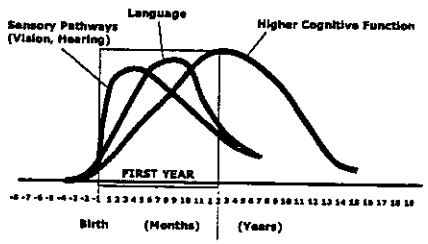
Sources of Imagination Library Funds



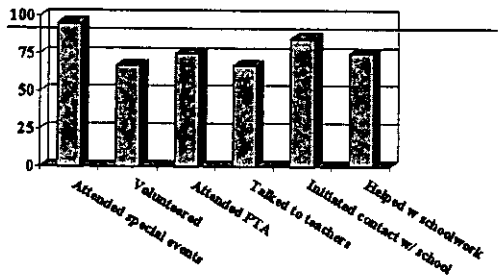
Legislative Priority

- Early Childhood Home Visitation Programs
  - Increase parent knowledge of early childhood development beginning at birth
  - Promote early literacy experiences
  - Improve parenting practices
  - Prevent child abuse and neglect
  - Provide early detection of developmental delays and health issues
  - Increase children's readiness to succeed in school
  - Increased parent involvement in school

Neural Connections in the Brain



PAT Parent Involvement at School



Legislative Priority

- Alaska Parents as Teachers 2008-09
  - 11 programs funded through federal grants
  - 47 communities served
  - 910 families served
  - 1,112 children served
  - 74 prenatal women served
  - 14 homeless families served
  - 762 children received developmental screenings with 162 found to need further evaluation
  - 336 families linked to other services

Head Start/Early Head Start

- Comprehensive school readiness program providing educational, health , nutritional social and other support services
- Eligibility criteria based on income level and poverty of access designation
- Models of service include classroom and home visitation
- Parents as partners in program design, implementation and evaluation

Alaska Head Start Association (AHSA)

- An Overview of Head Start in Alaska
  - 16 Head Start Grantees across the state
  - Providing services in over 100 communities
  - Serving over 3,500 children and employing over 950 staff members
  - Funded by Federal and State grants

Support Brings Success!

2008-2009 Alaska Head Start Summary Report

- 276 children identified as needing medical treatment
- 515 children identified as needing dental treatment
- 77 children identified as needing mental health services
- 379 children identified as having special needs
- 781 parents referred for emergency/crisis intervention services
- 1119 parents requested parenting information
- $27,744 – Average pay for a BA degreed Head Start Teacher in Alaska

Alaska Head Start Association (AHSA)

Legislative Priorities: Head Start & DKC

- AHSA Critical Issues 2010
  - Inflation proof current state investment in Head Start to prevent reduction of children served
  - Increase state investment in Head Start to expand services and address critical infrastructure needs such as facilities
  - Develop a comprehensive statewide plan to enhance service delivery and minimize duplication
  - Dedicate workforce development funds
  - Increase income eligibility guidelines for Denali Kid Care

thread, AK early care & ed connection

"the common thread" that ties together statewide support for families, early educators and Alaska communities

- Linked 7,600 families with referrals
- Educated 2,500 professionals
- Guided 200 programs to best practice
- Served 58 communities throughout AK

Alaskan Children With Working Parents

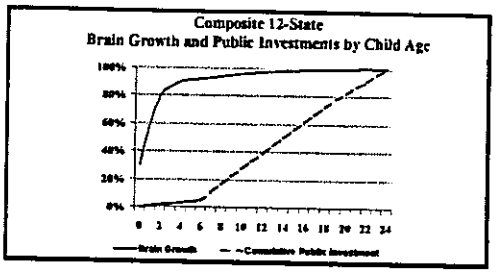
- In AK 60,000 children under age 6
- Of those 40,000 children have all of their parents in the workforce
- In AK less than 24,000 licensed or approved spaces in child care, head start, preschools

Challenges for many families…

- The average rate for Infant and Toddler care between $500- $1000 per month
- Most programs spend 70-80% of their budgets on Personnel Expenses
- Early Educators make an average of $9/hour and turnover is 46%

36% of households with children under age 6 reported work restrictions due to child care issues

Public Investment in Early Education



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Legislative Priority: Access to Quality Child Care:

- Goal: Provide lower income children the opportunity to access higher quality child care services through Child Care Assistance
  - Increase the reimbursement rate to the 75th percentile
  - Increase family eligibility to 85% of the state median income.

Family eligibility hasn't been changed since 2002

26

Legislative Priority: Quality Rating and Improvement System (QRIS)

- Helps parents make the best choices for their families
- Moves programs towards quality
- Provides outcome information for policy makers to assess different funding strategies

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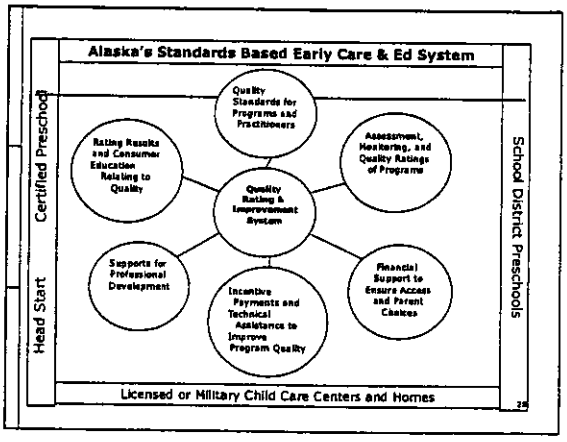

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Legislative Priority: Professional Development & Retention of Workforce

Purpose of Priority:

- Decrease financial barriers to professional development opportunities
- Increase recruitment and retention in the early care and education field

Research indicates the biggest factor in the quality of a program and in improving child outcomes is the teacher education level

29

Alaska's Child Care Workforce

- Less than 10% of the child care workforce has a college degree
- National Accreditation standards and Head Start standards are moving towards a BA teacher in each classroom
- In Child Care with the average wage of $9/hr and a 45% turnover rate additional support is needed to increase the quallfications of teachers

30

Alaska's Early Childhood Legislative Priorities 2010

- Denali Kid Care
- Head Start
- Home Visiting
- Early Childhood Partnerships
- Imagination Library
- Access to Quality Child Care
- Quality Rating and Improvement System
- Professional Development and Retention of Early Educators

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For More Information …

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- Candace Winkler, cwinkler@threadalaska.org
- Joy Lyon, jlyon@aeyc-sea.org
- Aeyc-sea.org
- Akheadstart.org
- BestBeginningsAlaska.org
- Ruralcap.com
- Threadalaska.org

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Alaska Association for the Education of Young Children (AK AEYC)

- AK AEYC mission is to lead, facilitate, and support the efforts of those working in the early care and education profession throughout Alaska.
- Membership of almost 1,000 professionals in the field of early care and education

Alaska AEYC

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Alaska Head Start Association (AHSA)

- The Alaska Head Start Association
  - A membership organization comprised of
    - Parents
    - Staff members
    - Friends in the community
  - Purpose
    - To collectively advocate on issues affecting Alaska's Head Start children and families
  - Legislative Committee
    - Legislative Tracker
    - Develop position statements

Best Beginnings: Alaska's Early Childhood Investment

- A public-private partnership mobilizing people and resources to ensure all Alaska children begin school ready to succeed
  - Parents as a child's first and most important teacher
  - Quality, affordable, accessible early care and education programs for families who want them, wherever they live
  - Early learning a top priority for all Alaskans

35

thread, Alaska's CCR&R Network

Southcentral Office (formerly Child Care Connection)
- Provides statewide leadership and management of Network
  - Offices in Anchorage and Wasilla
  - Outreach staff in Kenai, Valdez, and Kodiak

Southeast Office (services provided by AEYC-SEA)
- Office in Juneau
- Outreach staff in Sitka, Petersburg, Ketchikan, Wrangell

Interior/Northern Office (formerly C.A.R.E.S.)
- Office in Fairbanks

thread

ALASKA HEAD START ASSOCIATION
Critical Issues
2010

- **INCREASE STATE OF ALASKA INVESTMENT IN HEAD START BY $3,500,000**

During the summer of 2008 the Alaska Head Start Association worked to put together a comprehensive two-year Head Start expansion plan to present to the Department of Education and Early Development. This plan called for $2.5 million in new funding from the state of Alaska in FY 2010 and FY 2011 to enroll approximately 275 new children. Another $1.6 million was included for deferred maintenance and to assist grantees to maintain existing slots that would otherwise be eliminated due to increased operating costs. While AHSA appreciates the Legislature's appropriation of $600,000 for Head Start expansion in FY 2010, this amount allowed grantees to enroll only 59 new children in three communities. In addition, programs across the state have struggled to maintain the same quality and quantity of services because appropriations have failed to keep pace with rising costs. Increased energy costs continue to be a serious concern for programs.

ACTION NEEDED: ***Increase Head Start funding by a total of $3,500,000. This amount allows approximately 220 additional children to receive Head Start services, addresses critical infrastructure needs and prevents any reduction in the number of Head Start slots available in Alaska.***

- **SUPPORT A COMPREHENSIVE STATE-WIDE PLAN TO ENSURE THAT ALL EARLY CHILDHOOD EDUCATIONAL SYSTEMS AND SERVICES ARE COORDINATED AND COMPLEMENTARY**

The Alaska Head Start Association supports continuation and expansion of a Pilot Preschool Program. AHSA believes that the need for Early Childhood Education in our state far exceeds what our existing systems can provide. However, the association also believes that the state has a responsibility to ensure that all publicly funded systems, existing and new, are working together to provide services in a coordinated and complementary manner. Written agreements addressing eligibility, enrollment, and recruitment need to be in place between all early childhood systems that are providing services in a common area.

ACTION NEEDED: ***Ensure that a comprehensive state-wide plan addressing how early childhood services will be delivered is developed and implemented. Any new legislation should require written coordination agreements between early childhood systems to eliminate duplication or competition in early childhood service delivery.***

• DEDICATE WORKFORCE DEVELOPMENT FUNDS TO SUPPORT HEAD START TEACHER QUALIFICATIONS

The "Improving Head Start for School Readiness Act of 2007" has established the following professional development requirements for Head Start:

- By September 30, 2011 100% of Head Start teachers must have an associates degree in early childhood education
- By September 30, 2013 50% of Head Start teachers nationwide must have a bachelor's degree in early childhood or a bachelor's degree and course work equivalent to major in early childhood education.
- By September 30, 2013 100% of Head Start Education Coordinators and Curriculum Specialists must have a bachelor's degree.
- By September 30, 2013 100% of Head Start teaching assistants must have a CDA and be enrolled in a degree program.

Alaskan Head Start grantees have made significant progress over the past five years to try and meet the existing professional development requirements. However to meet these new requirements by the timeframes outlined we will need to have a coordinated statewide response. Obtaining degrees takes time, especially when staff are taking classes via distance delivery and working full time jobs. Often this means that early childhood educators are only able to take classes in the evenings and during the summer.

ACTION NEEDED: ***The Department of Labor and Workforce Development should designate workforce development funds for early childhood education because it is an under-developed profession.***

• SUPPORT INCREASED HEALTH CARE ACCESS FOR ALASKAN FAMILIES WITH YOUNG CHILDREN

The Alaska Head Start Association strongly supports an increase in funding for the Denali KidCare Program. By taking this action our state will restore and expand eligibility criteria for health care coverage for the children of Alaska's working families. The primary goal of Head Start is to make sure children are prepared for success as they enter their school years. A vital piece of this preparation is insuring that families have affordable, adequate health insurance coverage for their children, which Denali KidCare provides.

ACTION NEEDED: ***Increase the income eligibility guidelines for Denali KidCare to at least 200% of Alaska's federal poverty level.***

ALASKA HEAD START PROGRAMS

Head Start Grantees and the Communities They Serve 2009-2010

Aleutian/Pribolof Island Association
50 children
King Cove- Y
Sand Point-N
Unalaska-Y
St. Paul-Y

Association of Village Council Presidents
221 children
Akiachak-Y
Bethel-N
Cherfornak-Y
Kalskag-Y
Kotlik-Y
Nightmute-Y
Quinhagak-Y
Russian Mission-Y
Scammon Bay-Y
Tuluksak-Y

Bristol Bay Native Association
97 children
Dillingham-N
Manokotak—Y
Naknek-Y
New Stuyahok-Y
Togiak-N

Central Council of Tlingit & Haida Indian Tribes of Alaska
262 children
Angoon-N
Craig-N
Douglas-N
Hoonah-N
Juneau-N
Klawock-Y
Petersburg-N
Saxman-Y
Sitka-N
Wrangell-N
Yakutat-N

CCS Early Learning
260 children
Chugiak-N
Eagle River-N
Meadow Lakes-N
Palmer-N
Wasilla-N

Chugachmiut
22 children
Nanwalek-N
Port Graham-Y
Seldovia-Y

Council of Athabaskan Tribes
30 children
Arctic Village-N
Chalkyitsik-N
Circle-N
Fort Yukon-N
Venetie-N

Fairbanks Native Association
263 children
Fairbanks-N

Kawerak
225 children
Brevig Mission-Y
Little Diomede-Y
Elim-Y
Gambell-Y
Golovin-Y
Koyuk-Y
Nome-N
Shishmaref-Y
St. Michael-Y
Shaktoolik-Y
Teller-Y
Wales-Y
White Mountain-Y

Kenaitze Indian Tribe IRA
57 children
Kalifornisky Beach-N
Kenai-N
Soldotna-N
Nikiski-N

Kids' Corps, Inc.
352 children
Anchorage-N

Metlakatla Indian Community
31 children
Metlakatla-N

Play 'N Learn Community HS
126 children
Fairbanks-N
North Pole-N

RurAL CAP
823 children
Akiak-Y
Alakanuk-Y
Chevak-N
Emmonak-Y
Haines-Y
Homer-Y
Hooper Bay-N
Kake-Y
Ketchikan-Y
Kluti-Kaah-N
Kodiak-N
Kwethluk-Y
Marshall-Y
Mt. Village-Y
Napaskiak-Y
Nunapitchuk
Pilot Station-Y
St. Mary's-Y
Savoonga-Y
Selawik-Y
Stebbins-Y
Sterling-Y
Tanacross-Y
Toksook Bay-Y
Tok-Y

CDI Head Start
247 children
Anchorage -N

Tanana Chiefs Conference
99 children
Fort Yukon-Y
Holy Cross-Y
Huslia-Y
Kaltag-Y
McGrath-Y
Minto-Y
Nenana-Y
Nulato-Y
Tetlin-Y
Tanana-Y

Y=Serving the majority of eligible children

N=Not serving the majority of eligible children

Revised September, 2009

Alaska Head Start Association
Parents · Staff · Directors · Friends
Support Brings Success!

Alaska Head Start Association

Why Head Start Matters

Alaska's Head Start programs prepare young children for success in school and life.

1. **Head Start children are healthier than their peers from similar socio-economic backgrounds who are not enrolled in Head Start. Healthy children learn better.**

FACTS*
(The following figures refer to Head Start only. Early Head Start is not included.)

- 78% of Alaska's Head Start children received health screenings that meet Early Periodic Screening, Diagnosis and Treatment (EPSDT) standards. (EPSDT is Medicaid's well child check up program.) This compares to a 50% EPSDT medical screening rate for eligible 2-5 year olds statewide**.
- Of the 2,152 Head Start children who received health screenings, 356 were diagnosed as needing treatment for a variety of potentially serious conditions, including hearing & vision problems, anemia and asthma.

CONCLUSION
Without Head Start, we estimate that 100 or more children would enter kindergarten by 2009 with significant undiagnosed and untreated health problems.

**Based on federal 2007 Program Information Reports (PIR) for Alaska grantees.*
***For 2003, reported in the National Health Policy Forum issue brief #819, 11/20/2006.*

FACTS*
(The following figures refer to Head Start only. Early Head Start children are not included.)

- 88% of Alaska's Head Start children received dental exams. This compares to a 25% EPSDT dental screening rate for eligible 3-5 year olds statewide**.
- Of the 2,425 Head Start children who received dental exams, 586 were diagnosed as needing dental treatment. 376 of these children (64%) received treatment.

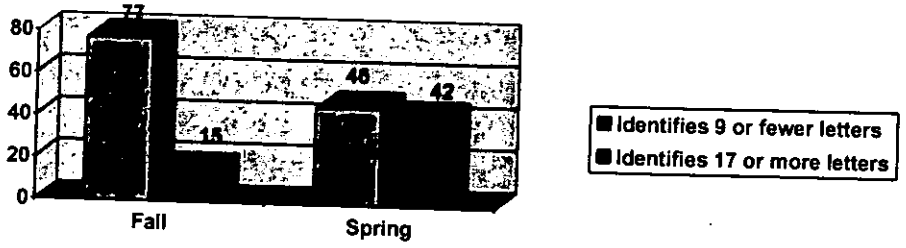
CONCLUSION
Without Head Start, we estimate that 270 or more children every year would live with untreated oral health needs. These conditions place a child's speech development, nutritional well-being, overall health and future oral health at risk.

**Based on federal 2007 Program Information Reports (PIR) for Alaska grantees.*
***For 2003, reported in the National Health Policy Forum issue brief #819, 11/20/2006.*

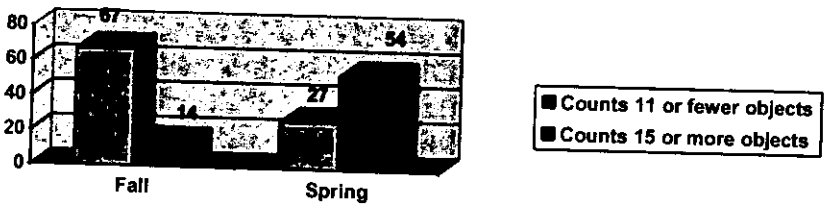
2. **Participation in Head Start improves literacy and math skills for many children who are at risk of starting kindergarten behind their better off peers in these areas.**

The following graphs are based on information taken from the National Head Start Reporting System (NRS) results of 11 Alaska grantees during the 2006-2007 program year. The NRS assesses only children who were going to kindergarten in 2007. The graphs include only those children assessed in both fall and spring— a total of 352 children in Region X programs and 329 children in AIAN programs.

Letter Recognition
(Percentages)



Early Math Skills
(Percentages)



Alaska's Head Start programs achieved results that approach national norms even though program characteristics differ from national averages in several significant ways.

- Alaska has fewer full day programs
- Alaska has fewer teachers with a Bachelor's degree

Program Characteristic	Alaska Program Averages	National Head Start Averages
Percentage of teachers with Bachelor's degree or higher	20%	44%
Percentage of children enrolled in full day programs	10%	53%

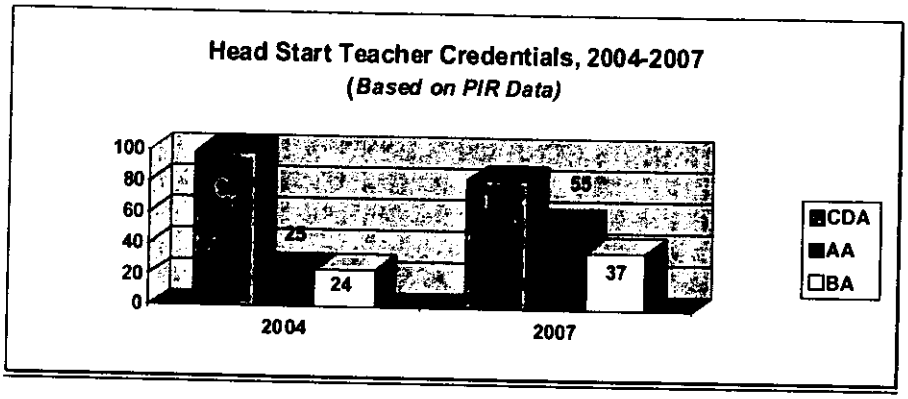
3. **Participation in Head Start increases the likelihood that children with previously undiagnosed disabilities will receive diagnosis and therapy for their disability before they enter kindergarten.**

FACTS*
(The following figures from the federal 2007 Program Information Report for Alaska grantees refer to Head Start only. Early Head Start children are not included.)

- 95% of Alaska's Head Start children received developmental screenings exams.
- Of the 2,600 Head Start children who received developmental screenings, 276 were eventually diagnosed with a disability.

CONCLUSION
Without Head Start, hundreds of Alaska's children would enter kindergarten every year with undiagnosed disabilities.

4. **The quality of Head Start teachers continues to improve in spite of funding and distance learning challenges.**



5. **Head Start provides economic benefits for all of Alaska.**

Federal Head Start grants injected over 27 million dollars into Alaska's economy in FY 2007. This sum does not include the many other sources of federal revenue, such as Child and Adult Care Food Program (CACFP) reimbursements, which Head Start programs attract. This investment provides an important source of economic activity and employment in many of the rural communities listed on page one. For example, Head Start programs employed 927 people in 2006.

The Future of Head Start in Alaska

Many studies link high quality early child development programs to large and long term economic savings. We believe that the early intervention, health, and school readiness results described above testify to the high quality of Alaska's Head Start programs.

System for Early Education Development

Professional Development and Retention of Early Educators
(Public Policy Priority for 2010)

THE ISSUE

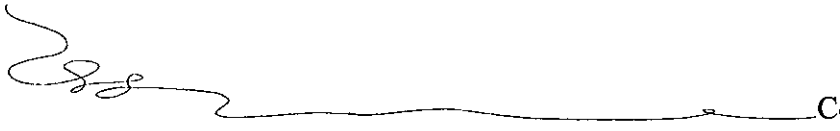
- The turnover rate for early care and education teachers in Alaska is approximately 46% (2003, Market Rate Survey). Teacher retention promotes attachment and quality relationships between young children and those who care for them which are crucial to optimal brain development and learning.
- Low wages and lack of financial resources for teacher's professional development impacts recruitment and retention of a qualified and stable workforce.
- Positive child outcomes are increased with higher levels of teacher preparation and formal education.

PROFESSIONAL DEVELOPMENT AND RETENTION OF EARLY EDUCATORS

- Three factors are positively associated with teacher quality: compensation, participation in professional development, and stability. Compensation appears to be the strongest predicator of classroom quality in child care centers (Kagan, et al., 2006). thread, Alaska's Child Care Resource and Referral Network, has the infrastructure to incentivize teachers with current credentials through the ROOTS (Retaining Our Outstanding Teacher) Awards. To impact retention, these awards must be calculated and distributed at significant levels that follow the SEED Professional Framework. Formal evaluation has shown that compensation programs have demonstrated considerable increased retention rates in states where initiatives exist.
- Scholarship type programs can reduce financial barriers to further education and training for teachers. thread provides up to $500 per year for qualified education expenses for early educators working in licensed programs. Increasing these annual awards an additional $500 would facilitate the completion of additional professional development and improve the quality of early care and education for Alaska's children.
- Research has consistently shown that higher levels of provider education and training are associated with more positive and stimulating teacher behavior resulting in more positive child outcomes. Education and training that increase positive interactions between adults and children impacts multiple areas of development (Pianta, 2006; Ramey et al., 2008).

ACTION NEEDED

- $1.5 million to increase professional development opportunities for early educators and to provide financial incentives to increase retention in the early education field



Connected with thread.

Rationale for Alaska SEED ROOTS Awards

The Alaska 2009 Child Care Market Rate Survey with 395 respondents provides data that supports the need for wage increases tied to increased professional development. The majority (81%) of responding programs report needing to hire new staff from once every month to 2-3 times per year and 61% of all providers report hiring and retaining qualified staff as "very difficult." Responses to questions about challenges with staff retention include lack of qualifications/education as the number one factor with lack of ability to offer benefits as second. Center/group home providers reported to hire and retain qualified caregivers requires on average $12.50 per hour.

Other national programs such as WAGE$ has produced the following recent outcomes:

- The annual turnover rate was 15% for WAGE$® Project participants, far less than the pre-program statewide turnover rate of 31% per year and less than the current statewide turnover rate of 24%.
- Sixty percent (64%) of WAGE$® Project participants indicated that they had taken college level coursework since applying to the Child Care WAGE$® Project and 86% plan to do so in the future.
- Eighteen percent (19%) of WAGE$® Project participants moved up a level on the supplement scale due to continued education.

To increase early educators' wages from the statewide average of $ 11 per hour (2008, wage survey, Alaska Department of Labor) to the desired $12 per hour would require the following increases. Each tier is tied to incremental educational attainment with a 60% increase for each one. Calculations are based on the current professional development of the early childhood field to include child care and Head Start.

TIER I: Child Development Associate Level (used SEED level 6& 7) includes CDA and unrelated AA with credits or Occupational Endorsement	223	223 x $2080= $463,840
TIER II: AA/AAS Level (used SEED levels 8 &9) includes related AA and ECE AA and unrelated BA	119	119 x $3328=$396,032
TIER III: BA/BS/MA Level (used SEED levels 9, 10, &11) related BA, unrelated BA with ECE credits, BA in ECE, & MA	129	129x $5324=$686,796

TOTAL: $1,546,668

3/1/10 PRESENTATION: ANCHORAGE URBAN LEAGUE & DIV. OF...

National Urban League
celebrating 100 years

ANCHORAGE URBAN LEAGUE

ALASKA SEEDS OF CHANGE

Providing Transitional Services for Our Youth

National Urban League
celebrating 100 years

ANCHORAGE URBAN LEAGUE

Mission:

The purpose of the Anchorage Urban League is to provide direct services to African-Americans and other people of color in our community – thereby empowering us to secure economic self-reliance and parity.

The Anchorage Urban League endeavors to enrich our community by embracing our diversity and addressing real needs among our population.

National Urban League
celebrating 100 years

ANCHORAGE URBAN LEAGUE

Alaska Seeds of Change - Challenges Facing Transitional Youth:

- High rates of unemployment, lower wages.
- High dropout rates.
- Involvement with criminal justice system.
- High rates of homelessness/unsafe housing.
- Development of mental health & substance abuse problems.
- Less community engagement.

National Urban League
celebrating 100 years

ANCHORAGE URBAN LEAGUE

Alaska Seeds of Change - Why a Social Enterprise?

- Funding sustainability.
- Providing services in a normalized setting.
- "Real world," challenging opportunities to acquire and apply skills.
- Youth recognized as resources and not merely as "problems."

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celebrating 100 years

ANCHORAGE URBAN LEAGUE

Alaska Seeds of Change - Program Highlights:

- Comprehensive, individualized transitional services for youth with complex emotional and behavioral needs.
- Youth acquire independent living skills (including employability skills and job experience) by participating in all major aspects of running an urban greenhouse business.
- Internships for students from the University of Alaska Anchorage. SOC will promote workforce development.
- Measure functional outcomes and implement evidence-supported practices.
- Help grow the local food production system through the use of innovative energy-conservation growing practices.

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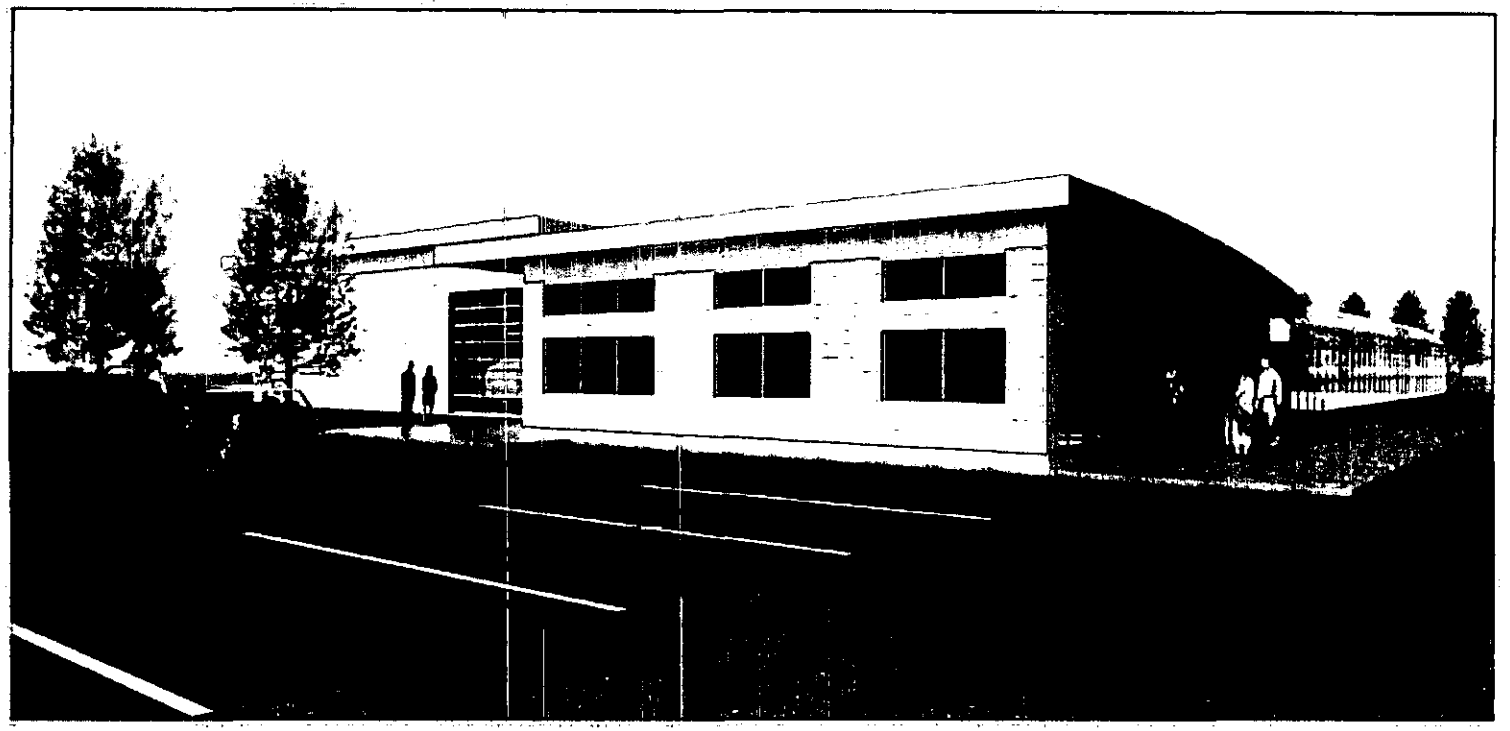
ANCHORAGE URBAN LEAGUE



RENDERING - NORTHWEST CORNER n.t.s.

Anchorage Urban League | Empowering Communities Changing Lives

ALASKA SEEDS OF CHANGE

kpb architects

National Urban League
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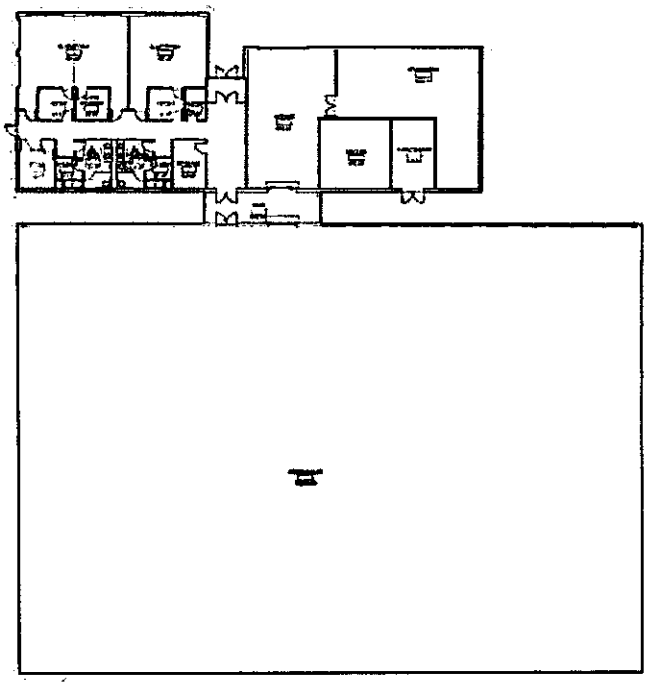
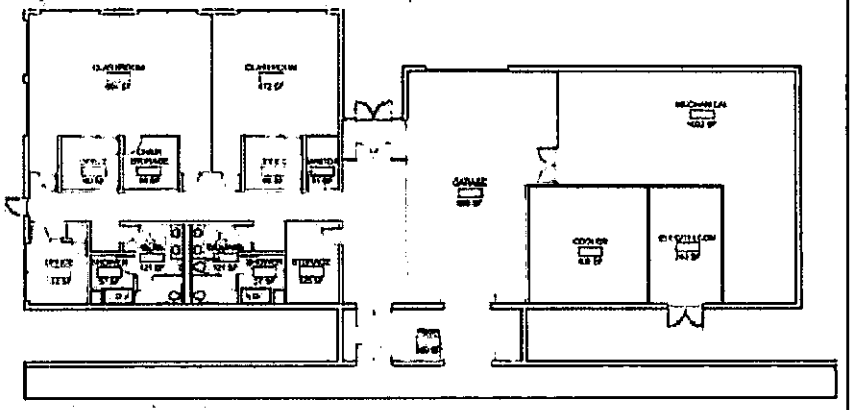
ANCHORAGE URBAN LEAGUE





CLASS/MEETING
ENTRY
GREENHOUSE
LOADING
MECH/ELEC
OFFICE
STORAGE
SUPPORT

OVERALL FLOOR PLAN N.T.S.

ENLARGED FLOOR PLAN

Anchorage Urban League | Empowering Communities Changing Lives

ALASKA SEEDS OF CHANGE

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ANCHORAGE URBAN LEAGUE

Alaska Seeds of Change - Goals and Outcomes:

- Higher rates of permanent employment and job retention.
- Increased high school graduation rates.
- Increased participation in vocational training.
- Safe and stable housing arrangements.
- Reduced reliance upon public support.
- Reduced involvement with the legal system.
- Creation of jobs that provide meaningful skills and work experience.

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ANCHORAGE URBAN LEAGUE

Alaska Seeds of Change - Goals and Outcomes (cont.):

- Reduced impact of mental health and substance abuse problems on daily functioning.
- Less victimization of transitional age youth.
- Greater youth participation in the community.
- Improved local community due to community g ardens.
- Increased dissemination of hydroponic greenhouse growing practices.

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ANCHORAGE URBAN LEAGUE

Project Status

AMTHA

Predevelopment funding

Foraker Group

Predevelopment services

Municipality of Anchorage

Site lease and energy source

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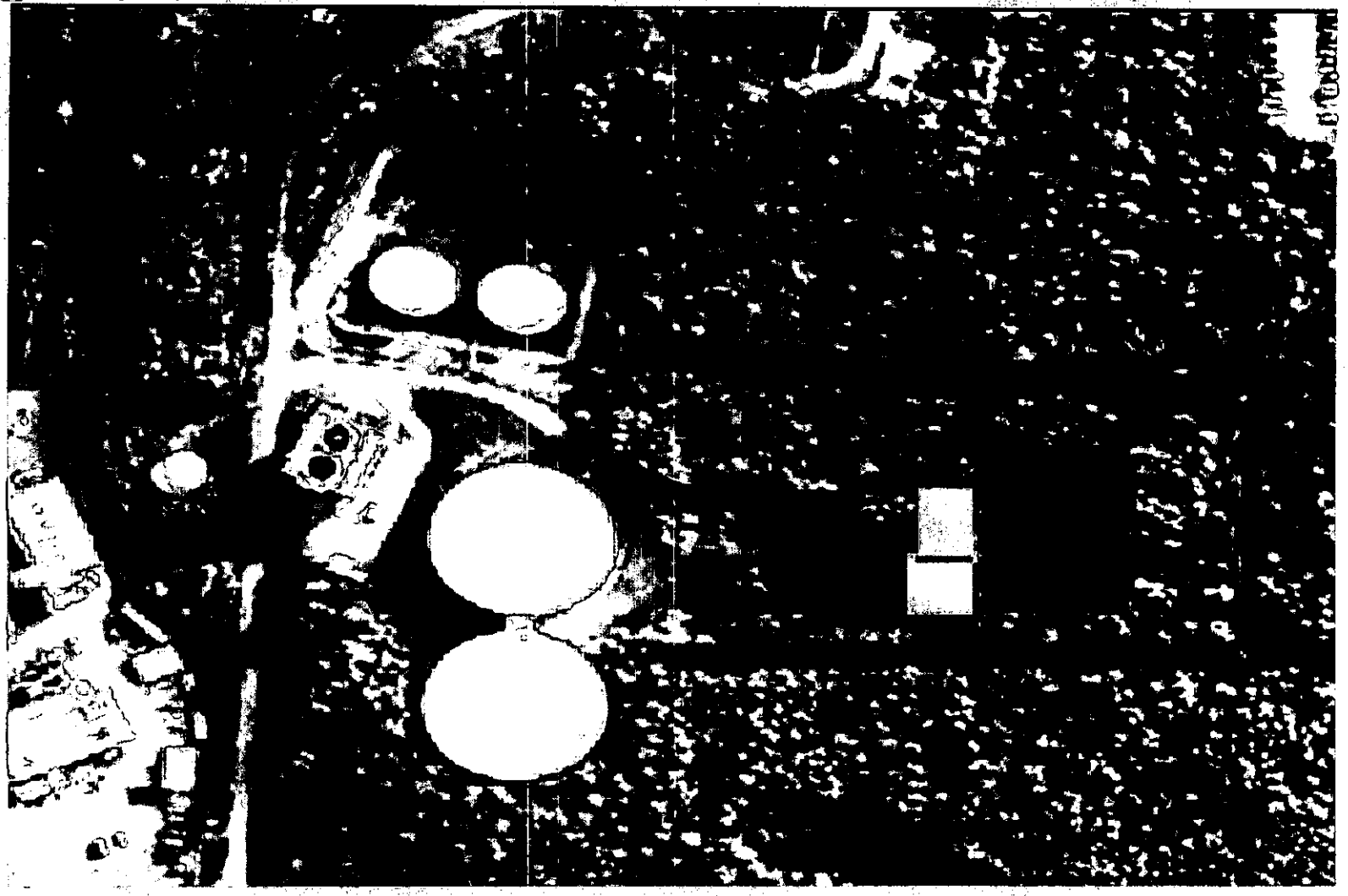
ANCHORAGE URBAN LEAGUE



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ANCHORAGE URBAN LEAGUE

Project Fiscal Plan

Cost of Greenhouse and Program Space	$5,321,000

Possible source of funds

DHSS /Denali BTKH Funding	2,800,000
Private Foundations	800,000
Private Corporate Grants	750,000
Legislative appropriation	1,000,000
Total	$5,350,000

Equity

Estimated Municipal land value	$823,000

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ANCHORAGE URBAN LEAGUE

Alaska Seeds of Change - Major Partners:

- Municipality of Anchorage
- Alaska Mental Health Trust Authority
- The Foraker Group
- State of Alaska
  - Division of Juvenile Justice
  - Division of Behavioral Health
  - Office of Children Services
- University of Alaska Anchorage, College of Health & Social Welfare
- NeighborWorks of Anchorage
- Denali Family Services
- Casey Family Foundation
- Facing Foster Care in Alaska
- University of Alaska Fairbanks, Cooperative Extension Services

2672

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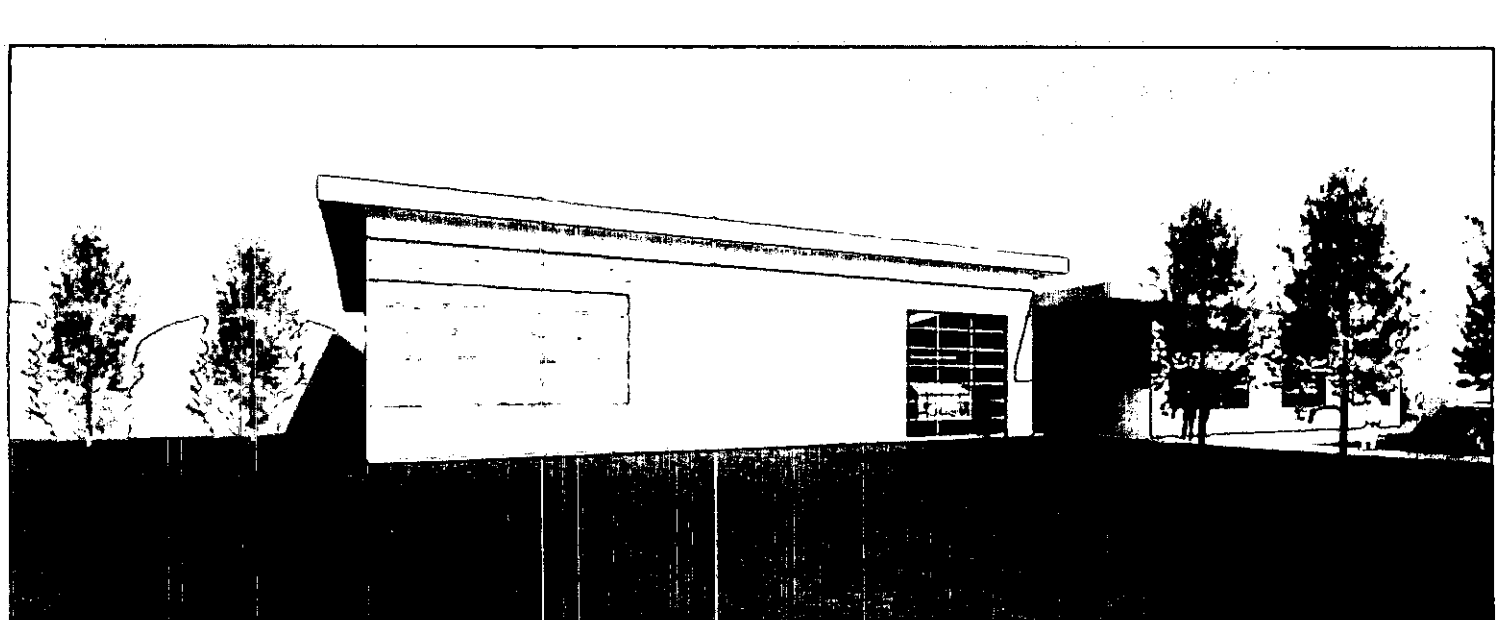
ANCHORAGE URBAN LEAGUE



RENDERING - NORTHEAST CORNER N.T.S.

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ALASKA SEEDS OF CHANGE

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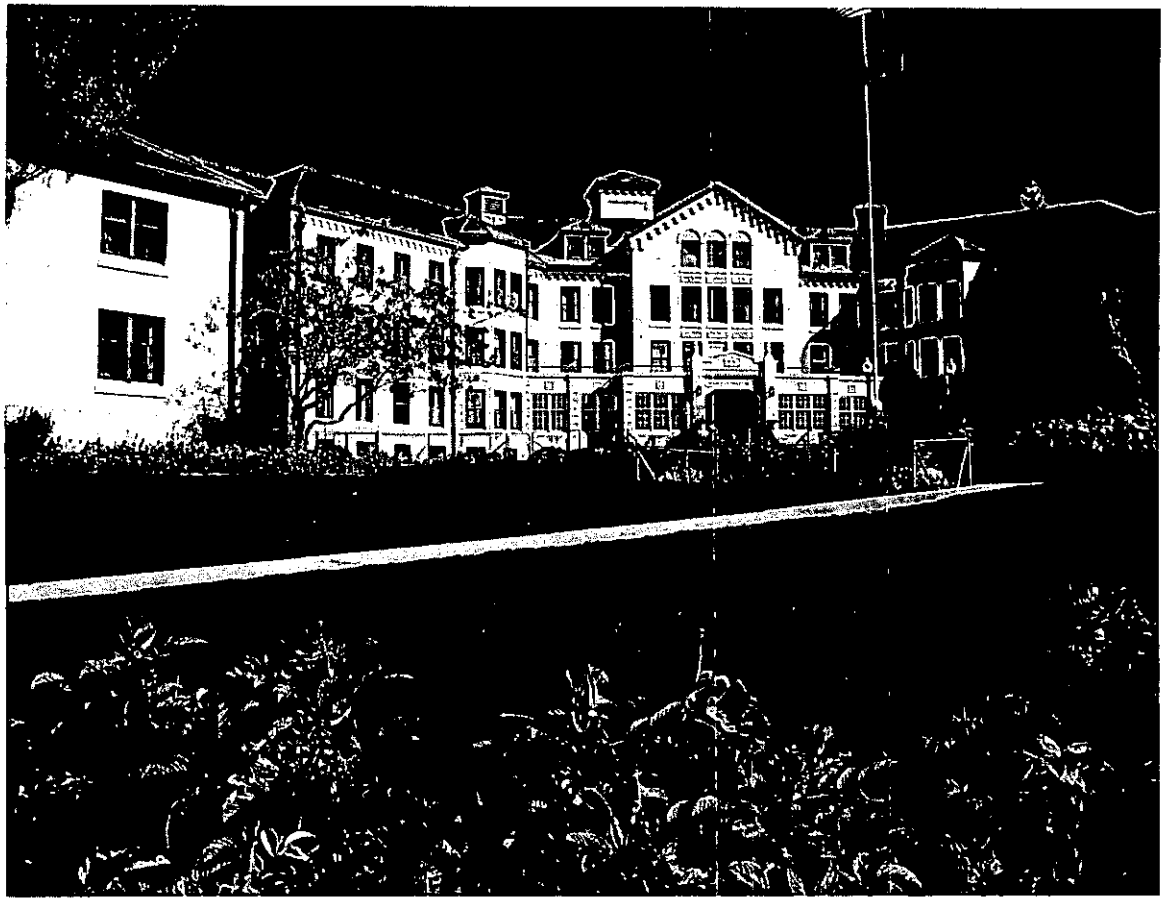
2673

The Alaska Division of Pioneer Homes; Planning for Tomorrow

February 2010

The Pioneer Homes have a long history of providing care to Alaska's elderly and are an important part of the senior services continuum of care.



The Sitka Pioneer Home built in 1913

Where the Alaska Elder population is going….

Table 1: Alaska population projections by age group for ages 60 and up, 2010-2030

Age	2010	2015	2020	2025	2030
60-64	35,359	43,061	44,317	40,560	33,434
65-69	21,872	31,865	39,135	40,455	36,954
70-74	13,251	19,091	28,193	35,020	36,363
75-79	8,854	10,924	15,916	23,880	29,953
80-84	6,026	6,655	8,278	12,264	18,645
85-89	3,435	4,033	4,475	5,635	8,414
90+	1,886	2,412	2,905	3,292	4,062

How we meet the need's of Alaska's elder's today

Table 2: Pioneer Homes Licensed Beds, June 2009

Pioneer Homes	Licensed Beds	Year Built
Sitka Pioneer Home	75	1913*
Fairbanks Pioneer Home	93	1967
Alaska Veterans & Pioneer Home in Palmer	79	1971
Ketchikan Pioneer Home	48	1981
Anchorage Pioneer Home	168	1982
Juneau Pioneer Home	45	1988
Total Licensed Beds	**508**	

Table 3: Occupancy by Pioneer Home, June 2009

	Available Beds	Occupied Beds	Percent Occupied
Anchorage	168	164	97.6%
Fairbanks	93	84	90.3%
Juneau	45	43	95.6%
Ketchikan	48	42	95.5%
Palmer	79	71	89.9%
Sitka	75	58	80.6%
All Pioneer Homes	**508**	**462**	**92.2%**

Table 4: Residents by service level by Pioneer Home, June 2009

Level I = Independent **Level 2 = Semi-Independent** **Level 3 = Dependant**

	Level 1	Level 2	Level 3	Total
Anchorage	38	48	78	**164**
Fairbanks	7	24	53	**84**
Juneau	1	13	29	**43**
Ketchikan	4	10	28	**42**
Palmer	5	14	52	**71**
Sitka	5	22	31	**58**
All Pioneer Homes	**60**	**131**	**271**	**462**

Table 5: Age of residents by Pioneer Home, June 2009

Pioneer Home	65-69	70-74	75-79	80-84	85-89	90+	Unknown
Anchorage	4	9	20	50	42	39	0
Fairbanks	1	3	5	15	30	30	0
Juneau	0	4	2	9	12	16	0
Ketchikan	1	4	4	9	4	14	4
Palmer	1	2	6	16	23	22	0
Sitka	4	10	12	17	11	4	0
All Pioneer Homes	**11**	**32**	**49**	**116**	**122**	**125**	**4**

Table 6: Wait list by Pioneer Home, June 2009

Pioneer Home	Active Wait List	Inactive Wait List
Anchorage	129	1,268
Fairbanks	86	1006
Juneau	62	904
Ketchikan	34	489
Palmer	122	960
Sitka	4	692
All Pioneer Homes	**437**	**5,319**

With an ever increasing waitlist should the Pioneer Homes system be proactive and begin planning expansion now instead of waiting until the state faces a crisis in the future?

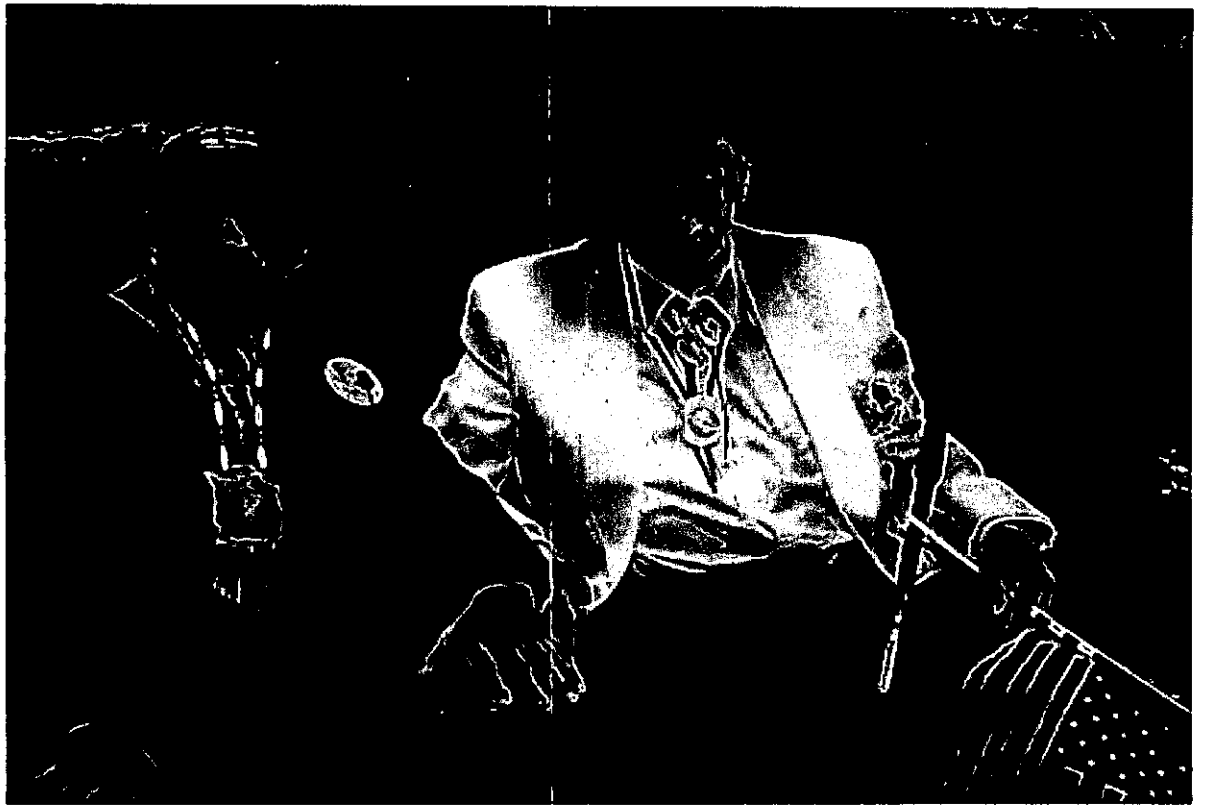


Table 7: Anchorage Pioneer Home service area population by age cohort, 2010-2030

	Projected Population					Percent Change			
Age	2010	2015	2020	2025	2030	2010-15	2015-20	2020-25	2025-30
65-69	8,825	13,331	16,029	16,859	15,643	51.1%	20.2%	5.2%	-7.2%
70-74	5,187	7,698	11,828	14,385	15,087	48.4%	53.7%	21.6%	4.9%
75-79	3,628	4,353	6,521	10,143	12,352	20.0%	49.8%	55.5%	21.8%
80-84	2,426	2,760	3,347	5,079	7,937	13.8%	21.3%	51.7%	56.3%
85-89	1,416	1,646	1,876	2,302	3,493	16.2%	14.0%	22.7%	51.7%
90+	802	1,018	1,220	1,403	1,694	26.9%	19.8%	15.0%	20.7%

Table 8: Palmer Veterans and Pioneer Home service area population by age, 2010-2030

	Projected Population					Percent Change			
Age	2010	2015	2020	2025	2030	2010-15	2015-20	2020-25	2025-30
65-69	2,519	3,657	5,108	5,648	5,529	45.2%	39.7%	10.6%	-2.1%
70-74	1,633	2,307	3,343	4,682	5,233	41.3%	44.9%	40.1%	11.8%
75-79	1,116	1,401	1,975	2,889	4,090	25.5%	41.0%	46.3%	41.6%
80-84	736	889	1,113	1,581	2,336	20.8%	25.2%	42.0%	47.8%
85-89	391	518	626	789	1,128	32.5%	20.8%	26.0%	43.0%
90+	186	280	378	466	590	50.5%	35.0%	23.3%	26.6%

Table 9: Fairbanks Pioneer Home service area population by age cohort, 2010-2030

	Projected Population					Percent Change			
Age	2010	2015	2020	2025	2030	2010-15	2015-20	2020-25	2025-30
65-69	3,129	4,616	5,650	5,636	5,214	47.5%	22.4%	-0.2%	-7.5%
70-74	1,851	2,725	4,078	5,051	5,064	47.2%	49.7%	23.9%	0.3%
75-79	1,178	1,523	2,268	3,451	4,319	29.3%	48.9%	52.2%	25.2%
80-84	809	867	1,137	1,726	2,673	7.2%	31.1%	51.8%	54.9%
85-89	429	540	582	773	1,185	25.9%	7.8%	32.8%	53.3%
90+	243	306	384	434	552	25.9%	25.5%	13.0%	27.2%

Table 10: Juneau Pioneer Home service area population by age cohort, 2010-2030

	Projected Population					Percent Change			
Age	2010	2015	2020	2025	2030	2010-15	2015-20	2020-25	2025-30
65-69	1411	2260	2615	2329	2062	60.2%	15.7%	-10.9%	-11.5%
70-74	879	1212	1971	2309	2086	37.9%	62.6%	17.1%	-9.7%
75-79	491	700	986	1636	1963	42.6%	40.9%	65.9%	20.0%
80-84	390	371	529	760	1284	-4.9%	42.6%	43.7%	68.9%
85-89	229	245	236	341	508	7.0%	-3.7%	44.5%	49.0%
90+	154	172	186	185	243	11.7%	8.1%	-0.5%	31.4%

Table 11: Ketchikan Pioneer Home service area population by age cohort, 2010-2030

	Projected Population					Percent Change			
Age	**2010**	**2015**	**2020**	**2025**	**2030**	**2010-15**	**2015-20**	**2020-25**	**2025-30**
65-69	810	1,000	1,191	1,095	898	23.5%	19.1%	-8.1%	18.0%
70-74	505	702	877	1,027	1,037	39.0%	24.9%	17.1%	1.0%
75-79	289	393	559	787	884	36.0%	42.2%	40.8%	12.3%
80-84	233	216	292	440	556	-7.3%	35.2%	50.7%	26.4%
85-89	133	151	140	224	284	13.5%	-7.3%	60.0%	26.8%
90+	66	81	98	105	124	22.7%	21.0%	7.1%	18.1%

Table 12: Sitka Pioneer Home Service Area service area population by age cohort, 2010-2030

	Projected Population					Percent Change			
Age	2010	2015	2020	2025	2030	2010-15	2015-20	2020-25	2025-30
65-69	641	809	891	946	692	26.2%	10.1%	6.2%	26.8%
70-74	472	558	708	789	849	18.2%	26.9%	11.4%	7.6%
75-79	277	382	454	589	668	37.9%	18.8%	29.7%	13.4%
80-84	227	208	285	348	460	-8.4%	37.0%	22.1%	32.2%
85-89	145	155	144	198	241	6.9%	-7.1%	37.5%	21.7%
90+	85	97	104	102	130	14.1%	7.2%	-1.9%	27.5%

How will the Alaska Pioneer Homes meet the needs of elder Alaskans in the future?

Table 13: New beds needed to meet projected demand, 2015-2030

*June 2009

Pioneer Home	Occupied Beds*	2015	2020	2025	2030
Anchorage	164	35	49	82	121
Fairbanks	84	20	23	37	65
Palmer	71	25	28	37	58
Juneau	43	5	9	15	27
Ketchikan	42	6	10	14	11
Sitka	58	7	12	17	16
Total	**462**	**98**	**131**	**202**	**298**

Total projected new beds needed for the period 2015 – 2030 = 729 (per Information Insights projection data).

Conclusion

- There is clearly a need to expand the service array for seniors in the next twenty years.
- As part of this service array, the Pioneer Homes should consider expanding bed capacity by approximately 200 beds in a phased approach.
- Emphasis should be on creating Level III beds, our most dependent level of care, because elders are entering our homes at higher acuity levels and consequently there is more demand for Level III beds.
- A study should be conducted to determine the feasibility of adding to the existing Homes in particular where we currently own land and/or determining where additional Homes could be built.

CONFIRMA-TIONS

2009

Official Business

Alaska State Legislature

Senate

Office of the Secretary

State Capitol, Room 213
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Memorandum

TO: Senator Davis, Chair
Health and Social Services Committee

FROM: Kirsten Waid
Secretary of the Senate

DATE: February 4, 2009

SUBJECT: Confirmation of Governor's Appointments

Pursuant to AS 39.05.080, the President has referred the following names, with attached resumes, for legislative confirmation to your committee for a hearing, recommendation and report:

Commissioner – Department of Health and Social Services
William H. Hogan Appointed: 7/24/2008

Board of Dental Examiners
Robyn Chaney – Dillingham
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. Mary Anne Navitsky – Sitka
Appointed: 3/1/2009 Term Expires: 3/1/2013

Deborah Stauffer – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. Clifford Douglas White – Dillingham
Appointed: 3/1/2009 Term Expires: 3/1/2013

Board of Marital and Family Therapy
Kimberly K. Horn – Juneau
Appointed: 2/3/2009 Term Expires: 3/1/2010

Patricia A. White – Juneau
Appointed: 8/22/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

State Medical Board
Edward A. Hall – Anchorage
Appointed: 5/19/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Casey M. Millar – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. David A. Miller – Juneau
Appointed: 3/1/2009 Term Expires: 3/1/2012

Dr. David J. Powers – Dillingham
Appointed: 12/2/2008 Term Expires: 3/1/2012

Alaska Mental Health Trust Authority Board of Trustees
Dr. William Doolittle – Fairbanks
Appointed: 3/24/2004
Reappointed: 3/1/2009 Term Expires: 3/1/2014

Chief Daniel Hoffman – Fairbanks
Appointed: 3/1/2009 Term Expires: 3/1/2014

Mary Jane Michael – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2010

Board of Certified Direct-Entry Midwives
Barbara Norton – Anchorage
Appointed: 6/3/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Nursing
Thomas Hendrix – Eagle River
Appointed: 3/1/2009 Term Expires: 3/1/2013

Janine L. McCready – Fairbanks
Appointed: 12/3/2008 Term Expires: 3/1/2011

Board of Examiners in Optometry
Dr. Dennis A. Swarner – Kenai
Appointed: 10/18/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Pharmacy
Leah Handley – Homer
Appointed: 3/1/2009 Term Expires: 3/1/2013

Steve R. Johnson – Palmer
Appointed: 12/3/2008 Term Expires: 3/1/2012

Chris "CJ" Kim – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2012

Mary D. Mundell – Wasilla
Appointed: 4/14/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Professional Counselors
Ray DePalatis – Anchorage
Appointed: 8/8/2008 Term Expires: 3/1/2009
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Lillian Mitchell – Anchorage
Appointed: 8/8/2008 Term Expires: 3/1/2012

Tashawna L. Olson – Homer
Appointed: 4/14/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Psychologist and Psychological Associate Examiners
Dr. Kristi H. Fuller – Anchorage
Appointed: 2/3/2009 Term Expires: 3/1/2013

Board of Social Work Examiners
Darrell Allman – Anchorage
Appointed: 4/22/2004
Reappointed: 10/16/2008 Term Expires: 3/1/2012

Gail La Rose-Henderson – Wasilla
Appointed: 2/24/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Patty McMillin – Bethel
Appointed: 3/1/2009 Term Expires: 3/1/2010

Attachments
KW:lc
gl # 4

questions to be asked by Sen Paskvan

Amory Lelake

From: Jake Hamburg
Sent: Wednesday, March 18, 2009 11:24 AM
To: Amory Lelake
Subject: HSS Confirmation Questions

I want to compliment you and your department for the 2009 Priorities list.

- Please describe the progress made on substance abuse prevention, intervention and treatment outlined in your 2009 priority list.
- Please describe the status of developing a long-term care plan and outline the plan.
- Please discuss social service staffing, and any progress made toward improving the staffing levels, as well as what is needed.
- How would you classify mental health treatment in Alaska?
- In Fairbanks, the waiting list for mental health care can be roughly 3 months if no physical harm has been committed by a patient, in corrections we fund treatment programs that face uselessness because of limited available access to out of facility treatment, and those that are lucky to find treatment can often see a different person each visit. Would you comment on this, and please discuss how you are working to address these problems.
- This committee has largely supported efforts to improve health care access and affordability. Please address your plan to address these same problems. Also, please share where you see needed improvements.
- Rates of domestic violence and sexual assault remain the highest in the country. What must be done to finally end this terrible problem in our state? How do you view the department's role in reducing the rates of domestic violence? Please describe the department's increased efforts.

Jake Hamburg

Senate Committee on Health & Social Services

Sen. Bettye Davis, Chair
Sen. Joe Paskvan, Vice Chair
Sen. Johnny Ellis

Sen. Joe Thomas
Sen. Fred Dyson

SENATE CONFIRMATION COMMITTEE REPORT

Date: 3/18/2009

In accordance with AS 39.05.080, the Health and Social Services Committee reviewed the following and recommends the appointments be forwarded to a joint session for consideration:

Commissioner Department of Health and Social Services:
William H. Hogan

State Medical Board:
Edward A Hall
Casey M. Millar
Dr. David Miller
Dr. David J. Powers.

Alaska Mental Health Trust Authority Board of Trustees:
Dr. William Doolittle
Mary Jane Michael
Chief Daniel Hoffman

Board of Dental Examiners:
Robyn Chaney
Dr. Mary Ann Navitsky
Deborah Stauffer
Dr. Clifford Douglas White

Board of Marital and Family Therapy:
Kimberly K. Horn
Patricia A. White

Board of Certified Direct-Entry Midwives:
Barbara Norton

Board of Nursing:
Thomas Hendrix
Janine L. McCready

Board of Examiners in Optometry:
Dr. Dennis A. Swarner

Board of Pharmacy:
Leah Handley
Steve R. Johnson
Chris "CJ" Kim
Mary D. Mundell

Board of Professional Counselors:
Ray DePalatis
Lillian Mitchell
Tashawna L. Olson

Board of Psychologist and Psychological Associate Examiners:
Dr. Kristin H. Fuller

Board of Social Work Examiners:
Darrell Allman
Gail La Rose-Henderson
Patty McMillin

This does not reflect an intent by any of the members to vote for or against the confirmation of the individuals during any further sessions.

Signature:	**Printed Last Name**
	PASKVAN
	DYSON
Chair: Betty Davis	DAVIS

Please return to the Senate Secretary's Office (Room 213).

Alaska Department of Health and Social Services

2009 PRIORITIES

The overriding theme for future direction for the Alaska Department of Health and Social Services is ***helping individuals and families create safe and healthy communities.***

Substance Abuse

Substance abuse affects every family and community in Alaska. It is a contributing factor in suicides, crime, unemployment, domestic violence, child abuse, school dropouts, juvenile delinquency, etc. We need to prevent, intervene early, treat and help people recover from substance abuse through public/ private partnerships and long-term strategies.

Major strategies include:

- **Prevention:** Implement Prevention of Underage Drinking Initiative; target substance abuse and suicide prevention programs to those communities most in need.
- **Early Intervention:** Integrate primary care with behavioral health (mental health and substance abuse); screen all youth in the juvenile justice system for substance abuse.
- **Treatment:** Develop and implement family-based treatment services (based on the California SHIELDS for FAMILIES project); submit substance abuse Medicaid Waiver targeting adults; implement involuntary treatment and secure detoxification services.
- **Recovery:** Support array of recovery services using performance-based standards and funding. Continue to integrate mental health and substance abuse services into a behavioral health system.

Health and Wellness

Many Alaskans lead less happy and less productive lives, and many die prematurely each year, because of disability and death caused by tobacco, alcohol abuse, injuries, obesity, diabetes, cancer, heart disease, and sexually transmitted diseases. The economic impact of chronic disease alone in Alaska is staggering: an estimated $600 million is spent annually on direct medical services and $1.9 billion in lost productivity. Most of this is attributable to personal choice involving diet, physical activity and tobacco use — and is preventable. We can do a better job of screening, diagnosing and treating these conditions.

Major strategies include:

- **Prevention:** Implement evidence-based, population-based health promotion efforts. Increase primary prevention approaches, including those targeting increased self responsibility, improved policies and environmental supports that encourages healthy choices. Educate about and improve methods for screening, diagnosis, and early treatment of conditions and behaviors most detrimental to the physical and mental health of Alaskans. Implement Early Childhood Comprehensive System recommendations (including a focus on early childhood mental health).
- **Access:** Grow the health care workforce and expand the number of Alaskans with health insurance.
- **Trauma system:** Develop a statewide trauma system.
- **Emergency Response Planning and Preparedness:** Work with communities to prevent health emergencies and prepare for pandemics and natural disasters.
- **Environmental Health Impacts:** Assess, guide and mitigate environmental impacts on health in Alaska. Develop expertise in performing health impact assessments.

Health Care Reform

Alaska's health care system continues to be fragmented and uncoordinated and doesn't produce the kinds of outcomes we expect. By strategically focusing on care management, reforming Medicaid, creating a Health Care Commission and growing our health care workforce, we can transform our health care system.

Major strategies include:

- **Care Management:** Improve care coordination; implement disease management program for chronic diseases and explore use of primary care case management strategy for most disabled populations; complete planning for the Bring the Kids Home Initiative.
- **Medicaid Reform:** Develop legislative and systemic recommendations for reforming Medicaid aimed at improving Medicaid sustainability.
- **Health Care Commission:** Establish a commission in order to build public awareness and define the future roles of the state, business, providers and individuals regarding health care funding and delivery.
- **Health Care Workforce:** Partner with the federal government and other states to increase training capacity and expand training programs for health care professions.

Continued ...

Alaska Department of Health and Social Services

2009 PRIORITIES

Long-Term Care

Seniors represent the fastest growing population in Alaska and it is our responsibility to determine what kinds of services we want for our aging parents (and grandparents) in order to keep them at home in their own communities. We need to develop a long-term care plan, improve services to those with Alzheimer's Disease and related disorders, and promote the expansion of aging and disability resource centers.

Major strategies include:

- **Long-Term Care Plan:** Develop an immediate and sustainable long-term care plan. DHSS has contracted with HCBS Strategies to develop this plan, which includes:
  - support for family caregivers;
  - improved service arrays and definitions of future roles of residential settings, e.g., the Pioneer Homes and nursing homes;
  - development of the workforce to meet long-term care needs; and
  - interdisciplinary departmental planning to provide quality assurance, provider training, audit and compliance coordination.
- **Long-Term Care and Services for Alaska Natives:** Work with the Alaska Native Tribal Health Consortium to identify and implement long-term care services.
- **Alzheimer Disease and Related Disorders Waiver:** Submit Waiver.
- **Aging and Disability Resource Centers:** Promote expansion of these centers.

Vulnerable Alaskans

We need to ensure that both kids and communities are safe, that developmentally disabled kids and adults have access to quality services and supports, and that individuals and families get the kind of financial and vocational supports they need to be contributing members of society. By focusing on family-centered services and through the use of performance-based standards and funding, we can better meet the needs of our most vulnerable citizens and their families.

Major strategies include:

- **Family-Centered Services Project:** Expand this project, which is designed to help families leave the public assistance rolls and find employment.
- **Performance-Based Standards:** Implement use of performance-based standards and funding for grantees.
- **Licensing, Certification and Training Standards:** Ensure providers comply with these standards.
- **Social Service Workforce:** Recruit and retain a qualified social services workforce using evidence-based practices to design and implement a department-wide approach.

Alaska Department of Health and Social Services
Organization Chart

Commissioner
Bill Hogan

Chief Medical Officer
Jay Butler, M.D.

PUBLIC HEALTH
Director: Beverly Wooley

- Public Health Nursing
- Epidemiology
- Chronic Disease Prevention & Health Promotion
- Injury Prevention & Emergency Medical Services
- Women's, Children's & Family Health
- Bureau of Vital Stat.
- State Laboratory
- State Medical Examiner's Office
- Health Care Facility Licensing

Public Health Preparedness Program

Boards, Commissions and Workgroups
* Alaska Health Care Commission
* Alaska Council on Emergency Medical Service
* Primary Care Council
* Regional Health Information Org.
* Electronic Health Record workgroups

Deputy Commissioner for Medicaid and Health Care Policy
Bill Streur

• HEALTH CARE SERVICES
- Medicaid Director
- Medicaid Policy & Planning
- Medicaid financing
- Medicaid reform
- Medicaid Management Information System
- Rate Review
- Tribal Health
- Certification
- Health Planning & Systems Development

Boards and Commissions
* Medical Care Advisory Committee
* Pharmacy/Therapeutics Comm.

Public Information
Clay Butcher

Legislative Relations
Wilda Laughlin

Special Assistant
Tara Horton

Office of Faith-Based and Community Initiatives
FBCI Advisory Council

Deputy Commissioner for Family, Community & Integrated Services
Patrick Hefley

ALASKA PIONEER HOMES
Director: David Cote

Boards & Commissions
* Alaska Pioneer Homes Advisory Board

BEHAVIORAL HEALTH
Director: Melissa Stone

Boards & Commissions
* Alaska Mental Health Board
* Advisory Board on Alcoholism and Drug Abuse
* Suicide Prevention Council

CHILDREN'S SERVICES
Director: Tammy Sandoval

Boards & Commissions
* Alaska Children's Trust

JUVENILE JUSTICE
Director: Steve McComb

* Juvenile Justice Advisory Committee

PUBLIC ASSISTANCE
Director: Ellie Fitzjarrald

SENIOR & DISABILITIES SERVICES
Director: Rebecca Hilgendorf

Boards & Commissions
* Governor's Council on Disabilities and Special Education
* Alaska Commission on Aging

Assistant Commissioner for Finance Management Services
Alison Elgee

- Performance/Quality Assurance
- Audits (including Legislative Audits)
- Hearings & Appeals
- Facilities
- Administrative Services
- Budget
- Revenue
- Fiscal
- Grants & Contracts
- Information Technology
- Regulations
- Legal Services Coordination

Effective Jan. 1, 2009, Rev. Jan. 21, 2009

Senate Committee on Health & Social Services

Sen. Bettye Davis, Chair
Sen. Joe Paskvan, Vice Chair
Sen. Johnny Ellis

Sen. Joe Thomas
Sen. Fred Dyson

Butrovich Room 205
465-4906

To: Senate Health & Social Services Committee Members

From: Senator Bettye Davis, Chair Senate H & SS BqD

Date: February 23, 2009

Re: Confirmation of Governor's Appointment

Attached is the Governor's appointments list which needs to be reviewed in preparation for confirmation. Please review each individual and attached resumes. If you have any individuals you wish to interview before the H&SS committee please let my aide, Lynda Zaugg know as soon as possible but no later then 3/13/09.

Thank you...

Alaska State Legislature

Senate

Office of the Secretary

Official Business

State Capitol, Room 213
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Memorandum

TO: Senator Davis, Chair
Health and Social Services Committee

FROM: Kirsten Waid
Secretary of the Senate

DATE: February 4, 2009

SUBJECT: Confirmation of Governor's Appointments

Pursuant to AS 39.05.080, the President has referred the following names, with attached resumes, for legislative confirmation to your committee for a hearing, recommendation and report:

Commissioner – Department of Health and Social Services
William H. Hogan Appointed: 7/24/2008

Board of Dental Examiners
Robyn Chaney – Dillingham
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. Mary Anne Navitsky – Sitka
Appointed: 3/1/2009 Term Expires: 3/1/2013

Deborah Stauffer – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. Clifford Douglas White – Dillingham
Appointed: 3/1/2009 Term Expires: 3/1/2013

Board of Marital and Family Therapy
Kimberly K. Horn – Juneau
Appointed: 2/3/2009 Term Expires: 3/1/2010

Patricia A. White – Juneau
Appointed: 8/22/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

State Medical Board
Edward A. Hall – Anchorage
Appointed: 5/19/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Casey M. Millar – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. David A. Miller – Juneau
Appointed: 3/1/2009 Term Expires: 3/1/2012

Dr. David J. Powers – Dillingham
Appointed: 12/2/2008 Term Expires: 3/1/2012

Alaska Mental Health Trust Authority Board of Trustees
Dr. William Doolittle – Fairbanks
Appointed: 3/24/2004
Reappointed: 3/1/2009 Term Expires: 3/1/2014

Chief Daniel Hoffman – Fairbanks
Appointed: 3/1/2009 Term Expires: 3/1/2014

Mary Jane Michael – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2010

Board of Certified Direct-Entry Midwives
Barbara Norton – Anchorage
Appointed: 6/3/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Nursing
Thomas Hendrix – Eagle River
Appointed: 3/1/2009 Term Expires: 3/1/2013

Janine L. McCready – Fairbanks
Appointed: 12/3/2008 Term Expires: 3/1/2011

Board of Examiners in Optometry
Dr. Dennis A. Swarner – Kenai
Appointed: 10/18/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Pharmacy
Leah Handley – Homer
Appointed: 3/1/2009 Term Expires: 3/1/2013

Steve R. Johnson – Palmer
Appointed: 12/3/2008 Term Expires: 3/1/2012

Chris "CJ" Kim – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2012

Mary D. Mundell – Wasilla
Appointed: 4/14/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Professional Counselors
Ray DePalatis – Anchorage
Appointed: 8/8/2008 Term Expires: 3/1/2009
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Lillian Mitchell – Anchorage
Appointed: 8/8/2008 Term Expires: 3/1/2012

Tashawna L. Olson – Homer
Appointed: 4/14/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Psychologist and Psychological Associate Examiners
Dr. Kristi H. Fuller – Anchorage
Appointed: 2/3/2009 Term Expires: 3/1/2013

Board of Social Work Examiners
Darrell Allman – Anchorage
Appointed: 4/22/2004
Reappointed: 10/16/2008 Term Expires: 3/1/2012

Gail La Rose-Henderson – Wasilla
Appointed: 2/24/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Patty McMillin – Bethel
Appointed: 3/1/2009 Term Expires: 3/1/2010

Attachments
KW:lc
gl # 4

WILLIAM H. HOGAN
P.O. Box 3896 Palmer, Alaska

William.Hogan@alaska.gov

EDUCATION

1991 Virginia Commonwealth University, Richmond, VA
Doctoral Work – Sociological Theory
1979 – 1980 West Virginia University, Morgantown, WV
Graduate – Master of Science in Social Work (MSW)
1976 – 1979 Syracuse University, Syracuse, NY
Graduate Course Work
1967- 1971 State University of New York at Buffalo, Buffalo, NY
Undergraduate – Bachelor of Arts in Sociology (B.A. Soc.)

PROFESSIONAL EXPERIENCE

2008-Current Alaska Department of Health and Social Services; Anchorage, Alaska – Commissioner –
Has authority and responsibility for all aspects of the department including policy development, planning, program and service delivery, finance and budgeting, information technology and statutory and regulatory compliance. The department is considered a "super agency" comprised of the Divisions of Public Health, Behavioral Health, Juvenile Justice, Public Assistance and Senior and Disabilities Services as well as the Office of Children's Services and the Alaska Pioneer Homes. In addition the department provides oversight and financing (Medicaid and state grants and contracts) of all health facilities through its Division of Health Care Services.
The department currently employs over 3600 staff and has a budget of $2.1 billion.

2005-2008 Alaska Department of Health and Social Services; Anchorage, Alaska – Deputy Commissioner, Family, Community and Integrated Services –
Had oversight responsibility for the Divisions of Public Assistance, Behavioral Health, Juvenile Justice, Senior and Disability Services, Office of Children's Services (Child Welfare) and the Alaska Pioneer Homes (Long Term Care). In addition was the primary liaison with the Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, Alaska Commission on Aging, Governor's Council on Special Education and Disabilities, Suicide Prevention Council and the Council on Domestic Violence and Sexual Assault. Also provided supervision to the Office of Faith Based and Community Initiatives.
In conjunction with directors, ensured each entity or agency met or exceeded performance goals while maintaining alignment with overall department vision, mission and values.

2003-2005 Alaska Department of Health & Social Services, Division of Behavioral Health; Juneau, Alaska - Director

Was responsible for directing, planning, organizing and managing statewide programs for mental health and substance abuse (behavioral health). Formulated policy for community mental health services, the state psychiatric center and community programs for those experiencing substance abuse problems. Monitored program performance, reviewed and evaluated existing policies, procedures, statutes, regulations and recommended changes as appropriate. Oversaw all Division program and policy functions, coordinated administrative and financial activities with other components of the Department and designed and implemented the Division's performance management program. Oversaw the integration of the mental health and substance abuse service delivery system (behavioral health) as well as the development and implementation of the "Bring the Kids Home" Initiative. This initiative, designed to bring Alaskan kids with a serious emotional disturbance back to the state from out of state Residential Psychiatric Treatment Centers – and to keep kids in Alaska - by building a comprehensive system of care and proactively managing care – is considered a model program. Developed the conceptual framework for the creation of Regional Behavioral Health Authorities designed to manage care for all behavioral health services provided to Seriously Emotionally Disturbed (SED) Children and Seriously and Persistently Mentally Ill (SPMI) adults. The Division of Behavioral Health has 320 staff with a budget of $275 million.

1998-2003 Life Quest, Wasilla, Alaska – Chief Executive Officer – Was responsible for designing, developing, implementing and managing all prevention, treatment and rehabilitation services in a private not for profit community mental health center. The organization served over 1200 individuals annually in a geographic area comparable to the size of the state of West Virginia. The agency employed 150 staff with a budget of $6.5 Million.

1997-1998 National Association of Social Workers, New York State Chapter, Albany, NY – Executive Director – Served as chief executive and was responsible for planning, organizing, directing, and implementing all chapter programs and activities. Had management responsibility for all administrative, financial, human resource, marketing, and educational functions. The New York Chapter was the largest of all NASW Chapters with approximately 12,500 members.

1993-1997 Southwest Mississippi Mental Health (SWMMH) Complex, McComb, MS – Executive Director – Responsible for directing, planning, coordinating, operating, and monitoring all mental health, developmental disabilities services and substance abuse programs within ten counties of Mississippi. Served as Chief Executive Officer of the SWMMH Commission and President of the SWMMH Foundation. Was administratively responsible for the supervision of 200 staff members and consultants, and a $6.5 million annual budget. Was instrumental in preparing Mississippi mental health providers for Medicaid Managed Care through the creation of a community mental health provider network.

1986-1993 Colonial Community Services Board, Williamsburg, VA – Coordinator – Planned and coordinated mental health and substance abuse prevention, treatment, and rehabilitation services in York County and the City of Poquoson, Virginia. Supervised 12 staff members and consultants. Maintained a caseload of 50 clients.

1987-1993 Systemetrics – Medical Record Reviewer/Analyst – Responsible for reviewing both care coordination and mental health records in outpatient, residential and acute inpatient settings in the first mental health managed care program undertaken by the Dept. of Defense.

1990-1993 Catholic Charities of Hampton Roads, Virginia Beach, VA – Private Practitioner – Provided individual, couple, and family therapy in a managed care environment. Member of managed care provider panel. Experienced obtaining preauthorization for services and complying with all managed care requirements.

1990-1993 Virginia Commonwealth University, Richmond, VA – Adjunct Faculty Member – Supervised gradate-level students.

1984-1986 Essex County Community Services Board, Elizabethtown, NY – Director – Planned, coordinated, and served as chief executive of mental health and substance abuse prevention, treatment, and rehabilitation programming in Essex County, N.Y. Supervised 28 staff members.

1982-1984 Appalachian Mental Health Center, Developmental Disabilities Program, Elkins, WV – Director – Developed, directed, and coordinated services for developmentally disabled children and adults in four counties in West Virginia. Supervised a staff of 26.

1980-1981 Appalachian Mental Health Center, Barbour County, Philippi, WV – Director – Coordinated and ensured the delivery of mental health and substance abuse services to county residents. Maintained a caseload of 35 clients and supervised a staff of 12.

1979 West Virginia University Center for Extension and Continuing Education, Morgantown, WV – Graduate Social Work Intern – Facilitated the planning and implementation of the Cooperative Extension Leadership Development Program, which included program-evaluation mechanisms, project planning, and grant writing

1979 Summit Center for Human Development, Clarksburg, WV – Graduate Intern and Staff Member – Developed and implemented a primary prevention project in a small mining community. Involved grant writing, developing and conducting needs-assessment surveys, organizing community education programs, and revitalizing the Harrison County Mental Health Association.

1975-1978 Oswego County Community Mental Health Center, Oswego, NY – Social Work Assistant – Developed community support programs for long-term psychiatric

clients. Acted as the liaison to state hospitals and provided case-management services to 50 clients.

PUBLICATONS AND PRESENTATIONS

Mental Health in Rural Alaska-What's Different. Party Lines, a publication of the National Association for Rural Mental Health, Summer 1999 edition.

Collaborative Services and Professional Roles for Non-Psychiatrists. Presented at the 1997 Primary Care/Behavioral Healthcare Summit, The Leadership Forum on Integrating Behavioral Healthcare and the General Medical Sector in Chicago, Illinois.

Grief and Death Issues: Working with Families Having Medically Fragile and Terminally Ill Children. Presented at the 1995 Mississippi Department of Human Services Regional Conference in McComb, Mississippi.

Successful Mental Health Program Development for Children in a Small Community. Presented at the 1987 Virginia State Social Work Conference in Williamsburg, Virginia and the 1988 National Council of Community Mental Health Centers Annual Meeting in Boston Massachusetts.

Protecting and At-Risk Disabled Adult in the Community. Presented at the 1983 Behavioral Health Conference at West Virginia University in Morgantown, West Virginia.

The Development of a Good-Neighbor Program: Using Local Resources as Federal Funds Disappear. Presented at the 1982 Behavioral Health Conference at West Virginia University in Morgantown, West Virginia.

Rural Psychiatric Rehabilitation: Effective Techniques in Selecting, Monitoring, and Evaluation the Progress of State Mental Health Clients in the Community. Presented at the 1979 National Council of Community Mental Health Center Annual Meeting in Washington, D.C.

Development of a Rural Psychiatric Aftercare Group, in the Psychosocial Rehabilitation Journal, Volume 2, Number 1, 1978.

References

Mr. Jeff Jessee, Chief Executive Officer, Alaska Mental Health Trust Authority; Anchorage, Alaska. 907-269-7963. jeff.jessee@alaska.gov

Mr. Joel Gilbertson, Vice President, Providence Health Systems; Anchorage, Alaska. 907-743-2784. Joel.Gilbertson@providence.org

Mr. Rod Betit, Chief Executive Officer, Alaska State Hospital and Nursing Home Association; Juneau, Alaska. 907-586-3881. rodbetit@msn.com

Robyn Chaney
PO Box 25
Dillingham, AK 99576
907-842-1253

Objective

Appointment to the Alaska State Board of Dental Examiners

Experience

Childcare & Pre-school

6/2002-present

- Provide in-home childcare and pre-school
- Infant/child CPR trained
- Care for children with severe allergies

Respite & Elder Care

9/2003-present

- Palliative care of one elder
- Assist with daily living & household chores
- Provided end-of-life care for terminally ill elder

Contract Employee

Annually Dillingham City School District, Dillingham, AK

- Migrant Education parent recruitment
- Federal Impact Aid recruitment and data compilation
- Substitute teacher

Education

1992-1995 Dillingham High School, Dillingham, AK

- Valedictorian

1995-1998 Stanford University, Palo Alto, CA

- President's Scholar
- Studied Human Biology, Japanese

Volunteer

Alaska Migrant Education Parent Advisory Committee
Dillingham City Schools Federal Programs Parent Advisory Committee
Dillingham City Schools Budget Committee
Dillingham City Schools ITLC Culture Class Teacher

References

References are available on request.

Mary Anne Navitsky DDS.
300 Monastery Street, Sitka AK. 99835
Phone: 907-747-6464 Fax 907-747-4861

Curriculum Vitae
for
Mary Anne Navitsky, D.D.S.

Education

Doctor of Dental Surgery, University of Iowa; Iowa City, Iowa, 1985
US Department of Education, Indian Fellowship (4 years)
Carmichael Award
Sealaska Heritage Foundation Scholarship
USPHS Internship, Pine Ridge Reservation, South Dakota
Royal College of Dentistry, Arrhus, Denmark, Exchange Student

Bachelor of Science; University of Washington, Seattle, Washington 1981
Major: Microbiology
Association of American Indian Physicians workshop
Don Bassett Award, Department of Microbiology
ANB/ANS Scholarship

Harvard University, Cambridge, Massachusetts, 1978, 1979
Harvard Health Careers Program

Association of Arts; Sheldon Jackson College; Sitka, Alaska 1978
Alaska Federation of Natives Externship
Incentive Award

Professional Membership

American Dental Association; 1985 to present
Alaska Dental Society ; 1985 to present

Professional Licensure

Alaska State Dental License

Awards

Eight Stars of Gold Citizenship Award
Steve Cooper award; 1990
PHS Public Health Service for promoting dental hygiene in Southeast Alaska; 1991
Certificate, American Dental Association Institute for Diversity in Leadership; Kellogg School of Management, North Western University, 2005

Statement

After serving six years with the United States Public Health Service, I have established my own private practice in my hometown of Sitka, Alaska. In the Navitsky Dental Clinic, I have provided care for the last eighteen years, managing all aspects of my clinic. In a community with many limitations, my practice is handicap accessible.

In Sitka, my practice is focused on prevention, restoration, fixed and removable prosthodontics, oral surgery, and dental education of the patient's investment in their dental needs and care. As part of the community, my practice determines and offers pro bono dental care every year for special need cases. We provide a yearly open house for kindergarten school children for early dental education. We also support long term facilities, such as the Sitka Pioneer Home, Sitka Community Hospital Resident Care, and the Sitka Against Family Violence with dental care and supplies.

Deborah W. Stauffer
3843 Eastwind Drive
Anchorage, AK 99516
(907) 345-1877
dstauffer@gci.net

OBJECTIVE: To serve as a member of the Alaska Board of Dental Examiners

QUALIFICATIONS

Strong background in dental hygiene clinical procedures and processes; program evaluation; educational methodology; curriculum development and evaluation. Excellent oral and written communication and proofreading skills. Creative problem-solver.

EDUCATION

1970	Certificate in Dental Hygiene, Temple University; Philadelphia PA
1975	B.S. in Interdisciplinary Studies, University of Alaska, Anchorage; Anchorage AK
1977	Dental Auxiliary Faculty Training Institute, University of Washington, Seattle WA
1982	M.S. in Vocational Education, University of Alaska, Juneau (currently named the University of Alaska Southeast); Juneau AK
1987	Ed.D. in Higher and Postsecondary Education, secondary emphasis in Educational Administration and concentration in Continuing Professional Education; University of Southern California, Los Angeles CA
1970-present	Various formal continuing professional development courses in dentistry and education

LICENSES AND CERTIFICATIONS

Alaska Dental Hygiene License – AA0088 – Held since 1971
Alaska Local Anesthesia License – AK 0014 – Held since 1982
Healthcare Provider (CPR) certification – Held since approximately 1975
Pennsylvania Dental Hygiene License – DH3593 (inactive) – 1970

EMPLOYMENT

2004 – 2006 *Doctoral Committee Member, University of La Verne*, LaVerne CA.
Emphasized University Student Services

2004 *Education Consultant, Cook Inlet Tribal Council, Inc.*, Anchorage
Developed entrepreneurship curriculum and student and teacher workbooks, and provided training to instructors geared to the Alaska Native population.

2001-present *Temporary Clinical Dental Hygienist*, Anchorage AK

Provide dental hygiene treatment services and health education for patients in general practices.

2001- present *Educational Consultant, International Training Institute*, Anchorage AK
Evaluate online interactive multimedia training curriculum for dental professionals.

2001 *Associate Dean for Academics, UAA College of Health, Education, and Social Welfare*
Administered all aspects of student-, program-, and curriculum-related issues for undergraduate and graduate programs in education, justice, social work, physical education, nursing, and human services. Taught clinical dental hygiene courses.

1990-1993 *Doctoral Program Manager and Adjunct Professor, Oregon State University*, Corvallis OR
Conducted student applicant recruitment, managed the program, and taught two classes for an off-campus (Anchorage) doctoral program in Vocational Education. OSU selected ten students and, in coordination with the dean and myself, developed a program that would meet the advanced education needs of this cohort group. Seven graduated and the remaining quit the program for personal reasons.

1988-2000 *Associate Dean for Academics, UAA College of Career and Vocational Education* (now known as the Community and Technical College)
Administered all aspects of student-, program-, and curriculum-related issues for approximately 30 career fields. Provided staff development for the College for as many as 75 full-time and 100 adjunct faculty per semester. Led the development, revision, and approval process for all noncredit, undergraduate, and graduate courses. Served as the program chairperson for Emergency Medicine and Fitness Technology. Presented numerous training and informational workshops for staff, potential students, matriculated students, and families about career selection, college choice, financial aid, and job-seeking skills as part of my responsibility for seeking potential students for all programs. Developed, conducted, and evaluated marketing strategies for all College programs. Recruited students. Supervised staff positions. Chaired and served on numerous search committees for faculty, staff, and administrative positions. Represented the College on all relevant University committees. Conducted statistical analyses of student- and program-related populations and issues. Taught face-to-face and online dental hygiene and graduate teacher education courses.

1975 – 1988 *Served as Teacher through tenured Professor of Dental Hygiene, UAA Dental Hygiene Program and Department of Dental Programs*

Helped to establish the first dental hygiene program in Alaska. Developed curriculum and taught all dental hygiene courses (except pharmacology) and also taught radiology, dental anatomy, and oral health education courses to dental assisting students. Served on numerous university and college committees, including faculty governance, curriculum, faculty and staff searches, and student recruitment and advising. Helped coordinate the merging of dental hygiene and dental assisting programs into one department with core courses. Served as chair of the department 1983-87. Hired adjunct faculty, supervised staff, developed budgets, and monitored finances. Led and/or was a member of accreditation and program review committees. Led community advisory committees. Developed, evaluated, and revised self-instructional aids.

1971-1975 *Clinical Dental Hygienist, Luther L. Paine, D.D.S.,* Anchorage AK.

Provided dental hygiene treatment and health education for patients in a general practice.

1970 *Clinical Dental Hygienist, Red Cross Volunteer*, Karamursal Air Station, Turkey

Provided dental hygiene treatment and health education for military personnel, dependents, and Turkish national patients.

COMMUNITY AND PROFESSIONAL SERVICE

2004-2006	UAA Graduate Committee member emphasizing Adult Education
2001-present	Academic advisor to students enrolled in various disciplines
2000	Dental Health Team member for World Special Olympics, Anchorage Alaska
1999-2005	Dental Health Team member for Alaska Special Olympics
1988-1999	Anchorage College and Career Fairs: Workshop organizer and presenter for various topics emphasizing career choice, education topics, and academic advising
1988-2000	Southcentral District Dental Society: Dental hygiene liaison
1980-1987	American Heart Association, Alaska Chapter: CPR instructor
1979	State of Alaska: Health curriculum evaluator
1976-1999	Dental health education and screening workshops for students, teachers, and school nurses, Anchorage School District
1976-1988	Dental continuing education presenter for Anchorage Community College
1975-2000	Various leadership positions for the Alaska State Dental Hygienists' Association and the Cook Inlet Dental Hygiene Association including President, Vice President, Secretary, Treasurer, Alternate Delegate to

	President, Vice President, Secretary, Treasurer, Alternate Delegate to the American Dental Hygienists' Association, Committee Chairperson of Continuing Education, Employment, Dental Health Education, and member of numerous committees and ad hoc groups
1970	Presided over the first Annual Session of the Pennsylvania Student Dental Hygienists' Association meeting

REFERENCES

Rebecca Poling, D.D.S., M.S., International Training Institute, 1000 O'Malley Road, Anchorage, AK 99515, (907) 351.1054, snowbird@alaska.net

Thomas G. Hipsher, D.D.S., 2000 Abbott Road, Suite 100, Anchorage AK 99515, (907) 349.5585, tgh@gci.net

Fred Summerfelt, RDH, M.Ed., 997 Sterling Lane, Flagstaff AZ 86001, (928) 779.3623, fred.summerfelt@mac.com

Curriculum Vitae

Clifford Douglas White, D.D.S./M.P.H.
CAPTAIN, USPHS (Retired)

Kanakanak Hospital
P.O. Box 130
Dillingham, Alaska 99576
Phone: (907) 842-5245
FAX: (918) 842-9517

January 06, 2009

Clifford D. White, D.D.S./M.P.H.
CAPTAIN, USPHS (Retired)
January 2009

EDUCATION:

Degree Programs

June 1982 — Doctor of Dental Surgery
University of Iowa Dental College, Iowa City, Iowa

June 1978 — Pre-dental Course of Study
Adams State College, Alamosa, Colorado

June 1976 — Bachelor of Arts, Majors in Marketing and Business Administration
Adams State College, Alamosa, Colorado

POST GRADUATE TRAINING

May 1991 — Masters of Public Health
University of Oklahoma, Norman, Oklahoma

PROFESSIONAL LICENSES/CERTIFICATIONS:

State of Oklahoma	License #4733	December 31, 2009
State of Colorado	License #5912	February 29, 2010
State of Alaska	License #1113	December 31, 2009

WORK EXPERIENCE:

Apr. 2004 To Present — **Chief Dental Officer**
Bristol Bay Area Health Corp., Kanakanak Hospital, Dillingham, Alaska

On April 01, 2004 I retired from the United States Public Health Service and assumed the same responsibilities and job title for BBAHC, as a civilian dentist.

Aug. 1997 To April 2004 — **Chief Dental Officer (O-6 billet)**
Bristol Bay Area Health Corp., Kanakanak Hospital, Dillingham, Alaska

Since coming to the Dillingham area seven years ago, I have come to appreciate the many difficulties in providing dental services in bush Alaska. My prior training and experience hardly prepared me for the special needs of my service population. The dental needs in isolated fishing villages are so much different

than rural 'Lower-48' Indian communities. I have increased patient access through better use of the facilities, improved patient awareness of dental disease through prevention activities, and provided dental services to Alaska natives wanting care through increased efficiency and motivation of staff.

- Supervise 4 dentists, 2 dental hygienists, 13 dental assistants, 2 administrative assistants, and a dental insurance clerk.
- Supervise the dental aspect of two HRSA grants that provide dental services to underserved populations.
- Helped plan and initiate an orthodontic program for the Bristol Bay area.
- Assisted with a $250,000 OPEL grant that was awarded to my program for the purpose of researching the dental decay process in remote villages.
- Initiated training of entire dental staff to become part of IHS demonstration program, dealing with diagnosis and treatment of dental decay using medical model.
- Coordinated training of professional staff in conjunction with the Air Force in Arctic Survival due to extensive bush travel in winter months.
- Designed new 16 chair dental clinic for construction beginning in near future.
- Provide comprehensive dental care to a native and non-native service population spread over 46,000 square miles in rural (bush) Alaska.
- Provide onsite dental services to 24 remote villages. Necessary to transport dental equipment and staff into villages by small aircraft.
- Manage an extensive prevention program that includes all villages.
- Because of remoteness, provide comprehensive oral surgery, endodontic, pediatric, periodontal, and prosthetic services, since specialty services are not otherwise available.
- Initiated methods I designed in Oklahoma, to improve patient scheduling, dental assistant utilization, dental chair usage, and efficiency of the clinic.
- Supervise, coordinate, and schedule 5-6 contracting dentists and several TDY dentists who provide dental services at various times throughout the year.

Aug. 1993 to Aug. 1997 **<u>Chief Dental Officer (O-6 billet)</u>**
Creek Nation-Okmulgee Dental Clinic, Okmulgee, Oklahoma

- Provided expertise in starting Expanded Function Program at the Claremore Hospital Dental Clinic. Scheduling examples were demonstrated and dental assistant usage was verified for proper clinic usage.
- Managed Okmulgee Health Center as the Facility Director for one year in addition to my dental responsibilities. The clinic was staffed by 2 physicians, 8 medical support staff, 3 dentists, 10 dental support staff, 1 pharmacist, and 5 medical records personnel. Annual budget was in excess of 2 million dollars. I interviewed and hired the majority of this staff

- Set up Policy and Procedures manuals for new clinic, as well as, all operational manuals needed for JCAHO accreditation.
- Supervised 3 dental clinics supported by 5 dentists, 12 dental assistants, 1 hygienist, 2 office clerks,
- Designed, organized and initiated a Crown and Bridge Program with tribal bingo funds in 1995, which provided recurring yearly funds.
- Designed, organized and initiated Denture and Partial Program with National Council funding in 1995, that provided funds through 1997.
- Designed and set-up new 12-chair dental clinic in Okmulgee, which opened in March of 95. I installed most of the equipment, cabinetry, and plumbing during my own time, because reliable installers could not be found in a timely manner.
- Member, Hospital and Clinics Governing Board for 2 years, which managed the entire Health Care System.
- Member of Division of Health Administration (DHA) Compensation Committee.
- Member of Division of Health Administration Executive Management.
- Member, Service Unit Infection Control Committee.
- Member, Service Unit Quality Improvement Committee.
- Member, Creek Nation Eligibility Committee.
- Okmulgee Facility Safety Officer.
- Member of Health Careers Advisory Committee with local Vo-tech.
- Provided PTA and grade school instruction on dental health prevention.
- Designed and implemented tribal orthodontic program in 1994.
- Designed and implemented tribal staff evaluation program.
- Member of several area-wide committees (Efficiency Design Team, Residency Utilization Committee, Yearly Area Dental Meetings, and Equipment Usage Committee).
- Instructor, the University of Oklahoma Preceptor Program.

Sept. 1991 to Aug. 1993 **Chief Dental Officer (O-6 billet)**
Sapulpa Indian Health Center, IHS, Sapulpa, Oklahoma

- Supervised 3 clinics supported by 4 dentists, 9 dental assistants, 1 hygienist, and 1 office manager.
- Because of success of efficiency model, all waiting lists were eliminated and patients could call for appointments for comprehensive care at anytime.
- Member, Creek Nation Hospital and Clinics Governing Board.
- Member, Creek Nation Executive Committee.
- Member, Sapulpa Clinic Infection Control Committee.
- Member, Creek Nation Quality Improvement Committee.
- Safety Officer, Sapulpa Indian Health Center.
- Test site for several new dental products and equipment (dental burs, prophy angles, impression materials, handpieces, etc.).

- Served on the Area Efficiency and Effectiveness Committee.
- Organized and coordinated annual Oklahoma Area Dental Meeting 1993.
- Proposed and initiated several dental programs to the Creek Nation with alternative funding.
- Completed a Masters of Public Health degree, using personal time.
- Formulated and initiated a pilot orthodontic program for Creek Nation with special bingo funds.
- Wrote a comprehensive Dental Quality Improvement Manual that was approved by the Health Board.
- Completed standardization of all dental clinics within Creek Nation.
- Completed a standardized Dental Policies and Procedures Manual for Creek Nation.
- Maintained an exceptionally high productivity level despite under-staffed clinic.
- Participated in and organized several Community Health Fairs and school-based programs involving prevention activities and health promotion and disease prevention activities dealing with both medical and dental needs.

Sept. 1989 to Sept. 1991 **Chief Dental Officer (O-5 billet)**
Sapulpa Indian Health Center, IHS, Sapulpa, Oklahoma

- Responsible for 3 separate dental clinics (Sapulpa, Okmulgee, and Eufaula) which were supported by 4 dentists, and 8 dental assistants.
- Service Unit Dental Prevention Officer.
- Chairman, Oklahoma Area Promotional Materials Committee.
- Sapulpa Clinic Safety Officer.
- Chairman, Creek Nation Infection Control Committee.
- Member, Creek nation Quality Assurance Committee.
- Continued to work on Master of Public Health degree.
- Initiated a Denture Program for the elderly with special funding for1990 fiscal year.
- Started standardization of dental clinics within the Creek Nation.
- Participated in many Health Fairs and local school systems with health promotion and disease prevention activities, such as smoking cessation, diabetic training, and oral hygiene education.

Sept. 1986 to Sept. 1989 **Facility Dental Officer (O-4 billet)**
Sapulpa Indian Health Center, IHS, Sapulpa, Oklahoma

- Responsible for Sapulpa Dental Clinic with staff of 1 dentist and 2 dental assistants.
- Responsible for coordinating information from the Sapulpa, Okmulgee and Eufaula dental clinics.

- Chairman, Oklahoma Area Promotional Materials Committee .
- Creek Nation Prevention Officer.
- Chairman, Sapulpa Clinic Safety Committee.
- Chairman, Sapulpa Clinic Infection Control Committee.
- Member, Sapulpa Clinic Quality Assurance Committee.
- Instructor, University of Oklahoma Dental Preceptor Program.
- Instructor for several dental assisting programs (2 Vo-Techs, & Bryant Institute).
- Started work on a Masters of Public Health at the University of Oklahoma, spring semester, 1989.
- Responsible for Sapulpa Dental Clinic with staff of 1 dentist and 2 dental assistants.
- Eliminated 4-year waiting list for adults by double booking and working extended hours.
- Stepped up community activities dealing with health promotion and disease prevention.

Aug. 1982 to Sept. 1986 **Facility Dental Officer (O-4 billet)**
Pawnee Indian Health Center, IHS, Pawnee, Oklahoma

- Responsible for Pawnee Dental Clinic with staff of 1 dentist, 2 dental assistants, and 1 receptionist.
- Chairman, Pawnee Service Unit Quality Assurance Committee.
- Member, Pawnee Service Unit Executive Committee.
- Eliminated 3-year waiting list for adults and children by working extended hours and implementing an effective and efficient dental program.
- Started comprehensive dental care for adults and children.
- Fluoridation of the Tri-County water system.
- Extensive community activities dealing with oral health.

PROFESSIONAL MEMBERSHIPS

1982-present	Commissioned Officers Association
1987-present	Association of Health Care Executives
1990-present	Reserve Officers Association
1990-present	Association of Military Surgeons of the U.S.
1997-Present	American Dental Association
1997-Present	Alaska Dental Society
1997-present	Coastal District Dental Society

AWARDS

PHS AWARDS

12/04 Unit Commendation
03/01 Unit Commendation
11/00 Unit Commendation
10/00 Unit Commendation

06/00 Outstanding Unit Commendation
02/99 Hazardous Duty Award
11/98 Unit Commendation
04/98 Commendation Medal
03/98 Isolated Hardship Award
01/98 Bicentennial Unit Commendation
07/92 Public Health Service Citation
06/89 Unit Commendation
05/89 Achievement Medal
05/86 Outstanding Unit Citation
02/85 Unit Commendation
01/84 Public Health Service Citation
03/83 Isolated Hardship Award
03/83 Hazardous Duty Award

IHS AWARDS

11/99 Area Award – Innovation in Program Development for Early Childhood Caries Treatment and Prevention
06/97 Area Award - Providing Dental care at Lowest Cost Per Service Minute.
06/97 Area Award - Providing the Greatest Number of Service Minutes per Employee.
10/95 Letter of Recognition for Weekend Activities form Area Director.
03/93 Indian Health Service Clinical Excellence Award for most outstanding mid-career dental officer.
04/91 Area Award - Providing Dental care at Lowest Cost Per Service Minute.
04/91 Area Award - Providing the Greatest Number of Service Minutes per Employee.

CIVILIAN AWARDS

08/88 Certificate of Award, Boy Scouts of America.
08/87 Listed with Who's Who in the South & Southwest
03/85 Scouter's Key Award, Boy Scouts of America
02/85 Listed with Outstanding Young Men of America
09/84 Woodbadge Adult Leadership Award, BSA
02/84 Listed with Outstanding Young Men of America
05/82 American Academy of Periodontology Student Award
05/78 Listed with Who's Who Among Students In American Universities and Colleges
05/77 Listed with The College Register for excellence in Math
05/77 Listed with the International American Academy of Science

NAVY AWARDS

06/74 Viet Nam Service Medal
07/72 Republic of Viet Nam Campaign Medal
07/72 Viet Nam Service Medal
06/72 Combat Action Medal
06/72 Sharpshooter Medal

10/70 National Defense Service Medal

PERSONAL

The most important and enjoyable special skills I have revolve around keeping up with my seven children and seven grandchildren. They keep me directly involved with activities such as baseball, softball, t-ball, soccer, drama, dance, wrestling, track, etc., etc., etc. I enjoy working with the youth, especially in a Scouting capacity. I have been either a Scoutmaster or a Scouting Coordinator for the past 20 years. I enjoy any activity involving the outdoors. The activities I especially savor are big game hunting, rock climbing, rappelling, hiking, orienteering, pioneering, swimming, and horseback riding.

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Marriage & Family Therapy
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Kimberly K Horn

Mailing Address: P.O. Box 33472, Juneau, AK 99803

Residence Address: 4003 mendenhall loop Rd

City, State and Zip Code: Juneau AK 99801

Home or Message Telephone: ___ Business Telephone: 586-6037

Fax Number: w: 586-6250 Cell Phone: ___

Email address: Khorn@juneau.lib.ak.us

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES Y NO ___ Voter Registration Number (Optional): ___

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): ___

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES ___ NO Y if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES Y NO ___

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES ___ NO Y

If "YES", explain:

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TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

Certified Law Enforcement officer (1997)

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

Business Administration (college 2 years)
Forensic Interviewer (Children)
Sexual Abuse Training (Law Enforcement Related)

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

Board Critical Incident Stress management (CISM)
(about 10 years)
Outstanding Police officer medal (2007)

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

Communications (dispatcher) 1984 - 1990
Community Service officer, 1990 - 1997
Police officer 1997 - present
all Juneau Police Department

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: SEX: FEMALE F MALE _____

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White X

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Kimberly K Hart Date: 1-23-09

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Kimberly Horn Date: 1-25-05

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/ Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
X	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Kim Horn (Age): 49 of (Hometown): Juneau
is (Job title/Place of employment): Investigator, Juneau Police Dept
(Name) holds (Listing of earned degrees like bachelor's, master's,
ect.): Certified law enforcement officer since 1997
(Or list relevant experience to the position you are being appointed to)
Currently assigned to the Investigations Unit.

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

6-8-04

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION/RESUME FORM

~~BOARDS & COMMISSIONS~~

JUN 0 8 2004

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resumé. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission for which I am applying: MARRIAGE & FAMILY THERAPISTS

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Patricia A. White

Mailing Address: 6008 Lemon ST

Residence Address: Same

City, State and Zip Code: Juneau, AK 99801

Home Telephone: ___ Business or Message Telephone: 4635895

Fax Number: 463-3166 Cell Phone: —

Email address : ptwhite@gci.net

AS 39.05.100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter? YES X NO ___

Voter Registration Number (Optional): ___ Social Security Number (Optional): ___

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES ___ NO X If "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO ___

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES ___ NO X

If "YES", explain:

TRAINING AND EXPERIENCE: (If resumé attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

LMFT, 1992

B. List both formal and informal education and training experiences: (Use additional paper if necessary)

Please review attached resume

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time served.

please review attached resume

Gastineau Human Services Board member, vice president 1992-1994

D. Employment work history - paid, unpaid or voluntary: (Use additional paper if necessary)

please review attached resume

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH:_____

SEX: Male_____ Female X

ETHNICITY: Alaska Native___ American Indian___ Asian or Pacific Islander___ Black___ Hispanic___ White X

MILITARY SERVICE (if applicable, give dates):_____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Patricia Arkota Date: 5-22-04

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Patricia A. White

6008 Lemon Street
Juneau, AK 99801
(907) 463-5895 (w)

EDUCATION

8/73 – 5/75 Masters of Science, Rehabilitation Counseling, University of Arizona, Tucson, Arizona. Practicum and internships included the following:

- Internship with the student services for a small rural college in Wyoming. Responsibilities included tutoring and counseling for disabled students. Performed surveys to assess student needs. Developed residence hall activities, recruitment guide, and a film series and community forum. Led discussion groups. Served as advisor to student newspaper. Provided work-study supervision.
- Practicum placements as a counselor in alcohol treatment program and adolescent outpatient substance abuse clinic.
- Counseled disabled clients and families who were referred by the University's Rehabilitation Department.
- Volunteered as co-leader of Rehabilitation Department's Group Process course.

9/69 – 1/72 Bachelor of Arts, Sociology, State University of New York, Oneonta, NY. Co-developed crisis hot line sponsored by the University and operated by the students. Recruited and trained 100 volunteers to staff the "crisis hot line." Hired a coordinator to supervise the "hot line" operations upon graduation. Chairwoman, Experimental College, a college within the University provided for independent study and alternative educational programs. Within a committee, the Experimental College awarded academic credit for nontraditional course work.

WORK EXPERIENCE

Teaching:

1/89-present **Trainer:** Provide training for local nonprofit organizations. Develop and provide the needs assessment, training materials, training and evaluation based on the organization's needs.

1/89 –8/95 **Adjunct instructor**, University of Alaska, Southeast, Human Relations in the Workplace; Clinical Psychology, counselor training coursework. Developed curriculum; Instructed course; Evaluated student efforts.

Administrative and Clinical

8/88-present **Patricia White, M.S., L.M.F.T., Counseling Services,** 130 Seward Street Suite, 218, Juneau, Alaska 99801

Counselor, consultant and trainer in private practice. Provide counseling to individuals, couples, families, and groups. Training contracts with REACH, Inc., Catholic Community Services, Johnson Youth Center, and Bartlett Regional Hospital.

8/90 –8/93 **Human Affairs of Alaska, Juneau Affiliate.**

Provided Employee Assistance Program (EAP) Services to contracted Businesses for Human Affairs of Alaska, Anchorage, Alaska.

8/93 – 11/97 **Contractor** for EAP for Vasquez Management, United Behavioral Health, Greens Creek Mines and Echo Bay Mining Company. Provided EAP Counseling and referral services to the United States Postal Service, the United States Coast Guard, and other businesses of Juneau, AK.

7/88 – 9/89 **Southeast Regional Training Coordinator,** National Council on Alcoholism, Juneau Affiliate, 211 4th Street, Suite 102, Juneau, AK.

Coordinated relevant training events for substance abuse counselors, prevention workers, and administrators in Southeast region. Provided technical assistance to communities and agencies in Southeast region with regard to substance abuse, education, prevention, treatment and rehabilitation. Coordinated video training programs and course work for counselor certification. Maintained supporting library and student files.

8/87 –7/88 **Clinical Services Supervisor/Program Director**, City and Borough of Juneau, Department of Health and Social Services, Division of Chemical Dependency, 3406 Old Glacier Highway, Juneau, AK 99801.

Administrative: Responsible for outpatient clinic's compliance with state and federal funding guidelines; policy and procedures manual; grant writing; record keeping; billing and client flow systems. Coordinated all referring agencies; collaboration of substance abuse services in the Borough including the School District's student assistance program.

Clinical: Supervised six full time counselors and three contract counselors in delivery of direct therapy services to 600 clients per year. Counselors worked in a hospital-based treatment program or an outpatient clinic. Responsible for the maintenance of state and federal standards for sound clinical approaches to addiction treatment and rehabilitation.

12/78 – 8/79 **Probations Subsidy Counselor Consultant to Cochise County Juvenile Court**, Cochise County Juvenile Court Center, P.O. 4219, Bisbee, AZ 85603.

Worked under the guidelines of Arizona Supreme Court. Developed and implemented a first offender program. Provided counseling for juvenile first-time felony offenders and families. Assessments, report writing, compliance with State of Arizona guidelines, and regular court appearances.

1/76 – 8/79 **Detention Home Parent**, Cochise County Juvenile Court Center, P.O. Box 4219, Bisbee, AZ 85603.

Worked with Center's director and probation officer. My husband and I provided 24 hour care, recreation and support counseling for up to 20 juveniles in detention. The facility provided housing for those incarcerated and those under protective care of the county.

3/72 –3/73 **Counselor**, Tucson Awareness House, Inc. Tucson, AZ

Provided counseling, crisis intervention, referrals, and recreational activities to clients and families. Team leader 12/72 in charge of training and scheduling counselors and volunteers, and coordinating all of the Eastside House activities.

Volunteer Work

1992-1994 **Board Member/Vice President,** Gastineau Human Services, Juneau, AK.

1989-1991 **Advisory Board Member,** Wellness Program, Juneau Racquet Club, Juneau, AK

1985-1987 **Secretary/Member,** Alaska Alcoholism and Drug Abuse Counselor Certification Review Board, a statewide, private nonprofit corporation for the certification of drug and alcohol counselors in the State of Alaska.

Membership: American Counseling Association.
Licenses: State of Alaska Marriage and Family Therapist. No. AA0088

5/83 –8/87 **Rehabilitation Therapist**, City and Borough of Juneau, Department of Health and Social Services, Division of Chemical Dependency, 3406 Old Glacier Highway, Juneau, AK 99801.

Provided professional level alcohol and drug rehabilitation counseling for inpatient and outpatient setting. Led therapy sessions, delivered lectures, and applied knowledge of group dynamics to assist in problem resolution. Completed case studies and reports on services; provided reviews, case histories and diagnoses to determine trends and progress to gain insight for further treatment and referral. Assisted clients through crisis situations, and in recognizing and resolving denial solutions. Communicated with staff from auxiliary services and programs. Developed Patient Orientation Packets and certificates of completion, and developed and implemented a Student Assistant Program in the local school district.

11/82 –5/83 **Program Coordinator**, Gastineau Manor, Inc. a continuing care facility for the treatment of alcoholism, 306 West Eighth Street, Juneau, AK 99801.

12/80 – 6/82 **Counselor**, Cochise Community Counseling Services, Copper Queen Station, Bisbee, AZ 85603

Lead counselor for emotionally disturbed and delinquent youth. This year-long program included individual and group therapy for clients and families, recreational activities and tutoring. Worked closely with Arizona Department of Economic Security's Sierra Vista Office to resolve problems of foster homes, adoptions, and treatment of sexual abuse and rehabilitation of teenage substance abusers. Worked with local school districts' psychological and counseling services to improve clients' school experiences. Supervised four counselors and volunteers.

8/79 – 12/80 **Family Counselor**, Cochise County Juvenile Court Center, P.O. Box 4219, Bisbee, AZ 85635

Worked as itinerant social worker in five rural communities through referrals from five probation officers. Provided individual, family and peer group counseling. Made reviews and recommendations to the courts as well as appearing as an expert witness. Developed recreational and special projects for clients. Worked closely with adoptive and foster home and Child Protective Services. Performed chemical assessments and referred chemically dependent clients to treatment programs. Spoke to community service organizations to encourage financial support for special needs clients. Supervised two interns. Responsible to the Superior Court Judge of Cochise County and the Arizona Supreme Court.

Edward A. Hall
Physician Assistant-Certified
13601 Windward Circle
Anchorage, AK 99516
(907) 345-9365

Work History

August 2001-Present: Beacon Occupational Health and Safety Services, Anchorage, Alaska

-Provide family practice and occupational health care to private patients and contract clientele. These include all aspects of family practice healthcare, including travel medicine, pre-hire physicals, post offer/pre-hire assessments and work comp follow-ups. Also serve as Clinic Manager.

June 1994-August 2001: Primary Care & Associates, Anchorage, Alaska

-Provided family practice health care as well as occupational physical assessments and work comp follow ups. Care included all aspect of family practice medicine.

January 1990-June 1994: Kaiser Permanente, San Diego, California

-Health Appraisal Clinic-provided complete review of systems, physical assessments and appropriate referral for follow-up evaluations of health care members.

Education

-Emory University- Atlanta, Georgia- PA and Master of Medical Science Degree, 1990: 8 monthly required clinical rotations with 5 one month elective rotations, which included general surgery, orthopedics and trauma surgery rotations
-California State University Sacramento: BS-Biology-1979

Certifications/Licenses

- Alaska State PA License-AK 329
- National Commission Certification of Physician Assistants (NCCPA) since 1990
- Member Alaska Academy of Physician Assistants
- Breath Alcohol Technician Certified (BAT)
- Certified in Drug Collection
- DEA License MHO337964

Affiliations

- PA Member Alaska State Medical Board since 3//05
- Work Comp Review Committee for State of Alaska

Social

Married, four children ages 17,19,21,23

References available upon request.

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Medical Board, public seat
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Casey (Kathleen) M. Millar

Mailing Address: 15801 Windsong Dr.

Residence Address: "

City, State and Zip Code: Anchorage, AK 99516

Home or Message Telephone: 907-522-2251 Business Telephone:

Fax Number: Cell Phone:

Email address: millar@gci.net

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.) _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO X

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

See attached

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

See attached

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

Volunteer Server @ the Anchorage Rescue Mission
Volunteer hosting weekly staff meetings for Young Life - Alaska

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

See attached

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: ____ SEX: FEMALE X MALE ____

ETHNICITY:
Alaska Native ____ American Indian ____ Asian or Pacific Islander ____ Black ____ Hispanic ____ White X

MILITARY SERVICE (if applicable, give dates): ____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Casey (Kathleen) Mika Date: 11-25-08

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Casey (Kathleen) Millar Date: 11-25-08

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/ Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
X	Medical Board #1
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Casey Miller (Age): 51 of (Hometown): Anchorage
is (Job title/Place of employment): ASD / Student Nutrition.
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): _____.

(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

Lifelong Alaskan resident. Currently employed with the Anchorage School District, Student Nutrition. Previous small business owner. Married to Stuart Millar and mother of five grown children. Previously served nine years on a Private School Board. Interests include cooking, travel and catering small gatherings.

15801 Wind Song Drive (907)522-2251 Home
Anchorage, AK 99516

Kathleen (Casey) Millar

Experience

August 2006 - Present — Anchorage School District — Anchorage, AK

Cafeteria Manager I

- Prepare and serve meals for 180 students a day; accounting of daily receipts; and prepare purchase orders for meals at Bowman Elementary and Huffman Elementary;

1996 – 2007 — Steamers Espresso — Anchorage, AK

Owner/Operator

- Owned and operated a successful drive-thru coffee kiosk.

1996-2005 — Heritage Christian School — Anchorage, AK

School Board Member

- Worked on budget, policy, procedure manuals, accreditation, and overall governance and compliance issues for elementary and secondary private school.

1979 - 1982 — Municipality of Anchorage — Anchorage, AK

Purchasing Department/ Construction Bid Clerk

Administrative Secretary for the Division of Public Works Director

Education

1977–1978 — Mesa Community College — Mesa, AZ

- General Studies

1978-1981 — University of Alaska, Anchorage

- General Studies
- Certificate for Slingerland Studies

Other Certificates: Food Safety Certificate.

CURRICULUM VITAE

DAVID A. MILLER, MD, FACS

OFFICE ADDRESS: Alaska Minimally Invasive Surgery Center
3268 Hospital Drive, Suite C
Juneau, AK 99801

PERSONAL: (907) 586-4126

EDUCATION:	Leavenworth High School Leavenworth, Kansas	1981
	B.S. Chemistry University of Kansas Lawrence, KS	1985
	M.D. Allopathic Medicine University of Kansas School of Medicine Kansas City, KS	1989
POST-GRADUATE	Internship – General Surgery Keesler Medical Center Keesler AFB Biloxi, MS	1989-1990
	Residency – General Surgery Keesler Medical Center Keesler AFB Bilox, MS	1990-1994
BOARD QUALIFICATIONS:	Board Certified and Diplomate of The American Board of Surgery	1995-present
LICENSURE:	State of Alaska #4283	Exp. 12/31/08
PROFESSIONAL AFFILIATIONS:	American College of Surgeons	1996-present
	Society of Laparoendoscopic Surgeons	2000-present
	Society of Air Force Clinical Surgeons	1994-2001
	38th Parallel Medical Society	1994-2001
PUBLICATIONS:	H-Type Tracheoesophageal Fistula Repair, 41st Annual Symposium, Society of Air Force Clinical Surgeons, San Antonio, TX	1994

CURRICULUM VITAE

DAVID J. POWERS, M.D.
P.O. BOX 324
DILLINGHAM, AK 99576
(907) 842-5201 EXT. 6218 (HOSPITAL)
(907) 842-1028 (HOME)

EDUCATION:

College:	1974-1978, Northwest Nazarene College, Nampa, Idaho
Degree:	BA Biology, Minor in Chemistry
Honors:	Freshman Chemistry Student Award Senior Biology Student Award Salutatorian of 1978 graduating class Received academic scholarship Sophomore, Junior, Senior years
Medical School:	1979-1983, Oral Roberts University School of Medicine
Degree:	M.D.
Honors:	Graduated upper 1/3 of 1983 graduating class
PGY I:	July 1983 – July 1984, Family Practice Internship at A.H. Gould, Family Practice Residency Program, University of Colorado Affiliated, Grand Junction, Colorado
PCY II & III:	July 1987 – July 1989, Family Practice Residency of Idaho, Boise, Idaho
Certification:	Board Certified, American Board of Family Practice 2003-2010

OCCUPATIONAL EXPERIENCE:

1994- Present	Kanakanak Hospital, P.O. Box 130 Dillingham, AK 99576, Staff Physician. Currently Clinical Director
1992 – 1994	Emergency Room Physician, Boise, Idaho
1990 - 1992	Kanakanak Hospital, P.O. Box 130, Dillingham, AK 99576, Staff Physician.
1989 – 1990	Locum Tenens and Emergency Room work
1987 – 1989	Completed Residency Training, Family Practice Residency of Idaho, Inc., Boise, ID
1986 – 1987	Indian Health Service, Juneau, AK, General Practice
1984 – 1986	Alaska Native Medical Center, Anchorage, AK, General Medical Officer, Orthopaedics

William H. Doolittle, MD FACP
PO Box 71046
Fairbanks, Alaska 99707
(907) 456-8881

Education

Residency, Walter Reed General Hospital Internal Medicine
Intensive Care and Coronary Care Units, 1961-64
Internship, Womack Army Hospital, July 1960-61
MD, University of Vermont, College of Medicine, 1960
BS, University of Vermont, Bachelor of Science, 1957

Credentials Licensure

Medical License, State of Alaska
Fellowship, American College of Physicians, 1971
Certified by American Board of Internal Medicine, 1968

Professional Employment

Active Staff, Fairbanks Memorial Hospital, Fairbanks, Alaska, 1967-99
Chief, General Medical Section, Walter Reed General Hospital, Washington, D.C. 1967-68
Director, Arctic Medical Research Laboratory, Ft. Wainwright, Alaska, 1968-73
Courtesy Staff, St. Joseph Hospital, Fairbanks, Alaska, 1965-67
Chief of Medicine, Bassett Army Hospital, Ft. Wainwright, Alaska, 1964-67
Courtesy Staff, Montgomery General Hospital, Olney, Maryland, 1962-64

Appointments

Chief of Medical Staff, Fairbanks Memorial Hospital, Fairbanks, Alaska, 1974-76 and 1984-85
Director, Respiratory Therapy, Fairbanks Memorial Hospital, 1982
Director, Coronary / Intensive Care Unit, Fairbanks Memorial Hospital, 1981-82
Chief of Medicine, Fairbanks Memorial Hospital, Fairbanks, Alaska, 1973-74 and 1981-82
Clinical Associate in Medical Science, University of Alaska Fairbanks

Gubernatorial Appointments

State Health Coordinating Council
Alternatives in Health Care Financing Task Force
Medical Care Advisory Council, Department of Health and Social Services
Former, Violent Crimes Compensation Committee

Borough Appointments

Northern Alaska Health Resources Agency

Boards & Professional Memberships

Alaska State Medical Association
American Medical Association
American Association of Military Surgeons
American College of Physicians
Medical Advisor, North Pole Fire & Rescue
Greater Fairbanks Community Hospital Foundation, 1967 to Present
President / Founder, Fairbanks Internal Medicine & Diagnostic Center, 1974-Present
Consultant, Medical, Division of Vocational Rehabilitation, State of Alaska, 1975-84 and 2002 to Present
Member, Local Operating Board, Fairbanks Memorial Hospital, 1985 to Present
Consultant, Division Vocational Rehabilitation, State of Alaska
Medical Expert, Hearings & Appeals, Social Security Administration
Board of Directors, First National Bank of Fairbanks, 1980-99
Former Chairman, Planning Committee, Fairbanks Memorial Hospital Foundation
Chairman, Ethics Committee, Fairbanks Memorial Hospital, 1986
Member, Finance Committee, Fairbanks Memorial Hospital, 1986
Committee Member, Trust Committee, Alaska Bancorporation, 1980-82
Director, Cardiopulmonary Rehabilitation Program, Fairbanks, 1976-1981
President, Rotary of Fairbanks, 1978
Former Examining Committee, Alaska Pacific Bancorporation, and First National Bank of Fairbanks
President, Physicians' Services, Inc. An IPA, 1977-82
Board Member, Alaska Industrial Medicine, 1977-82
President, Amalgamated Leasing Co., 1978-
Former Consultant, Institute of Arctic Biology, University of Alaska Fairbanks
Consultant, Surgeon General, US Army (MRDC), 1974-78

Awards, Decorations, and Honorary Appointments

Fellow, American College of Physicians, 1972-Present
Paul Harris Fellow, Rotary International
Rotarian of the Year Award, Fairbanks Rotary, 1980
Physician of the Year Award, Alaska State Medical Association, 1977
Alpha Omega Alpha National Honorary Medical Society, 1968-Present
Army Commendation Medal (3 Clusters)
Meritorious Service Medal, US Army
Legion of Merit, US Army
Mosby Scholarship Award for Scholastic Excellence, 1959

Publications

Sumner, D. S., R. C. Simmonds, R.K. LaMunyon, M. A. Boller, and W. H. Doolittle: Peripheral Blood Flow in Experimental Frostbite. Ann. Surg. 171:1. 1970.

Sumner, D. S., T. L. Criblez, J. K. Novak, W. H. Doolittle: Prediction of Tissue Loss in Experimental Frostbite with Xenon-133. Surg. Gynec. & Obstet. 131:417-423. 1970.

Huibregtse, W. H., W. H. Doolittle, L. H. Hartley, and L. G. Jones: Improvement in Physical Fitness Associated with Walking Six Miles per Day for Ten Days. Abstract - Am. Physiol. Soc. 27 Aug- 3 Sep. 1970.

Doolittle, W. H.: The Impact of Living in Cold Environment on Coronary Risk Factors. Presented -Conference "Man's Health in a Changing Arctic Environment." Arctic Health Research Center. USPHS, May 1970.

Doolittle, W. H.: Of Stocks, Bonds and Cold Injury, Arctic Oil Journal, Dec/ Jan 1971.

Doolittle, W. H.: More on Cold Injury, Arctic Oil Journal. Feb/Mar 1972.

Sumner, D. S., J. A. Boswick, T. L. Criblez, and W. H. Doolittle: Predictions of Tissue Loss in Human Frostbite with Xenon-133. Surg. 69(6) 1971.

Doolittle, W. H.: Revision -TB MED -81 " Cold Injury" 1970.

Doolittle, W. H.: Revision -Chapter -4: "Cold Injury", NATO HANDBOOK, Emergency War Surgery, Dec, 1970.

Doolittle, W. H.: "Winter Survival," The Wainwrighter, Aug, 1971.

Sumner, D. S., T. L. Criblez, and W. H. Doolittle: Host Factors in Human Frostbite, V.139(6), Military Medicine, June, 1974.

Doolittle, W. H.: People Problems in the Cold. Abstract: National Safety Congress, Chicago. Ill., Oct. 1972.

Patton, J. F., and W. H. Doolittle: Core Rewarming by Peritoneal Dialysis Following Induced Hypothermia in the Dog, J. Appl. Physiol. 33(6): 800, Dec. 1972.

Huibregtse, W. H., L. H. Hartley, L. G. Jones, W. H. Doolittle, and T. L. Criblez: Improvement of Aerobic Work Capacity Following Nonstrenuous Exercise. Arch Environ. Health, 27:12-15, Jul. 1973.

Patton, J. F., W. H. Doolittle, and M. P. Hamlet: Peritoneal Clearance of Urea and Potassium Following Experimental Hypothermia. J. Appl. Physiol. 36:403-406, Apr 1974.

Doolittle, W. H.: "Disturbances Due to Cold", Current Therapy, H. F. Conn, Ed., 1976.

Ibid. Current Therapy, H. F. Conn, Ed., 1977.

Doolittle, W. H., John Hayward, William Mills, Martin Nemiroff, Tim Samuelson (Moderator): "Hypothermia and Cold Water Near Drowning Guidelines. Results of a Conference, July 1981, State of Alaska, EMS Section, Division of Public Health, Alaska Department of Health and Social Services, April 1982.

Doolittle, W. H.: "Disturbances Due to Cold" in Conn's Current Therapy 1986, R. E. Rakel, Ed., W. B. Saunders, Phila. PA, 1986. Pp933-938.

Presentation: Regional Meeting, American College of Physicians, Doolittle, W. H., "Health Care Circa 1995: An Alaska Perspective", Feb 21, '87.

Daniel P. Hoffman
911 Cushman Street
Fairbanks, AK 99701
(907) 450-6513
dphoffman@ci.fairbanks.ak.us

Work Experience Summary:

Throughout my twenty-year tenure with the Fairbanks Police Department, I have accepted position assignments and promotions encompassing increasing levels of instruction, management oversight, and program administration. Currently serving as the Chief of Police, I am responsible for all planning, budgeting, and daily operations of our fifty-one (51) member department, with an approved (2008) budget of $6.1 million. Extensive operational and administrative experience in the high-liability field of modern policing has resulted in my development of an extremely comprehensive administrative skill-set, with an emphasis on:

- Program and budget development/administration
- Proper employee training, with utilization of sound risk-management practices
- Federal and State of Alaska grant application and administration
- Knowledge of current "best practices" in human resource management
- De-escalation and conflict-resolution skills.
- Policy and procedure development and implementation.

In addition to internal department operations, the position of Police Chief requires extensive community involvement through participation on numerous task-forces, boards, and commissions. Outreach through local service groups and charity events, conflict-resolution with citizen's groups, and regular education/interaction with federal, state, and local political leaders is also required. Additionally, significant community interaction and education through speaking engagements, written editorials, formulation/publishing of departmental *Annual Reports,* draft and revision of an ongoing *Three Year Strategic Plan,* and routine media interaction are necessary to keep our populace engaged. This segment of my service, in particular, has enhanced what I believe to be a very strong communications skill-set, emphasizing:

- Exceptional written communication skills.
- Strong public-speaking skills, with the ability to assume leadership and facilitate discussion.
- Exceptional planning and research skills, preparing information for effective presentation. (See *FPD Reports* at http://www.ci.fairbanks.ak.us/departments/police/news.htm)

Education:

A.J. Dimond High School
Anchorage, AK
1979-1983

University of Alaska, Fairbanks
1983-1988
B.S. Degree: Wildlife Biology
Minor: Criminal Justice

F.B.I. National Academy
225th Session, April-June 2006
United States Department of Justice

University of Alaska, Fairbanks
2005-2008
M.A. Degree: Justice Administration

Law Enforcement Employment:

City of Fairbanks Police Department, 911 Cushman Street, Fairbanks AK 99701

-Patrol Officer: March 1989- May 1995
-Field Training Officer: March 1993-May 1995
-F.P.D. Tactical Team: January 1990- April 1998
-Patrol Sergeant: May 1995- April 1998
-Investigations Supervisor: April 1998-February 2002
-Patrol Lieutenant: February 2002-2003
-Director, Alaska Police Corps: Feb 2003- May 2004
-Deputy Chief: June 2004- February 2005
-Police Chief: February 2005- Present

Current Boards & Commission Service:

- Governor's appointee, *Alaska Police Standards Council* (current service as Chair)
- Board member, *United Way of the Tanana Valley*
- Member, *Police Professional Advisory Committee*- Alaska Municipal League
- Member, *Fairbanks Local Emergency Planning Committee*
- Member, *Fairbanks Golden Heart Project* (Community chronic inebriate task force)
- Commissioner, *Alaska Law Enforcement Agency Accreditation Commission*
- Board Member (Ex-Officio), Fairbanks *Volunteers in Policing*

Instructional Capabilities:

Given my combination of education and professional experience, I am well qualified and prepared to instruct in any areas pertaining to organizational leadership, public agency administration, application of human-resource issues, and general criminal-justice and security practices. As an APSC Certified Police Instructor, I am comfortable with both classroom and dynamic/interactive presentations. I have published instructional articles in numerous law enforcement publications on topics pertaining to public safety and effective community education/interaction, to include: *Police Magazine, Law and Order, 911 Magazine,* and the *F.B.I. Law Enforcement Journal.* In 2008, I was invited to present an instructional symposium on effective community and media-relations strategies for the *International Association of Chiefs of Police* conference in San Diego, CA.

Professional and Service Associations:

- Alaska Peace Officers Association (Vice President, Farthest North Chapter)
- Alaska Association of Chiefs of Police (Executive Board Member)
- International Association of Chiefs of Police
- Rotary Club of Fairbanks

REFERENCES AND LETTERS OF RECOMMENDATION AVAILABLE UPON REQUEST

MARY JANE MICHAEL
2421 Wellington Court
Anchorage, AK 99517
Michaelmj@muni.org
Office: (907) 343-4365

244-994

PROFESSIONAL EXPERIENCE

Executive Director 2003 - Present
Office of Economic and Community Development, Municipality of Anchorage

For the past five years I have served as an executive to the Mayor, responsible for promoting public and private economic development projects for the Municipality of Anchorage. Highlights have included the new Dena'ina Civic and Convention Center schedule for completion September of 2008, the transfer of the Museum from a public to private non-profit entity, the Library Renewal Initiative, the reorganization of the Parks and Recreation Department and the creation of the Parks Foundation. I have oversight for the rewrite of the Municipality's land use codes to be completed in 2008, completion of the Downtown Comprehensive Plan and the revitalization of one of our most underserved neighborhoods, Mountain View. In addition to spearheading many projects for the city I am responsible for an array of department including: the Port of Anchorage, the Planning Department, Heritage Land Bank and Real Estate Services, the Libraries, Parks and Recreation, and the Department of Neighborhoods and the Anchorage Community Development Authority. Responsibilities also include formulating and approving budgets for each department, spearheading departmental reorganizations, long range transportation planning for Anchorage, multimillion dollar grant proposals, real estate, capital improvement project planning and local, state and federal budget request formulation.

Executive Director and CEO 1999 to 2003
Anchorage Neighborhood Housing Services /
Anchorage Mutual Housing Association

I served as the Chief Executive Officer for Anchorage Neighborhood Housing Services (ANHS) a non-profit community development corporation dedicated to promoting affordable housing and neighborhood revitalization. ANHS is affiliated with the National Neighborhood Reinvestment Corporation and is certified as a Community Financial Institution. From 1998-2003 ANHS loaned $18 million and leveraged $34 million in first mortgages. Of the 545 loans made to low to moderate income families, 91 of those borrowers have been persons who experience a disability. Also under my direction was the sister organization, Anchorage Mutual Housing Association, which owned and managed 1,150 units of affordable rental housing in twelve locations citywide. Total assets for both companies at the time was 62.2 million relations, legislative affairs, and the overall administration of the organization. Duties also include the oversight of Anchorage Mutual Housing Association.

Executive Director 1981 to 1999
The Arc of Anchorage, Anchorage, Alaska

For 18 years served as the Executive Director for The Arc of Anchorage. I was instrumental in building an organization with an initial grant of $180,000 to more than 12 million. Programs included an array of services for persons with developmental and other disabilities including a day activity center, residential care, case management, in-home family services, respite, and specialized services for persons who experience dual diagnosis and emotional disturbances. I also sought funding, purchased, renovated and/or constructed more than 60 housing units, single and multifamily, to ensure safe, affordable housing for those we served. I worked with the Governor's office and the legislature on many issues facing persons with disabilities throughout the State of Alaska. Responsibilities included assets management, program development, grant writing, public relations, fundraising, legislative affairs, and advocacy on behalf of person with developmental and other disabilities and their families.

State Executive Director. 1982 to 1996
The Arc of Alaska, Anchorage, Alaska

In a dual role along with being the Executive Director for The Arc of Anchorage, I also coordinated statewide efforts for The Arc of Alaska. I was responsible for coordinating with the national office, The Arc of the United States on national issues facing persons with developmental disabilities, as well as statewide efforts.

University Research Assistant. 1986
Department of Human Services, University of Northern Colorado

Project assistant for research assessing the long-term care needs of elderly developmentally disabled adults in the state of Colorado. Included surveying existing services for the developmentally disabled and elderly and determining feasibility of integrated programs.

EDUCATION

1986 **University of Northern Colorado, Greeley**
Master of Arts in Rehabilitation Counseling with an Emphasis in Vocational Evaluation

1976 **California State University, Fresno**
Bachelor of Science in Therapeutic Recreation

BOARDS

2002-pres The Arc of Anchorage Foundation
2003-pres Anchorage Community Development Authority
2004-pres CIVIC Ventures Board of Director's

2005	Anchorage Community Land Trust
) - 2005	Anchorage Convention and Visitors Bureau
)03 - 2005	Alaska Native Heritage Center
2002 - 2007	Special Olympics of Alaska

AWARDS AND HONORS

2005	Heart of the City Award "Visionary Award" Downtown Partnership
2005/1996	YWCA Outstanding Professional in Chosen Field Nomination
1999	International People First Conference Award
1998	Gold Key Award (Key Campaign)
1998	People First Award for Support
1997	State of Alaska, Recognition, Harborview Closure
1991	Legislative Commendation for Services to the Developmentally Disabled
1990	Outstanding Service to the National Conference of Executive Directors/The Arc of the United States
1986	Kappa Delta Pi Honor Society
1984	The Arc Alaska Board Commendation
1984	The Arc Board Commendation

app midwife/172

Barbara Norton, CNM, ANP
3730 Rhone Circle, Suite 101
Anchorage ,AK. 99508
(907) 561-5152

Work Experience:

Midwifery & Women's Health @ Geneva Woods and Geneva Woods Birth Center. Full-scope midwifery care. Gynecology, prenatal care, intrapartum care both in the hospital and birth center setting, and postpartum care. June 1995-present

Alaska Women's Health Services. Full-scope midwifery in large collaborative group practice. July 1994-June 1995

Education:

Education Programs Associates, Campbell, California
Midwifery Certificate. April 1994

University of California, San Francisco. Masters of Science, Nursing, Perinatal Clinical Nurse Specialist. August 1988

Education Programs Associates, Campbell, California
Family Planning Nurse Practitioner Certificate. December 1985

University of Nevada, Reno. Bachelors of Science, Nursing. May 1978

University of Nevada, Reno. Bachelors of Arts, Social Services & Corrections. December 1974

References:

Available upon request

3-4-04

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532
907-269-7463(IVY)

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Nursing
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:
Health Care Strategic Planning Council

Name: Thomas J. Hendrix

Mailing Address: 3336 Sun Valley Drive, Eagle River, AK 99577

Residence Address: 3336 Sun Valley Drive

City, State and Zip Code: Eagle River, AK. 99577

Home or Message Telephone: (907) 622-3379 Business Telephone: -Same-

Fax Number: _____ Cell Phone: N/A

Email address: tjh@utaonline.net

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel reimbursement etc.): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO ✓ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES ✓ NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO ✓

If "YES", explain:

Fax Received
NOV 13 2006
Office of the Governor

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

See attached vitae

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

See attached vitae

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

See attached vitae

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

See attached vitae

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to ille[illegible]st you.

DATE OF BIRTH: ____ ____ SEX: FEMALE _____ MALE ✓

ETHNICITY:
Alaska Native ____ American Indian ____ Asian or Pacific Islander ____ Black ____ Hispanic ____ White ✓

MILITARY SERVICE (if applicable, give dates): U.S. Air Force 1/72 thru 5/94

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Thomas Hendricks, PhD, RN Date: 11/11/08

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Thomas J. Hendrix, PhD RN Date: 11/11/08

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fishermen's Fund Advisory & Appeals
	Forestry
	Game
1	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
✓	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
3	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Dr. Thomas J. Hendrix, PhD RN, (Age): 55 of (Hometown): New York City.
is (Job title/Place of employment): an assistant professor at the University of Alaska.
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): Bachelors Nursing, Masters Nursing, Masters Health Services Administration and PhD in Health Policy and Administration with an emphasis in Health Economics

(Or list relevant experience to the position you are being appointed to)

Examples: Nursing Professor since 2000 at UAA since 2006.

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

THOMAS J. HENDRIX
UNIVERSITY OF ALASKA ANCHORAGE, SCHOOL OF NURSING
ACADEMIC VITA

A. Current Position/Title and Rank

Assistant Professor

B. Licensure/Certification

Registered Nurse, AK; 1988-present (active)
Registered Nurse, UT; 1999-present (active)
ACLS, American Heart Association; 1988-96
Registered Nurse, FL; 1984-89 (inactive)
Registered Nurse, MS; 1983-85 (inactive)

C. Education (Year, Degrees and Institutions)

Year	Degree	Institution
2000	PhD *Health Policy and Administration/Health Economics*	The Pennsylvania State University, University Park, PA
1999	MS *Adult Health Nursing*	The Pennsylvania State University, University Park, PA
1994	MS *Health Services Administration*	Central Michigan University, Mt Pleasant, MI
1983	BS *Nursing*	University of Southern Mississippi, Hattiesburg, MS

D. Work History/Experience (Dates, job title, and institution)

Dates	Position	Institution
2006-present	*Assistant Professor*	University of Alaska Anchorage, Anchorage, AK
2000-06	*Assistant Professor*	University of Utah College of Nursing ,Salt Lake City ,UT
1995-99	*Teaching/Research Assistant*	The Pennsylvania State University, University Park, PA
1993-95	*Nurse Manager, Medical-Surgical Unit*	US Air Force, USAF Hospital, Minot ,ND
1993	*Assistant Nurse Manager, Medical-Surgical Unit*	US Air Force Hospital, Minot ND
1992-93	*Assistant Nurse Manager, Medical-Surgical Unit*	USAF Hospital Elmendorf ,AFB AK

1988-92	***Staff Nurse, Medical-Surgical Unit***	Elmendorf AFB ,AK
1987-88	***Nurse Manager, Primary Care Outpatient Clinic***	USAF Hospital , Patrick AFB, FL
1983-87	***Staff Nurse Multiservice Inpatient Unit***	USAF Hospital, Patrick AFB ,FL
1981-83	***Clerk Veteran's Administration***	University of Southern Mississippi, Hattiesburg, MS
1977-81	***Master Instructor***	USAF Keesler AFB, MS
1972-77	***Electronics Technician***	USAF: Eglin AFB FL; Ubon Thailand; and Davis-Monthan AFB AZ

E. **Honors/Prizes/Awards**

Honors in Nursing, 2006
Honors in Nursing, 2005
Sigma Theta Tau International Gamma Rho Excellence in Teaching Award, 2004
College of Nursing Faculty Spirit Award, 2004
Honors in Nursing, 2004
Meritorious Service Medal, USAF, 1995
Senior Nurse Award, Air Force Nurse Corps, 1995
Commendation Medal, USAF, 1988, 1992
Scholarship Medal, American Legion, 1983
Master Instructor Award, USAF, 1980
Instructor of the Quarter, USAF, 1980
Instructor of the Month, USAF, 1980
Commandant's Award, USAF, 1979
Academic Award, USAF, 1979
Instructor of the Month, USAF, 1978

F. **Area(s) of Specialization:**

Health policy, Health economics, Health care delivery systems, Assessment/Fundamentals, Medical-Surgical nursing.

G. **Current and Past Areas of Teaching Responsibility**

Doctoral Course: Nursing Health Policy (Course Coordinator)
Master's Course: Health Care Delivery Systems, Health Policy
Undergraduate Courses: Physical Assessment/Fundamentals (Course Coordinator), Nursing Care of Adults (Course Coordinator), Health Policy (Course Coordinator), Acute and chronic mental and physical illness, Leadership, Capstone, Health Disruptions I (Course Coordinator), Concentration in Clinical Nursing

H. Research, Scholarship, and Other Creative Work

Dates	Title
2006-present	Assessing the Student Learning of "Reflective Thinking"
2004-present	Quality Adjustment Weighting for Fibromyalgia Outcomes
2001-2002	The Direct and Indirect Costs of Fibromyalgia
2000	The Effect of Nurse Inputs on the Production of Quality in Nursing Homes (dissertation)

I. Publications

1. Journal Publications

Hendrix, T, O'Malley, M, Sullivan, C & Carmen, B. (Sept 08). Journal of Nursing Education. Submitted for publication, Sept. 08.

Hendrix, T, O'Malley, M & Karlsen, K. (Sept 08). Medical error reporting in America: a changing landscape. Quality Management in Health Care. Submitted for publication, Sept 08.

Hendrix, Thomas J. (Sept 2008). The Presidential Candidates' Health Care Policy Plans: An Analysis. The American Nurse: (accepted for publication in September 2008)

Kiss, T., O'Malley, M & Hendrix, T. (2008). Self Efficacy-Based Training for Research Literature Appraisal: A Competency for Evidence-Based Practice. Journal of Nursing Staff Development. (accepted for publication)

Hendrix Thomas J. (May 2008). Certificates of Need in Alaska: Do We Need Them? The Alaska Nurse: Volume 58 No. 2, pp. 8 – 11.

Hendrix, Thomas J. (February, 2008). Initiating Market Forces in Alaskan Health Care. The Alaska Nurse: Volume 57, No. 4, pg 8.

Ornes, L., & Hendrix, T.J. (2006). A balanced look at prescription drug re-importation. *Journal of Gerontological Nursing*, 32(8), 15-19.

Hendrix, T.J., & Kaufmann, K. (2003-04, Winter). Opinion: Will medical savings accounts save you money? *University of Utah Health Sciences Report, 27*(3), 33.

Hendrix, T.J. (2003). Commentary on the economic evaluation of specialist cancer and palliative nursing: Macmillan Evaluation Study findings. *International Journal of Palliative Care, 9*(10), 438.

Hendrix, T.J. (2003). Optimization techniques: Industrial production tools with applications in nurse staffing efficiency research. *Outcomes Management for Nursing Practice, 7*(4), 194-197.

Hendrix, T.J., & Kaufman, K. (2003). Another step toward medical savings accounts: Theory, politics, pros, and cons. *Policy, Politics, & Nursing Practice, 4*(1), 82-95.

Wassem, R. A., & Hendrix, T. (2003). Direct and indirect costs of fibromyalgia to patients and their families. *The Journal of Orthopedic Nursing, 7*, 26-32.

Hendrix, T.J. (2002). The uninsured, tax credits and crowd-out. *Policy, Politics, & Nursing Practice, 3*(2), 160-166.

Hendrix, T.J. (2000). Optimal long-term care nurse staffing levels. *Nursing Economics*, 164-75.

Scanlon, D. P., & Hendrix, T. (1998, Autumn). Health plan accreditation: NCQA, JCAHO, or both. *Managed Care Quarterly*, 52-61.

2. Conference Proceedings

Hendrix, T.J, O'Malley, M., et al. (2008). Assessing student learning through reflective journaling. In *Proceedings of the Western Institute of Nursing, Western Institute of Nursing Annual Conference*, Orange County, CA.

Hendrix, T.J. (2005). Health Savings Accounts: a New Opportunity for Nurses. In *Proceedings of the Advances in marketing and Healthcare Research meeting*, Lake Tahoe, NV.

Hendrix, T. J. (2004). Optimization Techniques: Industrial Production Tools with applications in nurse staffing efficiency research. In *Proceedings of the Advances in Health Care Research meeting*, Breckenridge, CO.

Hendrix, T. J. (2003). Another step toward medical savings accounts: Theory, politics, pros and cons. In *Proceedings of the Agency for Health Care Research annual meeting*. Jackson, WY.

Hendrix, T. J. (2001). Optimal nursing home staffing to minimize decubitus ulcer cost. In *Proceedings of the Academy for Health Services Research and Health Policy annual meeting*. Atlanta, GA.

Hendrix, T. J. (2001). Optimal nurse staffing for minimal decubitus ulcer costs in nursing homes. In *Proceedings of the Western Institute of Nursing, Western Institute of Nursing Annual Conference*. Portland, OR.

3. <u>Manuscript Reviews</u>

Nursing Research, 9/07
Nursing Research, 7/05
Nursing Research, 3/05
Nursing Research, 7/04
International Journal of Palliative Care, 3/03

4. <u>Abstract Reviews</u>

Western Institute of Nursing, 11/07

5. <u>Textbook Reviews</u>

Medical-Surgical Nursing, 9th edition, 12/07
Upper Respiratory Chapter
Lower Respiratory Chapter

J. **Invited Speeches/Lectures/Demonstrations/Presentations**

Mo/Yr	Title, Sponsor
5/08	Podium Presentation: Medical Error Reporting: Implications for Nurses (with O'Malley). New Directions in the New Frontier National Conference. Alaska Native Medical Center, Indian Health Service (IHS), IHS National Nurse Leadership Council.
4/08	Poster Presentation: Assessing Student Learning of Reflective Journaling (with O'Malley, et al.). Western Institute of Nursing Annual Conference.
4/08	Invited Session Chair: Self Concept and Illness. Western Institute of Nursing Annual Conference
4/08	Presentation: Assessing Student Learning of 'Reflective Thinking' (with O'Malley). Faculty Affairs Annual Brown Bag.
6/07	Podium Presentation: "Prescription Drug Re-Importation, Implications for Nurses", Mountains of Evidence of Practice, Learning Under the Midnight Sun
4/07	Presentation: Prescription Drug Re-Importation: Nursing Implications, Faculty Affairs Annual Brown Bag, Anchorage, AK.
11/06	Invited Panelist: "Health: at what price?" University Community Forums, Anchorage, AK.
3/05	Podium Presentation: "Consumer-Directed Healthcare Creates New Opportunities for Nurses," Association for Marketing and Healthcare Research Annual Meeting, Reno, NV.
3/05	Session Chair: "Health Management and Policy," Association for Marketing and Healthcare Research Annual Meeting, Reno, NV
3/05	Podium Presentation: "Consumer Health Creates Opportunities for Nurse Agents: A New Role," BYU Annual Nursing Research Conference, Provo, UT
3/04	Podium Presentation: "Optimization Techniques: Industrial Production Tools with Applications in Nursing Staffing Efficiency Research," Advances in Health Care Research Annual Meeting, Breckenridge, CO
3/04	Invited Session Chair: "Consumer Responses in Health Care," Advances in Health Care Research Annual Meeting, Breckenridge, CO
3/03	Invited Moderator: "Alternate Sources of Research Funding," University of Utah College of Nursing, Salt Lake City, UT
3/03	Podium Presentation: "Another Step Toward Medical Savings Accounts: Theory, Politics, Pros and Cons" (with K. Kaufman), Advances in Health Care Research Annual Meeting, Jackson, WY
7/02	Invited Podium Presentation: "Cost-effectiveness Analysis in Practice," University Hospital Pediatric Group. Salt Lake City, UT
4/02	Podium Presentation: "Understanding the Mechanism of Quality Adjustment, Salt Lake Teachers Association Spring Meeting Salt Lake City, UT
3/02	Podium Presentation: "Producing Quality Outcomes that are Hard to Measure," Utah Teachers Association Spring Conference, Salt Lake City, UT
3/02	Poster Presentation: "The Costs and Impact of Living with Fibromyalgia" (with R. Wassem), Issues in Nursing/Health Care Research Conference, Park City, UT

6/01 Poster Presentation: "Optimal Nursing Home Staffing to Minimize Decubitus Ulcer Costs," Academy for Health Services Research and Health Policy Annual meeting, Atlanta, GA

4/01 Podium Presentation: "Optimal Nurse Staffing for Minimal Decubitus Ulcer Costs in Nursing Homes," Western Institute of Nursing Annual Conference, Seattle, WA

3/97 Podium Presentation: "Physician Acceptance of Computerized Medical Records at Ambulatory Care Sites" (with K. Dansky & L. Gramm), Academy of Management Annual Meeting, Boston, MA

K. University, Professional, and Public Service

1. University Committees

University Safety Committee

2. College/School Committees

Admissions Committee, Chairman
Graduate Committee
Baccalaureate Committee
Research and Scholarship Committee
School of Nursing Faculty Association

3. Professional Societies

a. Local/State

Alaska Healthcare Strategies Planning Council, 06/07
Executive appointment by Sarah Palin, Governor
Theta Omicron Chapter, Sigma Theta Tau International, 08/06 - present
Treasurer, 05/06-present
Alaska Nurses Association, 2007-present
Gamma Rho Chapter, Sigma Theta Tau International, 12/99- 08/06
Treasurer, 08/02-08/06

b. Regional

Western Institute of Nursing, 2000-present, Manuscript Reviewer, 2004-present

c. National

American Nurses Association, 2007 - present
Advances in Health Care Research, 2003-04
The Academy for Health Services Research and Health Policy, 2000-present
Health Policy & Administration Affiliate Program Group, 1998-present
Phi Kappa Phi, 1998-present
Phi Theta Kappa, 1977-present

d. International

Sigma Theta Tau International, 1999-present

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Nursing, public seat
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Janine L. McCready

Mailing Address: 560 Wigwam Way, Fairbanks, AK 99712

Residence Address: 560 Wigwam Way

City, State and Zip Code: Fairbanks, AK 99712

Home or Message Telephone: 457-8586 Business Telephone: _____

Fax Number: _____ Cell Phone: _____

Email address: wjmccready@mosquitonet.com

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO X

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

please see attached resume.

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

Please see attached resume.

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

Please see attached resume.

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

please see attached resume

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: _____ SEX: FEMALE X MALE _____

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White X

MILITARY SERVICE (if applicable, give dates): NONE

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Janice Lombardi McCready Date: Oct. 14, 2008

Please attach a current resume with your application.

Janine Lombardi McCready
560 Wigwam Way
Fairbanks, AK. 99712
(907) 457-8586
wjmccready@mosquitonet.com

EDUCATION

University of Alaska-Fairbanks
Teachers for Alaska Program
Teaching credential, June 1990.

Kutztown University of Pennsylvania
B.S. Biology Minor: Marine Science
Graduation: December 1983.

EDUCATION EXPERIENCE

Home School Co-op: 2000-2005
Ran a bi-weekly co-op for home school families, students preschool through junior high, for up to 50 students per semester.

L-M Educational Services: 1995 – 2001.
Home-based tutoring business, students in grade 4 – adults.

Lighthouse Community Christian School: 1993 – 1995.
Taught sciences and p.e., grades 7 – 12.

Nenana City Public School: 1990- 1992.
Taught sciences, health, p.e., exploratory, social skills, grades 6 – 12.

Other: Fairbanks North Star Borough S.D. Substitute teaching, 1992-93.
Koyuk Malemute School, Koyuk, AK. Student teaching, 1990.
Tri-Valley School, Healy, AK. Substitute teaching, 1988-89.

ENVIRONMENTAL EDUCATION/ INTERPRETATION EXPERIENCE

Doyon Tourism, Kantishna Roadhouse, Denali National Park. Summers 1996 – 2008.
Naturalist, guide. Herbarium project.

Camp Denali, Denali National Park. Summers 1992, 1993. Guide.

ARA, Denali National Park. Summers 1990, 1991. Bus driver tour guide.

Alaska Nature Tours, Haines, AK. Summer 1989. Naturalist/ guide.

Santa Ana National Wildlife Refuge, Alamo, TX. Fall 1984-Spring 85. Interpreter.

Hawk Mountain Sanctuary, Kempton, PA. Fall season, 1984. EE teacher, interpreter.

The Oceanic Society, Stamford, CT. Summer 1984.
Director, Sea Camp marine biology program.

Ontario Pioneer Camps, Port Sydney, Ontario, Canada. Winter-spring 1984.
EE teacher.

Wallops Island Marine Science Consortium Program for the Physically Handicapped, Wallops Island, VA. Summers 1980-81. Instructor, counselor.

WILDLIFE RESEARCH / MANAGEMENT EXPERIENCE

Institute of Marine Science, UAF, 1991, 1992. Volunteer on amphipod cruise/study.

U.S. Fish and Wildlife Service:
Timber wolf and white-tailed deer study, Ely, MN. Fall 1986
Kemp's ridley sea turtle project, Rancho Nuevo, Mexico. Spring-Summer 1985

Bird Rehabilitation:
Exxon Valdez Oil Spill Rehabilitation, Seward and Homer, AK. 1989
Santa Ana National Wildlife Refuge, Alamo, TX. 1985
Hawk Mountain Sanctuary, Kempton, PA. 1984

Other:
Lower Rio Grande Valley National Wildlife Refuge, bird census, 1985.
Hawk Mountain Sanctuary, raptor count, 1984.
California Department of Fish and Game, pinniped census, 1980.
Wallops Island Marine Science Consortium, research assistant on shark behavioral study, summers 1980-81.

NATIONAL PARK SERVICE EXPERIENCE

Denali National Park and Preserve, AK. Museum technician, interpretation, resource management volunteer. Summers 1986-88, Winter-spring 1989.

Channel Islands National Park, Ventura, CA. Resource management. Winter-spring 1987.

Cape Hatteras National Seashore, Buxton, N.C. Interpretation, visitor services, resource management volunteer. Summers 1982-83.

Optometry | 0 | 2

ENTERED 9/21/05

Optometrist Seat

~~Fax Received~~

SEP 19 2005

Office of the Governor

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Optometry
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:
None.

Name: DENNIS A. SWARNER, O.D.

Mailing Address: Box 1669

Residence Address: 2765 WATERGATE WAY

City, State and Zip Code: KENAI AK 99611

Home or Message Telephone: _____ Business Telephone: 907-283-7575

Fax Number: 907-283-6156 Cell Phone: _____

Email address: keeneye@rocketmail.com.

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES _____ NO X

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO X

If "YES", explain:

2769

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
Optometry License, Alaska, 1974

B. List both formal and informal education and training experiences: (Use additional paper if necessary).
Washington State University 1965-67, 1969-70
Pacific University College of Optometry, 1970-74 BS, OD degrees.
Numerous Continuing Education Classes every year.

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced. Kenai Lions Club, 1981-Present. Sec, Treas, President.
Kenai Chamber of Commerce Board of Directors, 1998-Present. Treas., Vice-Pres.
Kenai Peninsula Oilers Baseball Team, Board of Directors, 1984-94,
AFS Student Exchange, Peninsula Chapter Officer, 1994-2002
Star of the North Lutheran Church Council, 1976-1994

D. Employment work history - paid, unpaid or voluntary: (Use additional paper if necessary).
Self-employed, Kenai Vision Center, 1975-Present

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will no be used to illegally discriminate against you.

DATE OF BIRTH: _____ SEX: FEMALE _____ MALE _____

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White ___

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): _____ Date: 9-19-05

Please attach a current resume with your application.

STATE OF ALASKA
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BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board Of Pharmacy, public seat
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Leah L. Handley

Mailing Address: 1850 Cottonwood Lane Homer, Alaska 99603

Residence Address: 1850 Cottonwood Lane

City, State and Zip Code: Homer, Alaska 99603

Home or Message Telephone: 907-235-2838 Business Telephone: N/A

Fax Number: _____ Cell Phone: N/A

Email address: leah.fernwood@gmail.com

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO X

If "YES", explain:

Fax Received
JAN 16 2009
Office of the Governor

2771

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

Open Bible College, Des Moines, Iowa 1980, 1981 2yr. Bible

Omaha Lutheran Bible School 1986, 1987 1 yr.
UCCS Fall 1987 Kenai Pen. College 1988-1991 AA

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

Various Republican Party District positions 1984 through present

Homer Bed and Breakfast Association VP 2003/2004 President 2005/2006

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

Owner/Operator Fernwood Estates Bed and Breakfast Homer 1999-2006
Homemaker (voluntary!)
Homeschooler (unpaid!)

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DATE OF BIRTH: SEX: FEMALE X MALE _____

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White X

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Leah L. Handley Date: Jan. 16, 2009

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Leah L. Handley Date: Jan. 16, 2009

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Kuik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
1	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Leah L. Handley (Age): 49 of (Hometown): Homer
is (Job title/Place of employment): previously operated Fernwood Estates B&B in Homer
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): Associate of Arts UAA/Kenai homeschooling mother of 3
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

STATE OF ALASKA
OFFICE OF THE GOVERNOR
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BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: _____
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Steve Johnson

Mailing Address: PO Box 4393

Residence Address: _____

City, State and Zip Code: Palmer, AK 99645

Home or Message Telephone: 907-746-4081 Business Telephone: _____

Fax Number: _____ Cell Phone: _____

Email address: _____

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel reimbursement etc): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO X

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

Alaska licensed pharmacist for 10 years License #1244.
Pharmacy technician for 10 years before becoming a pharmacist

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

BS in Pharmaceutical Sciences from the University of New Mexico finished in December 1997

C. List any community service; municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

Various community outreaches with my chuch since 2002

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

I work as a temporary pharmacist through PharmAssist Staffing all over the state of Alaska in various settings including hospital, retail, long term care,home IV infusion, correctional, and psychiatric medicine.

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: _____ SEX: FEMALE _____ MALE X

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White X

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employers or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): _____ Date: 2/20/08

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Steve Johnson Date: 02/20/2008

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clearcy Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/ Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/ Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	National Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
X	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Steve Johnson, (Age): 37 of (Hometown): Palmer Alaska
is (Job title/Place of employment): Pharmacist / PharmAssist Staffing.
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): Steve Johnson, BS Pharmaceutical Sciences.
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

Steve Johnson, 37 of Palmer, is the owner of the largest pharmacist staffing agency in Alaska specializing in temporary and permanent staffing throughout the state. As a full-time temporary pharmacist since 2001, I can bring a broad base of knowledge to the board from my experience staffing a varitey of pharmacy settings including hospital, large volume retail, independent, institutional, home infusion, correctional and psychiatric pharmacy.

Steve Johnson
P.O. Box 4393, Palmer, AK 99645
(907) 746-4061

Education

Registered Pharmacist, State of Alaska License #1244; University of New Mexico, Albuquerque, NM
Bachelor of Science: Pharmaceutical Sciences, December 1997

Summary of Qualifications

- Strong computer skills and a variety of pharmacy experience facilitate the ability to provide scheduled and emergency relief for hospital, clinical and high volume retail locations with minimal training.
- Current BLS, ACLS, and PALS certified

Hospital Skills

- Interact with health care professionals to help facilitate patient care
- Review charts for interactions and appropriateness
- Pharmaceutically assist Code Team during emergencies
- Provide patient education
- Develop, coordinate, and maintain both clinical and distributive pharmaceutical care services
- Review, enter and verify accuracy of orders
- Compounding and sterile technique skills
- Prepare IV admixtures including epidurals, TPN's and chemotherapeutic agents
- Supervise technicians

Retail Skills

- Able to handle high volume pace
- Regularly provide drug utilization review and patient counseling
- Maintain inventory control
- Process electronic insurance billing
- Interview, hire, fire, train and supervise staff as needed for a high volume retail chain pharmacy.

Experience

1/01-present *Relief Pharmacist* PharmAssist Staffing, various locations and pharmacies in Alaska including: Providence Hospital (Extended Care, inpatient, retail), Geneva Woods (infusion, retail, med set), Alaska Psychiatric Institution, Dept. of Corrections, Valley Hospital (now Mat-Su Regional Hospital), Anchorage Neighborhood Health, Costco, Wal-Mart, Kmart, and Three Bears Pharmacy

3/00-8/01	*Staff Pharmacist*	Valley Hospital, Palmer, AK (part time)
8/99-8/01	*Retail Pharmacist*	Carrs/Safeway, Palmer, AK
10/98-8/99	*Pharmacy Manager*	Kmart, Northway Mall, Anchorage, AK
6/98-10/98	*Pharmacist*	Wal-Mart, A Street, Anchorage, AK (part time)
3/98-3/00	*Staff Pharmacist*	Providence Hospital Inpatient Pharmacy, Anchorage, AK

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BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

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Board or Commission and seat for which I am applying: Board of Pharmacy, Pharmacist
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served: None

Name: Christopher J. Kim (CJ.)

Mailing Address: 9995 Endicott St.

Residence Address: Same

City, State and Zip Code: Anchorage, AK 99502

Home or Message Telephone: _____ Business Telephone: 907-339-1360

Fax Number: 907-339-1319 Cell Phone: _____

Email address: Govmeto@gmail.com

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO X

If "YES", explain:

Fax Received
JAN 27 2009
Office of the Governor

2780 P 1/4 1813 Huffman Cairs 907-339-1319 09:09 2009-01-22

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

Pharmacist License 1999 - Present

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

BS. of Pharmacy ; Oregon State University

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

CARR/Safeway Corp. RPh 1994 - Present

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DATE OF BIRTH: SEX: FEMALE _____ MALE X

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander X Black ___ Hispanic ___ White ___

MILITARY SERVICE (if applicable, give dates): _____ _____ _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in Ink): Christopher J. Kern Date: 1/22/2009

Please attach a current resume with your application.

2781 p 2/4 Huffman Carrs 1813 907-339-1319 09:06 2009-01-22

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Chaistopher J Kim Date: 1/22/2009

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Foresiry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
X	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

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If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): C.J. Kim (Age): 28 of (Hometown): Anchorage
is (Job title/Place of employment): PHARMACIST / SAFEWAY.
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): B.S. Pharmacy.
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

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STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Pharmacy
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: MARY D. MUNDELL

Mailing Address: 1751 E. Gavonce Way, Ste G, WASILLA, AK. 99654

Residence Address: P.O. Box 671587

City, State and Zip Code: CHUGIAK, AK. 99567

Home or Message Telephone: ____ Business Telephone: 373-7933

Fax Number: 373-7939 Cell Phone: ____

Email address: Susprof@mtaonline.net

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES * NO ____ Voter Registration Number (Optional): ____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES ____ NO * if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you will to do so?
YES * NO ____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES ____ NO *

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
AK Business License - 418530 Pharmacy License - 403
AK-856 Pharmacist License DEA License - BS 7479959

B. List both formal and informal education and training experiences: (Use additional paper if necessary).
See Attached

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.
See Attached

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).
See Attached

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will no be used to illegally discriminate against you.

DATE OF BIRTH: __ . __ . __ SEX: FEMALE X MALE ____

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White X

MILITARY SERVICE (if applicable, give dates): N/A

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Mary D. Mundell Date: 3/30/2005

Please attach a current resume with your application.

PROFESSIONAL PROFILE

Mary D. Mundell, RPh
PO Box 671587
Chugiak, Alaska 99567
PH: 907-688-6924

JOB OBJECTIVE:

- Seeking opportunity to interact with patients, physicians, and health care professionals on a more clinically oriented basis.

SUMMARY OF QUALIFICATIONS:

- Proven ability to work with physicians, peers, professionals, patients, and the public.
- Considered by employers and peers to be creative, dependable, a leader and problem solver.
- Have been directly responsible for supervision and training of pharmacists, interns, and technicians.

EDUCATION:

- Idaho State University: B.S. degree in Pharmacy with minor in biology (1982).

AWARDS AND LICENSES:

- Who's Who in American Colleges and Universities, 1981.
- Listed in Review and Research's Outstanding College Graduates of 1982.
- Pharmacy Faculty Award for Student Most Improved in Scholarship and Leadership.
- President's Scholarship, Idaho State University.
- College of Pharmacy Student Senator.
- ASISU Film Program for eight years; Assisted chairman in allocating of $65,000 budget.
- AAPCC Licensed Poison Control Specialist.
- Licensed pharmacy intern preceptor.
- Licensed in Alaska and Idaho.

PHARMACY WORK HISTORY:

- 11/98 to present: Pharmacy Manager, Valley Hospital Pharmacy and Wasilla Infusion Therapy: prepare annual budgets, maintain all JCAHO requirements for both pharmacies including pain management, narcotic controls, medication error prevention. Committee involvement includes P&T Committee, Audit Committee, Ethics Committee, Patient Care Committee, and presented information to Surgery/Tissue, Primary Care, and Medical Staff. Chaired and attended numerous subcommittees and task forces. Instituted strict formulary and inventory control measures. Managed combined annual gross charges of over 5 million dollars.

- 1997 to 11/98: Valley Hospital, Palmer, Alaska. Staff pharmacist. Monitor patient ivs,

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medications; computerized order entry; check all unit dose cassettes. Supervise technicians filling of pyxis machines Perform pharmacokinetics on aminoglycoside orders, calculate heparin doses based on weight protocols, make and check all chemotherapy for all patients admitted for chemotherapy, attend all Code Blue calls.

- 1993 to 1997: Fred Meyer Staff Pharmacist, Anchorage, Alaska. Deal with computerized third party payers, mail order and retail prescription duties. Give community lectures to Senior Citizens groups on medication, herbal, and vitamin use.

- 1991 to 1993: Alaska Regional Hospital, Anchorage, Alaska. Monitor tpn, nicu tpn, Tokos-Out Patient therapy, fill outpatient prescriptions. Use computerized pharmacokinetics program and attended pharmacokinetics training at University of Minnesota. Check all unit-dose cassettes. Extensive computer order entry and responsible for billing procedures. Supervised iv and unit-dose technicians.

- 1986 to 1991: Providence Hospital, Anchorage, Alaska. Monitor all chemotherapy, tpn, nicu tpn, and home health patients. Responsible for all administrative and quality assurance aspects of Anchorage Poison Center as well as teaching, updating, and orientation of pharmacy staff in the Poison Center. Attended New York City Poison Center course on Poison Control. Fill and dispense physician orders and check unit-dose cassettes. Supervise both unit-dose and iv technicians. Present clinical meetings for pharmacy staff and give community lectures on poison control and stroke. Presented poster on the overdose of intrathecal amphotericin B at the ASHP Midyear Clinical meeting and served as Alaska delegate to ASHP.

- 1985 to 1986: Pole Line Drug and Super Save Drug, Pocatello, Idaho. Responsible for dispensing, computerized patient profile monitoring, drug consultation, and supervision of interns, technicians and clerks. Limited third party billing and inventory.

- 1984: Treasure Valley Pharmaceutical Services, Boise, Idaho. Responsible for the pharmaceutical needs of 800 beds in twelve nursing homes, shelter care, and alcohol rehabilitation units. Supervised technicians and was preceptor for summer interns. Responsible for all inventory control and orders. Consultant pharmacist for all shelter care and alcohol rehabilitation units.

- 1982 to 1983: Pocatello Regional Medical Center, Pocatello, Idaho. Responsible for unit-dose dispensing iv admixtures, tpn admixtures. Also, did clinical rotation with oncology physician which included assessing cancer chemotherapeutic regimens and the cancers for which they are used. Read x-rays, cat scans and assisted with bone marrow and liver biopsies. Gave clinical presentations of patients to Idaho State University pharmacy faculty. Worked with pharmacy faculty to establish an advanced clinical rotation in oncology which has evolved into an accredited university course.

References Upon Request

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STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Professional Counselors
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served: N/A

Name: Ray DePalatis

Mailing Address: 12930 Summer Circle

Residence Address: SAME

City, State and Zip Code: Anchorage Alaska 99516

Home or Message Telephone: 907 345 5983 Business Telephone: 907 562 6418

Fax Number: 907 563 8287 Cell Phone: _____

Email address: ozlid@alaska.net

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO X

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: _____ SEX: FEMALE _____ MALE X

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White X

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): _____ Date: _____

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: [illegible] Date: [illegible]

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
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	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
#1	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

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If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Ray DePalatis, (Age): 46 of (Hometown): Anchorage
is (Job title/Place of employment): Co Director of Severson & DePalatis Christian Counseling.
(Name) holds (Listing of earned degrees like bachelor's, master's,
ect.): a PHD in Psychology from Capella University, a masters degree in
(Or list relevant experience to the position you are being appointed to)
Community Counseling from Albertson College, and a bachelors degree in Human
Examples: Biology from Stanford University

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

VITA

Ray S. DePalatis, Ph.D., L.P.C.
3150 "C" St., Suite 280
Anchorage, Alaska 99503
Office (907) 562-6418
Fax (907) 563-8287
ozlid@alaska.net

COUNSELING EMPLOYMENT HISTORY

7/01 - present	Severson & DePalatis Christian Counseling, Inc., Anchorage, AK. Secretary-Treasurer / Counselor
1/94 - 6/01	Severson Christian Counseling Services, Anchorage, AK. Counselor
8/93 - 12/93	Malheur County Mental Health Center, Ontario, OR. Counseling Practicum
12/92 - 12/93	Cole Community Church, Boise, ID. Counseling Intern

EDUCATION

Ph.D., Psychology – Harold Abel School of Psychology: Capella University, 2001 – 2006.
M.Ed., Community Counseling - Albertson College (Caldwell, ID), 1991 - 1993.
M.A., Biblical Studies - Cole Center for Biblical Studies (Boise, ID), 1990 - 1993.
B.A., Human Biology & Health Administration - Stanford University, 1980 -1984.

LICENSES AND CERTIFICATIONS

Board Certified Professional Christian Counselor (BCPCC): December 2007 – present.
Licensed Professional Counselor (LPC #12): State of Alaska, January 2000 - present.
Nationally Certified Counselor (NCC): April 1997 - present.
Licensed Professional Counselor (LPC #513): State of Idaho, July 1994 - 2000.

PROFESSIONAL ORGANIZATIONS

American Association of Christian Counselors
American Counseling Association
American Psychological Association
Christian Care Network
International Society for the Study of Trauma and Dissociation
Society for Christian Psychology

COMMUNITY SERVICE

Living Waters Education & Research Center, Inc. Anchorage, Alaska. Vice President-Treasurer. November 1992 - present.
Southcentral Foundation: Family Wellness Warrior's Initiative Committee. Anchorage, Alaska. Committee Member. June 2000 – October 2007.

CONTINUING EDUCATION

CPE: Continuing Psychology Education. Ethics. Self Study. May 2007.

University of Miami, School of Medicine. CITI: The Protection of Human Research Subjects. August 2005.

International Society for the Study of Dissociation: 21st International Fall Conference. New Orleans, Louisiana. November 2004.

CONTINUING EDUCATION (Cont.)

National Indian Child Welfare Association. Conference on Child Abuse and Neglect: Protecting our Children. Portland, Oregon. April 2003.

Open Hearts Ministries. Survivors of Abuse Leadership Training. Muskegon, Michigan. May 2002.

Children's Hospital-San Diego: Center for Child Protection. The San Diego Conference of Responding to Child Maltreatment. San Diego, California. January 2002.

Standing Together Against Rape. The Ribbon & the Feather, Their Message & Mission 2002 Training Conference. Anchorage, Alaska. September 2002.

American Association of Christian Counselors. World Conference. Nashville, Tennessee. August 2001.

Open Hearts Ministries. Survivors of Abuse Leadership Training. Muskegon, Michigan. May 2001.

National Indian Child Welfare Association. Conference on Child Abuse and Neglect: Protecting our Children. Anchorage, Alaska. April 2001.

National Association of Social Workers: Alaska Chapter. Traditional Healing. Anchorage, Alaska. March 2001.

American Counseling Association. Ethics in Counseling. Self Study. February 2001.

Children's Hospital-San Diego: Center for Child Protection. The San Diego Conference of Responding to Child Maltreatment. San Diego, California. January 2001.

Impact Seminars, Inc. The Nature of Rage. Anchorage, Alaska. December 2000.

American Association of Christian Counselors. Regional Conference. Los Angeles, California. February 1999.

American Association of Christian Counselors. World Conference. Dallas, Texas. November 1997.

Prevention of Legal Problems in the Practice of Marriage and Family Therapy. Anchorage, Alaska. December 1996.

False Intimacy: Understanding the Struggle of Sexual Addiction. Anchorage, Alaska. November 1995.

Life Innovations, Inc. Prepare Enrich Training Seminar. Anchorage, Alaska. October 1995.

International Congress on the Family. Denver, Colorado. July 1995.

Patrick Carnes, "Don't Call it Love - Trauma Bonds". Anchorage, Alaska. June 1995.

CONTINUING EDUCATION (Cont.)

Institute for Biblical Counseling - Wounded Heart. Sexual Abuse Seminar. Anchorage, Alaska. July 1994.

Masters & Johnson Sexual Trauma Program. Treatment of Sexual Trauma, Dissociative Disorders & Sexual Compulsivity. Anchorage, Alaska. May 1994.

Institute for Biblical Counseling. Advanced Seminar IV. Colorado Springs, Colorado. April 1992.

Institute for Biblical Counseling - Wounded Heart. Sexual Abuse Seminar. Anchorage, Alaska. July 1989.

Institute for Biblical Counseling. Basic Seminar. Anchorage, Alaska. July 1988.

From: JMitchREV@aol.com [mailto:JMitchREV@aol.com]
Sent: Friday, May 09, 2008 7:21 PM
To: Frye, Ivy J (GOV)
Subject: Medical Emergency Services Board

Hi Ivy. My name is Lillian Mitchell, a RN that retired from Providence Alaska Medical Center in 2005 after working there over 27 years. I had worked for Providence several years before in the late 60's and early 70's. I have a BA degree in human resources and a MAT. I am 67 years old. I am currently involved in volunteer work with the Alaska state fair and I am involved in the Parish nurse ministry with my church. I served on the board of directors for the Blood Bank of Alaska for several years. I have lived in Anchorage over 34 years, arriving in Alaska the first time in 1968 when my husband was assigned here with the Air Force. If you need additional information, please e-mail me. I would like information regarding the medical emergency Board, the duties, purpose, location and expectations etc. Thanks, Lillian Mitchell.
9033376887

app/bc/199

Fax Received
DEC 07 2004
Office of the Governor

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION/RESUME FORM

INSTRUCTIONS

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Board or Commission for which I am applying: Licensed Prof. Counselors

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Tashawna L. Olson

Mailing Address: Box 2914

Residence Address: Westwood Estates, Rosewood Ct. Lot #17

City, State and Zip Code: Homer, AK 99603

Home Telephone: 907-235-8808 Business or Message Telephone: same

Fax Number: — Cell Phone: —

Email address : saje@ak.net

AS 39.05.100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter? YES X NO

Voter Registration Number (Optional): Social Security Number (Optional):

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES NO X If "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for will be evaluated and a determination will be made after a review of all relevant facts.

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YES X NO

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES NO X

If "YES", explain:

TRAINING AND EXPERIENCE: (If resumé attached, it is not necessary to complete items A-D) (see Vitae (Emailed to you))

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

B. List both formal and informal education and training experiences: (Use additional paper if necessary)

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time served.

D. Employment work history - paid, unpaid or voluntary: (Use additional paper if necessary)

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DATE OF BIRTH: Nov. 29, 1950

SEX: Male____ Female K

ETHNICITY: Alaska Native___ American Indian___ Asian or Pacific Islander___ Black___ Hispanic___ White K

MILITARY SERVICE (if applicable, give dates): —

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Rebecca L Olson Date: Dec. 6, 2004

Vitae

Tashawna (Shawnie) Lillian Olson
PO Box 2914
Homer, AK 99603
(907) 235-8808 saje@ak.net

Objective:
Human Services

Academic Preparation:

Professional Counseling Credential, state of Alaska 2000- present, LPC
Concentration: Private Counseling

HIV/AIDS Training Credential, Institute for the Advancement of Sexual Awareness, San Francisco, CA 1988

M.A. in Guidance and Counseling, The Vermont College 1986
Concentration: Individual Counseling
Thesis: *Guidance Counseling – An Overview and a National Guidance Survey*
Advisor: Dr. Barbara Rosenblum

M.S. in Music Education, The Pennsylvania State University, University Park, PA 1976
Concentration: Music Therapy, Psychology
Thesis: *Music Therapy for Emotionally Disturbed Children*
Advisor: Dr. J. David Boyle

B.S. in Music Education, The Pennsylvania State University, University Park, PA 1972

Course Work: Sociology, Parenting, Personality, Career Exploration, and Ethics in Counseling

Special Training: Conflict Mediation, Communication, Natural Helpers, Grief, Stress, and Light Adjustment – Unwinding the Biological Clock (PSU 2004)

Professional Experience:

University of Alaska Anchorage, Southeast, and Fairbanks 1997-2004
-Adjunct Professor teaching the Alaska School Counseling Program

Kenai Peninsula Borough School District 2003
-ATOSS (out of school program for student's with substance and/or violence issues) counseling and tutorial, parental counseling sessions, supervision of program for the Homer area, worked closely with Cook Inlet Council for Drug and Alcohol Abuse

Private Practice, Shawnie Olson – Licensed Professional Counselor, 2000-present
-Counseling private clients (adolescents through adulthood) Focus on: emotional and physical abuse, adolescent issues, grief, stress, depression, life changes, difficult life circumstances, family issues, anger management, addiction, marital counseling, healthy life-styles, etc.

Executive Director and Advisor- Alaska School Counseling Association Executive Board – 2001-presen
-Responsible for over-seeing the Professional Development Conference for the Alaska School Counseling Association for the state of Alaska, finding exhibitors and speakers, responding to counselors across the state of Alaska

Guidance Counselor, 1983-2002
Kenai Peninsula Borough School District, Homer High School, AK
-Individual Counseling, Counseling Curriculum Development and Delivery, Group Counseling (social issues and academics), Natural Helper Coordinator and Outreach, Intervention Team, Student Assistance Program, System Support, Career Planning (including resumes, college selection, college boards, scholarship support and a comprehensive 9-12 career program), community agency liaison

Counseling, Music, and Generalist, 1981-1983
Kenai Peninsula Borough School District, Ninilchik, AK (2 years)
- Music Program K-12 (vocal, instrumental, general), Crisis Counseling, Junior High Counseling, Junior High English, Art, Yearbook

Music Teacher, 1973-1980
Various music positions held in vocal, general and instrumental music on the East Coast including: Baldwin Electronic Piano Laborary, Newport News, VA; Bellefonte Area Middle School, PA; Randolph County Schools, WV; West Rutland School, VT

Public Relations Assistant, 1978-1979
Davis & Elkins College, Elkins, WV
-Researched and wrote articles for all D & E publications, conducted phone interviews, coordinated with media, faculty and various college departments

Presentations:
How to Run a Small Group – Group Counseling, Professional Development Conference, Anchorage, AK 2002

Parenting a Challenging Freshman, Homer High School, Homer, AK 2002

Stress, Professional Development Conference, Anchorage, AK 1997, 1998, 1999

Self Esteem, Professional Development Conference, Anchorage, AK 2000

Natural Helper Trainer; Meier Lake, Barrow, Bethel, Kenai District, Anchorage, Homer 1994-2002
-Trained counselors and other professionals from all over Alaska to implement and maintain a Natural Helper Program
-Student trainings for Homer High School students 1989-2004

AIDS/HIV Workshops – community and student groups, Homer High School, Homer, AK 1989-1995

Numerous Homer High School, Kenai Peninsula Borough and PTSO presentations on relevant counseling topics

Professional Service:

Alaska School Counseling Association Executive Board 1996-present
-Served as Secretary, President, Past-President, currently Advisor
-Author of various counseling articles in the quarterly AK School Counseling Asso. Newsletter

Co-chair of the re-write of The Alaska School Comprehensive Counseling Program 1999 (guide utilized by counselors in Alaskan schools)

Honors and Awards:

Award of Distinction, Alaska School Counseling Association, Anchorage, AK, 2003
Counselor of the Year, state of Alaska 2001
Counselor of the Year, Kenai Peninsula Borough School District Award, 2001

Community Involvement:

Homer United Methodist Church, organist 1981 – present; choir 2001 – present, church committees
Christmas Cantata, Methodist Church and Grace Lutheran Church and others, 2002 & 2003
Pratt Museum, Ritz - recording secretary, 1990 – present
Pier I Theatre, musical director, keyboards & vocal training – fall 1981, '82; summers 2003, '04
Raven's Club, member
Chamber of Commerce, member
Various community projects

References:

Dr. Richard Krieger
Retired Principal/Educator/Colleague
Homer, AK
(907) 235-9309 Email: kriegers@xyz.net

Kenneth Satre
Retired Principal/Colleague
Homer, AK
(907) 235-2353 Email: satrefam@xyz.net

Dr. Allan Morotti
University of Alaska Fairbanks
Professor- Counseling/Colleague AkSCA
Fairbanks, AK
(907) 474-6440 Email: faam1@uaf.edu

Valerie Ann Demming, LPC
Adjunct for UAA/Private Counselor/Colleague
Anchorage, AK
(907) 245-3467 Email: vademming@att.net

James D. Ballentine
Retired Counselor/Adjunct Prof./Colleague (19 yrs)
Homer, AK
(907) 235-8027 Email: Jamie@xyz.net

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: (For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: **Kristi H. Fuller, Ph.D.,ABPP-CN**

Mailing Address: **1007 W 3rd Ave # 203 Anchorage, AK 99501**

Residence Address: **6310 Kalmia**

City, State and Zip Code: **Anchorage, AK 99507**

Home or Message Telephone: _____ Business Telephone: **907 561 0552**

Fax Number: **907 561 0562** _____ Cell Phone: _____

Email address: **fullerdiagnostics@gmail.com** **www.fulleralaska.com**

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES__X____ NO_____Voter Registration Number (Optional):

Social Security Number (Optional, required if appointed for travel, reimbursement etc.) _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____NO X__ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so? YES X NO__
Could you or any member of your family be affected financially by decisions to be made by the board or Commission for which you have applied? YES___NO__X (except for the fact that both I an my husband are licensed Psychologists) If "YES", explain:

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Social Security Number (Optional, required if appointed for travel, reimbursement etc.) _____

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Could you or any member of your family be affected financially by decisions to be made by the board or Commission for which you have applied? YES___NO__X (except for the fact that both I an my husband are licensed Psychologists) If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

Alaska PSY 436

American Board of Professional Psychology – Clinical Neuropsychology 5905

B. List both formal and informal education and training experiences: (Use additional paper if necessary). **University of Idaho, Bachelor of Science 1989, Louisiana State University MA 1991, Louisiana State University Ph.D. 1994 APA internship 1993-1994 Tacoma VAMC Post Doctoral Residency Oregon Health Sciences University 1994-1996, Board Certification in Clinical Neuropsychology 2004, Continuing Education National Academy of Neuropsychology, International Neuropsychology Society 1990-current**

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced. **Work Sample Reviews, American Academy of Neuropsychology, Invited Speaker, UAA Alaska Children's Services Parent Volunteer Firebirds/Northstar Hockey, and Anchorage Figure Skating Association**

C. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).
Clinical Externship and Research Assistant Louisiana State University 1989-1993. Intern Tacoma VAMC 1993-1994, Resident OHSU 1994-1996, Alaska Guidance and Diagnostic Clinic 1996-1997, Providence Health System 1997-2005, Private Practice 2005-Current

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH:_____ SEX: FEMALE_____ MALE ____

ETHNICITY:
Alaska Native ____ American Indian ____ Asian or Pacific Islander ____ Black ____ Hispanic ____
White__x__ MILITARY SERVICE (if applicable, give dates): N/A

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Kristi H Fuller Date: 1/20/09

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Kristi H Fuller Date: 1/20/09

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
#1	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

Kristi H. Fuller, Ph.D.,ABPP-CN
Board Certified Clinical Neuropsychologist

Richard D. Fuller, Ph.D.
Clinical Neuropsychologist

Curriculum Vitae

Kristi Hulse Fuller, Ph.D., ABPP-CN
May 2007

Personal Data:

Mailing Address: Kristi Fuller, Ph.D.,ABPP-CN
P.O. Box 92303
Anchorage, AK 99509

Physical Address: 1007 W 3rd Ave Suite 203
Anchorage, AK 99501

Office Phone: 907-561-0552
Office Fax: 907-561-0562

Licensure:

Licensed in the State of Alaska as Psychologist # 436 (October 1996).

Board Certified in Clinical Neuropsychology, American Board of Professional Psychology #5905 (October 2004).

Education:

Ph.D. (1994) Louisiana State University
APA Approved Program
Clinical Psychology

Dissertation Title: The Impact of Trait Anxiety on Slow-Wave Sleep Processes

Minor Area: Behavioral Neurology

M.A. (1991) Louisiana State University

outpatients referred by community physicians and agencies (Office of Children's Services, Department of Vocational Rehabilitation, Juvenile Justice), as well as inpatient neuropsychological and psychological consultations for patients at Providence Alaska Medical Center. Brief, goal focused cognitive behavioral treatment of anxiety, mood, and behavioral disorders was also provided on a limited basis.

10/1996 to 10/1997 Alaska Guidance and Diagnostic Clinic
3260 Providence Drive, Suite 422
Anchorage, AK 99508 Telephone (907) 561-0044
Neuropsychologist; private practice (full time)

Full time private practice, emphasis was in neuropsychological and psychological evaluations of children and adolescents (age range 3 to 18) with identified cognitive risk factors. Individual and family treatment for children and adolescents with anxiety, depression, adjustment and behavioral disorders was provided on a limited basis. Patient populations included outpatients and adolescents receiving treatment at the Providence Discovery Program.

9/1994 to 9/1996 Oregon Health Sciences University
3181 S.W. Sam Jackson Park Road
Portland, OR 97201
Post-Doctoral Residency in Medical Psychology (full time)
Emphasis in Clinical Neuropsychology

Duties included psychological and neuropsychological assessment of patients referred by various hospital clinics (e.g. Pediatrics, Oncology, Neurology, Psychiatry) and state agencies (e.g. Child and Family Services, Juvenile Justice System, Vocational Rehabilitation, Social Security). Clinical responsibilities included hospital wide consultation services, and short-term, goal focused psychotherapy for outpatients referred by primary care physicians. Agency evaluation questions included legal capacities (medical decision making, parenting, driving). Clinical supervisors were board certified through the American Board of Professional Psychology (ABPP). Other responsibilities included presentations at the medical psychology department's weekly seminar series, and providing instruction and consultation regarding cognitive and mental health issues to nursing, medical, and physician assistant students. Conducted quarterly Quality Assurance reviews of departmental providers, participated in systematic review and documentation of clinic services including utilization review and treatment efficacy.

Supervisors: Arthur N. Wiens, Ph.D., ABPP
Ruth G. Matarazzo, Ph.D., ABCN, ABPP
Antonia Forster, Ph.D., ABPP
John R. Crossen, Ph.D.

9/2003 to 9/1994 **American Lake Veterans Medical Center**
Tacoma, WA
APA approved Pre-Doctoral Internship in Clinical Psychology

Selected clinical rotations included geriatric psychology, consultation service, acute inpatient psychiatry, chronic post-traumatic stress disorder unit, and domiciliary for homeless veterans. Duties during all rotations included group and individual psychotherapy, assessment (neuropsychological and psychological), and consultation with multidisciplinary treatment teams. Additional duties included quarterly presentations at departmental seminar and participation in departmental quality assurance and productivity review programs.

Primary Supervisor: Mona Weir, Ph.D.

08/1991 to 08/1993 Family Therapy Clinic
7423 Picardy
Baton Rouge, LA 70808
Louisiana State University Externship (20-30 hours per week)

Primary duties included neuropsychological evaluation of outpatients eligible for state vocational rehabilitation services, evaluation of children and adolescents referred by the State Office of Mental Retardation, and neuropsychological and psychological evaluations of inpatients at our Lady of the Lake Regional Medical Center's general medical and psychiatric units. Additional duties included individual and group psychotherapy utilizing brief, goal focused cognitive-behavioral interventions and completing civil forensic evaluations (TBI, toxin exposure).

Supervisors: Wm. Drew Gouvier, Ph.D.
Don A. Williamson, Ph.D.

08/1991 to 05/1993 Parkland Hospital, Baton Rouge, LA
2414 Bunker Hill Drive
Baton Rouge, LA 70808
Psychological Associate (15-20 hours a week)

Provided cognitive, educational, and personality evaluations of psychiatric inpatients under supervision of hospital psychologist. Primary patient population included children and adolescents with acute behavioral and psychiatric symptoms.

Supervisor: Jean George, Ph.D.

08/1989 to 06/1992 Louisiana State University Practicums

1. Earl K. Long Hospital, Baton Rouge, LA
   (10 to 20 hours per week)
2. Psychological Services Center, LSU
   (12 to 20 hours per week)

Duties included psychological and neuropsychological assessments as well as individual and group psychotherapy. Primary populations included adolescents and adults (1) referrals from neurologists and general medicine physicians (2) individuals self-referred for treatment of anxiety, depression, somatoform disorders, sleep disorders, and eating disorders.

Supervisors: Donald A. Williamson, Ph.D.
W. Drew Gouvier, Ph.D.
William F. Waters, Ph.D., ABPP

Publications:

Dahlborg, S.A., Petrillo, A., Crossen, J.R., Roman-Goldstein, S., Doolittle, N.D., Fuller, K.H., & Neault, E.A. (1998). The Potential for complete and durable response in nonglial primary brain tumors in pediatric patients and young adults with enhanced chemotherapy delivery. Cancer J Sci Am 4, 110-124.

Wiens, A.N., Fuller, K.H. & Crossen, J.R. (1997). Paced Auditory Serial Addition Test: Adult norms and moderator variables. Journal of Clinical and Experimental Neuropsychology, 19, 473-483.

Fuller, K.H., Waters, W.F., Binks, P. & Anderson, T. (1997). Generalized anxiety and sleep architecture: A polysomnographic study. Sleep, 20, 370-376.

Fuller, K.H., Gouvier, W.D. & Savage, R.M. (1997). Comparison of list B and list C of the rey auditory verbal learning test. The Clinical Neuropsychologist, 11, 201-205.

Wiens, A.N., Brazil, P.B., Fuller, K.H., & Solomon, S.E. (1996). The practioner's new weapon: Data (Feature article). The Psychotherapy Bulletin 30, 46-53

Fuller, K.H., Waters, W.F., Scott, O. (1994). An investigation of slow-wave sleep processes in chronic PTSD patients. Journal of Anxiety Disorders, 8 227-236.

Gouvier, W.D., Coon, R.C., Todd, M. & Fuller, K.H. (1994). Verbal interactions with individuals presenting with and without physical disability. Rehabilitation Psychology, 39, 263-268.

Gouvier, W.D., Coon, R., Fuller, K.H., & Arnoldi, K.R. (1992). Evaluation of linguistic variations by college students with and without head-injuries. Rehabilitation Psychology, 37, 165-174.

Coon, R.C., Gouvier, W.D., Caldwell, K & Hulse, K. (1991). Perception of register variation in speech and its relations to differential judgments about handicapping conditions. Journal of Head Injury, 37, 16-20.

Presentations:

Fuller, K.H., Wier, M. Sanderlin, M & David, W. (1996, November) Neuropsychological Functioning in Chronic Post-Traumatic Disorder Patients with and without History of Traumatic Brain Injury. Paper presented at the annual meeting of the National Academy of Neuropsychology, New Orleans, LA.

Fuller, K.H., Waters, W., Binks, P. & Anderson, T. (1995, June) The Impact of Anxiety and Worry on Sleep Architecture. Paper presented at the 9th Annual Meeting of the Association of Professional Sleep Societies (APSS), Nashville, TN.

Fuller, K.H., Waters, W., & Scott, O. (1993, June) An Investigation of Slow Wave Sleep Processes Among Chronic PTSD Patients. Paper presented at the 7th Annual Meeting of the Association of Professional Sleep Societies (APSS), Los Angeles, CA.

Todd, M., Gouvier, W.D., Coon, R., & Fuller, K.H. (1992, November) Verbal Interactions with Disabled versus Non-Disabled Individuals. Paper presented at the 12th Annual Meeting of the National Academy of Neuropsychology, Pittsburgh, PA.

Hulse, K., Gouvier, W.D., & Savage, R. (1991, November) A Comparison of List B and List C of the Rey Auditory Verbal Learning Test. Paper presented at the 11th Annual Meeting of the National Academy of Neuropsychology, Dallas, TX.

Additional topics of specialty papers presented to clinician and student groups available upon request.

Professional references are available upon request.

Darrell Lynn Allman, LCSW, DCSW, CDC II
7120 McLin Circle Anchorage, Alaska 99507
907-344-0520
Email - allmanfamily@gci.net

Education

United States Air Force Biomedical Science Fellowship in Substance Abuse *Willford Hall Medical Center, Lackland AFB Texas*	*1993*
Master of Social Work *University of Georgia, Athens, Georgia*	*1984*
Bachelor of Arts - Psychology & Sociology *University of Kentucky, Lexington Kentucky*	*1981*

Memberships & Affiliations

Vice Chair - State of Alaska Board of Social Work Examiners (State)
Committee Member - Association of Social Work Boards (National)
Member of The National Association of Social Workers

Career History - for past 19 years.

Department of Veterans Affairs	Social Worker (Homeless Veterans Service / Veterans Industries) Anchorage, Alaska	*8/2007 to present*
Department of Veterans Affairs	Social Worker / Addictions Therapist. (SW&BHS) Anchorage, Alaska	*12/2005 to 8/2007*
Southcentral Foundation	Clinical Manager / Quyana Clubhouse Anchorage, Alaska	*9/2000 to 12/2005*
Magellan Behavioral Health	Clinician / Case Manager Anchorage, Alaska	*4/1999 to 8/2000*
US Air Force Family Advocacy Program	Family Advocacy Treatment Manager Elmendorf Air Force Base, Alaska	*10/1997 to 4/1999*
United States Air Force	Captain Biomedical Science Officer / Chief of Mental Health / Family Advocacy	*6/1989 to 9/1997*

La Rose -

Gail Henderson, MSW, LCSW
PO Box 4595
Palmer, AK 99645

(907) 746-4673 wk

Objective: Application to be considered appointment to the Board of Social Work Examiners as a Licensed Clinical Social Worker.

Education:

1997-1999 Masters in Social Work, University of Alaska, Anchorage
1986-1989 Bachelor of Arts in Psychology, Fort Lewis College, Durango, Colorado

Certificates/License:

2001 Sept LCSW
1995 April Nationally Certified Addiction Counselor, Level II
1994 April State Certified Alcoholism and Drug Abuse Counselor, Level II

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JUNEAU

Work Experience:

May 2001- Current

Private Practice: Individual, marital, and family counseling. Volunteer as a member of the FASD diagnostic team for the Mat-Su Community.

February 2000-May 2001

Mat-Su Recovery Center, Inc.: Clinical Care Coordinator- Adolescent Program. Duties include: Overall clinical and administrative responsibility, including program development / oversight and human resources for treatment and prevention programs. Assist with marketing and outreach efforts, writing, editing, and administering grants.

Day Treatment Clinician. Duties include: maintaining therapeutic milieu for adolescents experiencing chemical dependency/mental health issues. Facilitate individual therapy sessions and process groups with adolescents. Engage families in individual, couples, and family therapy. Provide on-site supervision to adolescent treatment counselors. Participate in a self-directed team management model. Assist in maintaining standards for CARF certification as a program.

May 1999- February 2000

Kids Are People, Inc.: Programs Case Manager. Duties included: Clinical and administrative supervision of 22 employees of three programs: a 6 bed emergency youth shelter, family mediation program, and an alternative to detention (electronic monitoring) program. Maintained grant requirements, and State licensing criteria. Wrote and was awarded a $500,000 grant for an adolescent transitional living center.

Gail Henderson, MSW, LCSW
PO Box 4595
Palmer, AK 99645

(907) 746-4673 wk

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September 1998- May 1999

Division of Family and Youth Services: Practicum Student. Duties included: Interviewing youth and families to determine risk of harm and level of intervention. Case management through on-going home visits and family reunification planning. Worked with Foster Care Review Board, guardian ad litums, and lawyers to maintain integrity of client rights. Utilized and became familiar with ICWA and tribal court procedures. Provided individual and family counseling.

September 1997- May 1998

Alaska Psychiatric Institute: Practicum Student. Participated in multi-disciplinary treatment team reviews for acute care adult patients. Initiated individual sessions to complete social histories and begin discharge planning. Facilitated a weekly woman's group to engage patients in social interaction, and education.

May 1994-November 1998

Charter North Counseling Center: Clinical Therapist. Duties include: facilitation of group therapy (process/didactic), individual sessions, treatment planning, crisis management, and alcohol/drug evaluations for ASAP/DOT/self referrals. Random alcohol/drug urinalysis program, program development, and case management. Provide services in both inpatient and outpatient settings, with adolescents and adults.

References Upon Request

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

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Board or Commission and seat for which I am applying: Board of Social Work Examiners
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Patty McMillin

Mailing Address: PO Box 2803

Residence Address: 1017 Naun Rag

City, State and Zip Code: Bethel, AK 99559

Home or Message Telephone: _____ Business Telephone: 543-4874

Fax Number: 543-4925 Cell Phone: _____

Email address: Patty-McMillin@LKSD.org

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO ✓ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

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YES ✓ NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO ✓

If "YES", explain:

PATTY MCMILLIN, LMSW
PO Box 2803, Bethel, Alaska 99559
Email: Patty_McMillin@lksd.org
FAX: 907-543-4925

OVERVIEW

I am currently the Lead Social Worker for the Lower Kuskokwim School District. This is my fifth year in this position. It is an administrative position with such duties as hiring, training and supervising a staff of MSWs. I am also responsible for evaluating staff and service delivery. I have created a program for keeping statistical information for our department, and am currently working with the ASDN as a sub-recipient for a competitive DOE grant. We are creating a cross-age peer e-mentoring program for 4-8 grade students in our district.
I am a member of the Bethel Child Protective Multi-Disciplinary Team, The Bethel Children's Advocacy Center MDT and the Delta Inter-Agency Team. I have been trained and worked with Wrap Around services and Intensive In-Home Family services. I have completed and am certified in the Pathways to Hope program and the Gatekeepers Suicide Prevention program.
Additionally, I am independently contracted with the Alaska Court System as a Mediator and Family Group Conference facilitator working with CINA cases and am also contracted with Catholic Social Services as a Home Study Writer for adoptions.
To keep my soul healthy, I play and teach piano lessons. I currently have twenty students.
For sanity, I spin (as in "create yarn on a spinning wheel"), knit, crochet, do counted cross-stitch, quilting and weaving. Some of my intellectual passions are studying history, anthropology and comparative religions.
I previously worked for three years with the Lower Kuskokwim School District as an itinerant School Social Worker. This involved traveling 4-5 days a week throughout the school year to the 21 small and isolated Yup'ik villages in the district. In that context I worked extensively with students, school staffs, families, ICWA workers, VPSO's, Alaska State Troopers, tribal councils and courts. I have subsequently developed familiarity with other involved agencies such as the Office of Children's Services, DJJ and the local community Behavioral Health department, under the umbrella of the Yukon Kuskokwim Native Health Corporation. I have coordinated care with treatment programs and in-patient care settings both within and outside of the State of Alaska and participated in after-care planning for students returning to our district.
I have strong written and oral communication skills; experience in cross-cultural work with Hispanic migrant workers, Native Americans and Native Alaskans; experience with organizing and working with both grass roots and professional groups; and demonstrated ability in teaching/training based on past experience teaching and training children and adults in various settings.

EDUCATION

April, 2001	Master of Social Work	Grand Valley State University Allendale, Michigan
May, 1997	Bachelor of Social Work (with Highest Distinction)	Ferris State University Big Rapids, Michigan

HONORS

1996-1997	Who's Who in American Universities	Ferris State University
1998	CH.A.D.D. Coordinator of the Year	State ADD Council of Michigan
2008	Outstanding Inclusive Practices	Alaska Governor's Council on Disabilities and Special Education

EMPLOYMENT

July, 2004 - Present — **Lower Kuskokwim School District**
Lead Social Worker — **Bethel, Alaska**

I supervise and administrate a department consisting of ten School Social Workers who serve in twenty-one villages (each with a K-12 school) and five schools in Bethel. I am responsible for recruiting, hiring, training and supervising the department. I report to the Superintendent and the Board of Education for the district. I interface with other administrative personnel and teaching staff within the school district as well as other agencies both locally and throughout the state. I am the point of entry for referrals from agencies such as OCS and the Children's Advocacy Center. I am the primary responder for crisis intervention and crisis response for the school district; coordinating with other LKSD administrative/teaching staff, other local and referral agencies as needed, and my own department. I sit on both the Bethel Child Protection Multi-Disciplinary Team and the local Children's Advocacy MDT. I have created and presented various trainings on child safety, mandated reporting of child abuse, the impact of domestic violence on child development and other child behavioral health issues for the school district staff, village child protective teams, Tribal organizations and Head Start staffs. I have created, presented and trained my staff in classroom presentations, which are age and culturally appropriate, on topics such as safe touch, suicide, drug and alcohol abuse, abusive dating relationships and complicated grief issues. I participated, by invitation, in a panel presentation at the Alaska State Behavioral Health Summit on the suicide prevention work my department has implemented.

June, 2005 - Present — **Alaska Court System**
Mediator and Family Group Conference Facilitator — **Anchorage, Alaska**

I am contracted with the Alaska State Court system to provide mediation services and to facilitate Family Group Conferencing in Child in Need of Aid cases with a court referral. The court system provides extensive and ongoing training in these models.

October, 2007 - Present — **Catholic Social Services**
Home Study Writer — **Anchorage, Alaska**

I have been trained and am contracted with Catholic Social Services to conduct and write home studies of prospective adoptive homes for the court.

August, 2001 - June, 2004 — **Lower Kuskokwim School District**
School Social Worker (Itinerant) — **Bethel, Alaska**

I traveled to villages in the LKSD area and worked with children, families, schools, communities and other agencies to provide behavioral health services. I did behavioral health assessments, crisis intervention, suicide assessments, referrals, classroom observations and behavior management plans, as well as ongoing counseling. I coordinated with the Tundra Women's Center (for domestic violence), the Children's Advocacy Center (for juvenile victims of sexual assault), Public Health, the Yukon-Kuskokwim Health Corporation, OCS, DJJ, ICWA, Behavioral Health Aids, Family Advocates and Health Educators to provide community and school programs, and individual and family services.

2000-2001 — **Master's Practicum**
Outpatient Clinical Therapist — **Kalkaska Community Mental Health**

In this capacity, I did intake assessments, crisis assessments, individual, family and group therapy using appropriate modalities with an emphasis on Brief Therapy and Cognitive Therapy. I co-led a therapy group for adults who were diagnosed with Borderline Personality Disorders utilizing Dialectical Behavioral Therapy. I organized and led a Parenting Class. I assisted in individual and group sessions and assessments for prison alternative treatment and outreach.

PROFESSIONAL AFFILIATIONS

National Association of Social Workers
Alaska State Chapter, NASW
National Music Teachers Association

SUMMARY OF LIFE EXPERIENCES

2 years	Guest Teacher, Traverse City Area Schools, Traverse City, Michigan
2 years	Resident Hall Counselor, Interlochen Arts Academy, Interlochen, Michigan
2 years	Adjunct Faculty, Northwestern Michigan College Early Childhood Development, Human Growth & Development
2 years	Training Facilitator, Michigan Community Coordinated Child Care
5 years	Group Home Childcare Provider, Licensed to care for twelve children. Traverse City, Michigan
3 years	Migrant Workers' Infant Care Program, Traverse City, Michigan
4 years	Surrogate Parenting severe psychotic and schizophrenic clients Delaware Valley Mental Health Foundation, Doylestown, Pennsylvania
4 years	Foster Parenting children from 3 days to 17 years of age Lutheran Family Services, Harleysville, Pennsylvania
4 years	Board of Directors of the Quakertown Friends' School, Quakertown, Pennsylvania
6 years	Music Director, Ridge Valley United Church of Christ, Sellersville, Pennsylvania
3 years	Parent-Infant/Toddler Program, Northwestern Michigan College Facilitated a program designed to enhance parent-child relationships through educating young parents in child health and development, infant cues, effective communication techniques and parenting styles
2 years	Parent Advocate, Association of Children's Mental Health Providing advocacy in schools and communities and empowering parents through education and counseling.
15 years	Public Speaking and in-service training facilitator on issues of IDEA, 504 and behavioral disorders in children
22 years	Private Instructor: piano, voice and drama
36 years	Parenting

Joseph A. Masters
Appointed: 9/12/2008

Alaska State Board of Public Accountancy
Carla Bassler – Anchorage
Appointed: 3/14/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

John Floyd – Anchorage
Appointed: 10/16/2008 Term Expires: 3/1/2012

Kathleen A. Reid – Fairbanks
Appointed: 10/16/2008
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Elaine Williamson – Fairbanks
Appointed: 10/18/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Alcoholic Beverage Control Board
Ethan Billings – Juneau
Appointed: 3/1/2009 Term Expires: 3/1/2012

Belen Cook – Cordova
Appointed: 12/29/2008 Term Expires: 3/1/2010

Ellen Ganley – Fairbanks
Appointed: 3/1/2009 Term Expires: 3/1/2012

State Board of Registration for Architects, Engineers, and Land Surveyors
Boyd Brownfield – Anchorage
Appointed: 6/9/2008 Term Expires: 3/1/2012

Eric Eriksen – Juneau
Appointed: 3/1/2009 Term Expires: 3/1/2013

Craig Fredeen – Anchorage
Appointed: 6/9/2008 Term Expires: 3/1/2012

Richard Heieren – Fairbanks
Appointed: 3/9/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Harley Hightower – Anchorage
Appointed: 3/9/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Richard Rearick – Eagle River
Appointed: 2/3/2009 Term Expires: 3/1/2012

Don Shiesl – Wasilla
Appointed: 10/16/2008 Term Expires: 3/1/2010

State Assessment Review Board
Ronald Brown - Anchorage
Appointed: 12/2/2008

Board of Governors of the Alaska Bar
Dr. David L. Eichler – North Pole
Appointed: 3/1/2009 Term Expires: 3/1/2012

Board of Barbers and Hairdressers
Carol Hernley – Cordova
Appointed: 5/7/2008 Term Expires: 3/1/2012

Debra Long – Fairbanks
Appointed: 5/7/2008 Term Expires: 3/1/2012

Big Game Commercial Services Board
Paul E. Johnson – Elfin Cove
Appointed: 7/24/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Dirk Nickisch – Coldfoot
Appointed: 11/19/2008 Term Expires: 3/1/2009
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Betty Jo "BJ" Schmitz – North Pole
Appointed: 7/24/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Chiropractic Examiners
Dr. Dan Holt – Juneau
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. Rosemary Zimmerman – Girdwood
Appointed: 7/25/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Alaska Commercial Fisheries Entry Commission
Judge Peter Froehlich – Juneau
Appointed: 8/2/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Dental Examiners
Robyn Chaney – Dillingham
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. Mary Anne Navitsky – Sitka
Appointed: 3/1/2009 Term Expires: 3/1/2013

Deborah Stauffer – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. Clifford Douglas White – Dillingham
Appointed: 3/1/2009 Term Expires: 3/1/2013

Board of Education and Early Development
Janel Keplinger – Kodiak
Appointed: 3/1/2009 Term Expires: 3/1/2014

Carol "Bunny" Schaeffer – Kotzebue

Appointed: 3/24/2004
Reappointed: 3/1/2009 Term Expires: 3/1/2014

Board of Game
Cliff Judkins – Wasilla
Appointed: 1/21/2003
Reappointed: 3/3/2006
Reappointed: 3/1/2009 Term Expires: 6/30/2012

Teresa Sager-Albaugh – Mentasta Pass
Appointed: 3/1/2009 Term Expires: 6/30/2012

State Commission for Human Rights
Faith Peters – Tanana
Appointed: 3/1/2009 Term Expires: 3/1/2014

Commission on Judicial Conduct
Chris Brown – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2013

Jan S. Ostrovsky – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2013

Alaska Judicial Council
William F. Clarke – Chugiak
Appointed: 10/16/2008 Term Expires: 3/1/2013

Kathleen R. Tompkins-Miller – Fairbanks
Appointed: 3/1/2009 Term Expires: 3/1/2015

Alaska Labor Relations Agency
Tyler E. Andrews – Anchorage
Appointed: 6/9/2008 Term Expires: 3/1/2009
Reappointed: 3/1/2009 Term Expires: 3/1/2012

Will Askren – Anchorage
Appointed: 6/9/2008 Term Expires: 3/1/2011

Gary P. Bader – Anchorage
Appointed: 3/24/2004
Reappointed: 6/17/2008 Term Expires: 3/1/2010

Aaron T. Isaacs, Jr. – Anchorage
Appointed: 1/18/2002
Reappointed: 3/9/2005
Reappointed: 6/9/2008 Term Expires: 3/1/2011

Matthew R. McSorley – Anchorage
Appointed: 12/15/2005
Reappointed: 3/1/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2012

Board of Marine Pilots
Dale O. Collins – Ketchikan
Appointed: 4/18/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Michael Heimbuch - Homer
Appointed: 2/3/2009 Term Expires: 3/1/2012

Board of Marital and Family Therapy
Kimberly K. Horn – Juneau
Appointed: 2/3/2009 Term Expires: 3/1/2010

Patricia A. White – Juneau
Appointed: 8/22/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

State Medical Board
Edward A. Hall – Anchorage
Appointed: 5/19/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Casey M. Millar – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2013

Dr. David A. Miller – Juneau
Appointed: 3/1/2009 Term Expires: 3/1/2012

Dr. David J. Powers – Dillingham
Appointed: 12/2/2008 Term Expires: 3/1/2012

Alaska Mental Health Trust Authority Board of Trustees
Dr. William Doolittle – Fairbanks
Appointed: 3/24/2004
Reappointed: 3/1/2009 Term Expires: 3/1/2014

Chief Daniel Hoffman – Fairbanks
Appointed: 3/1/2009 Term Expires: 3/1/2014

Mary Jane Michael – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2010

Board of Certified Direct-Entry Midwives
Barbara Norton – Anchorage
Appointed: 6/3/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Nursing
Thomas Hendrix – Eagle River
Appointed: 3/1/2009 Term Expires: 3/1/2013

Janine L. McCready – Fairbanks
Appointed: 12/3/2008 Term Expires: 3/1/2011

Occupational Safety and Health Review Board
Thomas A. Trosvig – Kodiak
Appointed: 1/23/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Alaska Oil and Gas Conservation Commission
John K. Norman – Anchorage

Appointed: 1/23/2004
Reappointed: 3/1/2009 Term Expires: 3/1/2015

Board of Examiners in Optometry
Dr. Dennis A. Swarner – Kenai
Appointed: 10/18/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Board of Parole
Lonzo Henderson – Anchorage
Appointed: 12/29/2008 Term Expires: 3/1/2014

Board of Pharmacy
Leah Handley – Homer
Appointed: 3/1/2009 Term Expires: 3/1/2013

Steve R. Johnson – Palmer
Appointed: 12/3/2008 Term Expires: 3/1/2012

Chris "CJ" Kim – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2012

Mary D. Mundell – Wasilla
Appointed: 4/14/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

State Physical Therapy and Occupational Therapy Board
Jay McDiarmid – Fairbanks
Appointed: 4/14/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Dr. Marc Slonimski – Fairbanks
Appointed: 3/1/2009 Term Expires: 3/1/2012

Board of Professional Counselors
Ray DePalatis – Anchorage
Appointed: 8/8/2008 Term Expires: 3/1/2009
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Lillian Mitchell – Anchorage
Appointed: 8/8/2008 Term Expires: 3/1/2012

Tashawna L. Olson – Homer
Appointed: 4/14/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Professional Teaching Practices Commission
Cindy Lou Aillaud – Delta Junction
Appointed: 10/26/2006
Reappointed: 3/1/2008 Term Expires: 3/1/2011

Linda L. Black – Anchorage
Appointed: 3/1/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2012

Jill Exe – Barrow

Appointed: 3/1/2009 Term Expires: 3/1/2012

Louis Pondolfino – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2012

Board of Psychologist and Psychological Associate Examiners
Dr. Kristi H. Fuller – Anchorage
Appointed: 2/3/2009 Term Expires: 3/1/2013

Alaska Public Offices Commission
Kathleen "Kate" Ballenger – Kodiak
Appointed: 5/7/2008 Term Expires: 3/1/2011

Board of Certified Real Estate Appraisers
Richard "Butch" D. Olmstead – Ketchikan
Appointed: 12/15/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Gene H. Shafer – Fairbanks
Appointed: 3/1/2004
Reappointed: 10/16/2008 Term Expires: 3/1/2012

Real Estate Commission
Nancy Davis – Sitka
Appointed: 3/1/2009 Term Expires: 3/1/2013

Barbara A. Dickson – Anchorage
Appointed: 2/3/2009 Term Expires: 3/1/2011

Gene DuVal – Fairbanks
Appointed: 4/13/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Regulatory Commission of Alaska
Paul Lisankie – Anchorage
Appointed: 3/1/2009 Term Expires: 3/1/2015

Board of Social Work Examiners
Darrell Allman – Anchorage
Appointed: 4/22/2004
Reappointed: 10/16/2008 Term Expires: 3/1/2012

Gail La Rose-Henderson – Wasilla
Appointed: 2/24/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2013

Patty McMillin – Bethel
Appointed: 3/1/2009 Term Expires: 3/1/2010

Board of Veterinary Examiners
Margaret J. Eastman – North Pole
Appointed: 10/16/2008 Term Expires: 3/1/2012

Violent Crimes Compensation Board
Dr. Regina C. Chennault – Soldotna
Appointed: 10/18/2005

Reappointed: 3/1/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2012

Workers' Compensation Appeals Commission
Philip E. Ulmer – Eagle River
Appointed: 11/18/2005
Reappointed: 3/1/2009 Term Expires: 3/1/2014

Alaska Workers' Compensation Board
Richard H. Behrends – Juneau
Appointed: 11/21/2000
Reappointed: 3/25/2003
Reappointed: 3/10/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2012

Mark A. Crutchfield – Anchorage
Appointed: 10/11/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2012

Howard A. Hansen – Wasilla
Appointed: 12/26/2007
Reappointed: 3/1/2009 Term Expires: 3/1/2012

Linda F. Hutchings – Soldotna
Appointed: 9/27/2005
Reappointed: 3/1/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2012

Sarah LeFebvre – Fairbanks
Appointed: 3/1/2009 Term Expires: 3/1/2010

Kiana Peacock - Anchorage
Appointed: 1/8/2009 Term Expires: 3/1/2011

Daniel Repasky – Anchorage
Appointed: 1/8/2009 Term Expires: 3/1/2010

Marc D. Stemp – Anchorage
Appointed: 3/1/2007 Term Expires: 3/1/2010

Patricia A. Vollendorf – Anchorage
Appointed: 4/12/2004
Reappointed: 3/10/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2012

Robert C. Weel – Anchorage
Appointed: 1/23/2006
Reappointed: 3/1/2006
Reappointed: 3/1/2009 Term Expires: 3/1/2012

CONFIRMA-TIONS

2010

SENATE
CONFIRMATION COMMITTEE REPORT

Date: 3-10-2010

In accordance with AS 39.05.080, the Health and Social Services Committee reviewed the following and recommends the appointments be forwarded to a joint session for consideration:

Board of Dental Examiners
Dr. Thomas J. Wells - Anchorage
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Marital and Family Therapy
Kennith E. McCarty - Kodiak
Appointed: 3/1/2010 Term Expires: 3/1/2013

Alaska Mental Health Trust Authority Board of Trustees
Laraine L. Derr - Juneau
Appointed: 10/19/2005
Reappointed: 3/1/2010 Term Expires: 3/1/2015

Mary Jane Michael - Anchorage
Appointed: 3/1/2009
Reappointed: 3/1/2010 Term Expires: 3/1/2015

Carlton R. Smith - Juneau
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Certified Direct-Entry Midwives
Jennifer Grimwood - Cordova
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Nursing
Nancy Bienvenue - Fairbanks
Appointed: 3/1/2010 Term Expires: 3/1/2014

Kevin B. Dougherty - Eagle River
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Examiners in Optometry
JoAnne Bell-Graves - Juneau
Appointed: 3/1/2010 Term Expires: 3/1/2014

James C. Graves - Fairbanks
Appointed: 4/3/2006
Reappointed: 3/1/2010 Term Expires: 3/1/2014

Board of Pharmacy
Anne F. Gruening - Juneau
Appointed: 3/1/2010 Term Expires: 3/1/2014

Richard C. Holm - North Pole
Appointed: 3/31/2006
Reappointed: 3/1/2010 Term Expires: 3/1/2014

State Physical Therapy and Occupational Therapy Board
Dr. Darin M. Bell - Seward
Appointed: 6/22/2009
Reappointed: 3/1/2010 Term Expires: 3/1/2012

Judy Bogard - Fairbanks
Appointed: 3/1/2010 Term Expires: 3/1/2014

Mary M. Robinson - Moose Pass
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Professional Counselors
Jennifer Burkholder - Anchorage
Appointed: 4/4/2006
Reappointed: 3/1/2010 Term Expires: 3/1/2014

Emily A. Zimbrich - Haines
Appointed: 4/4/2006
Reappointed: 3/1/2010 Term Expires: 3/1/2014

Board of Psychologist and Psychological Associate Examiners
Dr. Iva Greywolf - Sitka
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Social Work Examiners
Jason D. Floyd - Valdez
Appointed: 4/4/2006
Reappointed: 3/1/2010 Term Expires: 3/1/2014

Alaska State Legislature

Senate

Office of the Secretary

Official Business

State Capitol, Room 211
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Memorandum

TO: Senator Davis, Chair
Health and Social Services Committee

FROM: Kirsten Waid
Secretary of the Senate

DATE: March 8, 2010

SUBJECT: Confirmation of Governor's Appointments

Pursuant to AS 39.05.080, the President has referred the following names, with attached resumes, for legislative confirmation to your committee for a hearing, recommendation and report:

Board of Marital and Family Therapy
Wendy S. Hamilton – Douglas
Appointed: 3/1/2010 Term Expires: 3/1/2014

State Medical Board
Dr. William W. Resinger – Palmer
Appointed: 9/21/2007
Reappointed: 3/1/2010 Term Expires: 3/1/2014

Attachment: Resumes

KW:sgf
gl#4

LARAINE L. DERR

Left message 3/2

9325 View Drive
Juneau, Alaska 99801

FAX (907) 790-1803
Home (907) 789-3634

Work Experience:

2007-Current — Owner-operator, Chez Alaska Cooking School

Full-time cooking school for education and entertainment. Employs five chefs. Provides demonstration classes for cruise ship tours from May through September. Hands-on classes the remainder of the year, contract with Johnson Youth Center for culinary arts curriculum, home schooled student weekly classes, CBJ bi-monthly Wellness classes.

August, 2005 - July, 2006 — Business Adminstrator – part-time – Alaska Youth Choir

October, 2004 - May, 2005 — Director, Governor's Boards and Commissions Office, State of Alaska

Responsible for recommendations to Governor for 120 Boards and Commissions with over 1100 members. Governor's staff liaison to Departments of Education, Revenue, the University of Alaska, and the Alaska Industrial Development Board.

February, 1997 - Oct., 2004 — President/CEO, Alaska State Hospital and Nursing Home Association

Responsible for 37-member association's daily activities, working in concert with the board of directors executive committee and members to jointly achieve the goals, mission and vision established and approved by the board and implemented by the executive committee with reliance upon the chairs of the standing committees. .

February, 1995 - Feb., 1997 — Administrative Head, School of Business & Public Administration, University of Alaska Southeast

Responsible for statewide Bachelor in Business Administration program and Certified Public Manager Program. Department of 18 faculty, 10 staff.

July 1, 1994 - Dec., 1994 — Commissioner of Revenue, Department of Revenue/State of Alaska

Administrator in charge of Department of 400 employees. Responsible for the following Divisions: Oil & Gas Audit, Income & Excise Taxes, Child Support Enforcement, Charitable Gaming, Treasury, Alcohol Beverage & Control Board, Municipal Bond Bank, Permanent Fund Dividend, Administrative Services and the Hearing Officers. Member of following Boards: Alaska Permanent Fund Corporation, Alaska Housing & Finance Corporation., Alaska Industrial & Energy Development Corporation, Alaska Student Loan Corporation., State Bond Committee, Municipal Bond Bank, Executive Committee of National MultiState Tax Commission and Federal Tax Commission.

April, 1993 - July, 1994 — Deputy Commissioner, Department of Revenue, State of Alaska

Administrator in charge of Treasury for the State responsible for approximately $3 billion in investments, cash management of all funds that flow through the State of Alaska, and accounting for all assets held and invested for the State; administrative officer of the Alaska State Pension Investment Board, fiduciaries for Public Employees', Teachers', Military and Judicial Retirement Funds which have over $6 billion; responsible for Treasury budget of $22 million, debt management which arranges for all bond issues.

1987 - 1993 — Director of Business Services, Juneau School District, Juneau

Administrator in charge of finance, budget, maintenance, data processing services, facilities, and pupil transportation. Responsible for $37 million budget; 5 program directors with 160 classified employees; on-going interactions with school board, city assembly, and legislature, facilities committees, budget task force committee, parent groups; financial advisor for negotiations with classified and certificated staffs; constructing new facilities, dealing with federal and state agencies

1981-1987 — Statistical Supervisor, Planner, Project Director, State Department of Education, Juneau

Supervisor of unit that was responsible for state aid payments to all districts, federal PL874 aid to districts, federal liaison for interaction on National Common Core of Data; manager of state wide study on foundation funding

1983-Present

Organized and instructed several classes in leadership, computer spreadsheets, data bases, and word processing, *University of Alaska Southeast and in-district*

1981 — Legislative Administrative Assistant, Alaska State Legislature, Juneau

Dictated correspondence and conducted constituent office visits. Developed reports for and attended committee meetings

1975-1980 — Chemist and Engineer, Alaska Lumber and Pulp, Sitka, AK

Two and one half years as utility chemist; two and one half years as appropriations engineer responsible for contracts management. Position involved working throughout mill to assure pulp was "on-grade", coordination with professionals through laborers.

1973-1975 — Analytical Coordinator, Oregon State College, Corvallis, OR

Managed five laboratories participating in international research effort to model biological world

1967-1972 — Technician, University of Alaska, Fairbanks, AK

Soils laboratory technician in laboratory doing research on arctic tundra, analysis of soils for pipeline installation, interior forest growth

1964-1967 — Technician, Colorado State University, Ft. Collins, CO

Research in veterinarian medicine, 1 year; research in forestry, 1 year; microbiology, 1 year

Volunteer Experience:

Current:
Vice-Chair and Finance Chair, Alaska Mental Health Trust
Chair, University of Alaska College of Fellows
Member, Juneau Convention & Visitor Bureau
Member, Juneau Women's Network
Member, PEO
Chair, Advisory Board, Certified Public Manager Program, University Statewide
Member, University of Alaska Foundation Finance and Audit Committee
Current board member and Charter member, Southeast Alaska Food Bank, Food chair and cook, Thanksgiving in March fundraiser
Costume designer and seamstress, Juneau Douglas High School Theater
Board Member & Treasurer, The Whale Project

Past:
First Lady's Volunteer of Year, Statewide Award, 2006
Juneau, Citizen of the Year, 1996
Delegate, National White House Conference on Aging, 2005
Delegate, Nation White House Conference on Indian Education, 1990
Member, Alaska 2000 Committee, Appointed by Commissioner of Education
President, University of Alaska Southeast Alumni Association
President, Alaska School Business Officer's Association, Member, American School Business Officer's Association
Chairman of Board, Alaska Division, American Cancer Society, past local president, chairman of Western Area Leadership Conference, western United States
Member, Constituting Convention for formation of the Alaska Synod of the Evangelical Lutheran Church in America
Chairman, finance committee, council member, Resurrection Lutheran Church
Chairman, Sitka School Board
Chairman, Fourth District Republicans
Member, Past Chairman, Big Brothers/Big Sister
Member, Tongass Girl Scout Board

Education:

Doctorate of Laws Honorary Degree, University of Alaska, 2009
Master's in Business Administration, University of Alaska Southeast, 1984
Bachelor of Arts in Education, Chemistry, Wayne State College, Nebraska, 1964

Have made presentations at many workshops, training seminars and published in national journals.

Mary Jane Michael
2421 Wellington Court
Anchorage, Alaska 99517
maryjanemichaelak@gmail.com
Home (907) 258-2701 Cell (907)440-1707

PROFESSIONAL EXPERIENCE

Executive Director 2003 to 2009
Office of Economic and Community Development, Municipality of Anchorage
For the past six years served as an executive to the Mayor, responsible for promoting public and private economic development projects for the Municipality of Anchorage. Highlights have included the new Dena'ina Civic and Convention Center completed in September of 2008, the transfer of the Museum from a public to private non-profit entity, the Library Renewal Initiative, reorganization of the Parks and Recreation Department and the creation of the Parks and Library Foundations which raised more than $30 million combined. Supervised the completion of the Downtown Comprehensive Plan and helped spearhead the revitalization of one of our most underserved neighborhoods, Mountain View. Responsible for seven departments including the Planning Department, Heritage Land Bank and Real Estate Services, Libraries, Parks and Recreation, the Department of Neighborhoods, the Port of Anchorage, and the Anchorage Community Development Authority. Responsibilities also included formulating and approving budgets, departmental reorganizations, multimillion dollar grant writing, real estate, capital improvement project planning and local, state, and federal requests.

Executive Director and CEO 1999 to 2003
Anchorage Neighborhood Housing Services
Executive Director for Anchorage Neighborhood Housing Services (ANHS) a non-profit community development corporation dedicated to promoting affordable housing and neighborhood revitalization. ANHS is affiliated with the National Neighborhood Reinvestment Corporation and is certified as a Community Financial Institution. From 1998 to 2003 ANHS loaned $18 million and leveraged $34 million in first mortgages. Of the 545 loans made to low to moderate income families, 91 of those borrowers were persons with a disability. Additionally, ANHS owned and managed 1,150 units of affordable rental housing in twelve locations citywide. Total assets at the time were $62.2 million. Other responsibilities included overall management, legislative affairs, and grant writing.

Executive Director 1981 to 1999
The ARC of Anchorage
For 18 years served as the Executive Director for The Arc of Anchorage. The agency grew from a budget of $180,000 a year to $12 million serving more than 400 individuals. Programs included an array of services for children and adults with developmental and other disabilities including a day activity center, 24 hour residential care, case management, in-home family services, respite, and specialized services for persons with

dual diagnosis and emotional disturbances. Responsible for securing the funding, purchased, renovated and/or constructed more than 60 housing units, single and multifamily, to ensure safe, affordable housing. Worked with the Governor's Office and the legislature on many issues facing persons with disabilities throughout the State of Alaska. Other duties included assets management, program development, grant writing, public relations, fundraising, legislative affairs, and advocacy.

EDUCATION

1986 University of Northern Colorado, Greeley
Master of Arts in Rehabilitation Counseling with an emphasis in vocational evaluation

1976 California State University, Fresno
Bachelor of Science in Therapeutic Recreation

BOARDS

2009 to present	Alaska Mental Health Trust Authority
2000 to present	The Arc of Anchorage Foundation
2003 to 2006	Anchorage Community Development Authority
2004 to 2006	Civic Ventures Board of Director's
2004 to 2005	Anchorage Community Land Trust
2003 to 2005	Anchorage Convention and Visitors Bureau
2003 to 2005	Alaska Native Heritage Center
2002 to 2007	Special Olympics of Alaska

AWARDS AND HONORS

2009	Legislative Commendation for Service to the City of Anchorage and the State of Alaska
2005	Heart of the City Award "Visionary Award" Downtown Partnership
1996/2005	YWCA Outstanding Professional in Chosen Field Nomination
1999	International People First Conference Award
1998	Gold Key Award, Key Campaign
1998	People First Award for Support
1997	State of Alaska, Recognition of Harborview Hospital Closure
1991	Legislative Commendation for Services to the Developmentally Disabled
1990	Outstanding Service to the National Conference of Executive Directors/ The Arc of the United States
1986	Kappa Delta Pi Honor Society
1984	The Arc of Alaska Commendation
1984	The Arc of Anchorage Board Commendation

left message 8:56 am 3/2/10

CARLTON SMITH

3000 Goodwin Road, Juneau, AK 99801 ▪ (907) 463.4800 wk ▪ carltonsmith@gci.net

Corporate leader and investment professional with 20+ year success record of crafting financial turnarounds and growth by instituting corporate governance true to core mission, creating financial discipline within subsidiaries, and structuring top asset portfolio performance to fuel cash flow / long-term growth.

Extensive corporate board experience. Stanford graduate. Skilled steward for real estate, portfolio management, land, and ANCSA settlement trusts for corporate/high-net-worth investor portfolios up to *$225+M.* Own positive relations with government and Alaskan community. Deep understanding and respect for native culture and goals.

Value Offered

- **Strategic Leadership & Opportunities Analysis** – Evaluated the competition, establishing lead banking facilities for Kootznoowoo Real Estate LLC entities. Forged organizational and financial strategies that cut portfolio admin costs and radically increased ROI on their $10M business revenue and a $12M real estate portfolio.
- **Financial Management & Turnarounds** – Restructured Kootznoowoo Inc., restoring profits in less than 2 years. Led loan workout with Wells Fargo Bank, forestalling foreclosure.
- **Boards & Due Diligence** – Director, corporate officer, and board advisor for multiple ANCSA corporations. Named to national Dept. of Commerce panel to evaluate new Native American Entrepreneurship and Trade office. Assistant Corp. Secretary to Sealaska and subsidiaries; driver of all outreach to 15,000 shareholders.
- **Corporate Real Estate** – Assess, broker opportunities, and acquire properties for ~ *$50M* portfolios. Oversee property management agreements for portfolio holdings with external property managers in multiple markets.
- **Trusts & Investment Policy** – Facilitated Kootznoowoo executives, staff, and auditing team in setting audit standards, corporate governance, investment guidelines, and portfolio performance standards. Managed stock, real estate, and business investments in Permanent Fund and Elder's Settlement Trusts. Managing member of 3 LLC real estate entities: Chatham Properties, Mitchell Bay Properties, and Admiralty Bay Properties, LLC.
- **Land Management** – Deep knowledge of land stewardship. At Kootznoowoo, oversaw 31,000 acres of ANCSA land, handling environmental, security, timber harvests, marketing, and co-management with US Forest Service.

Professional Experience

THE CARLTON SMITH COMPANY, www.thecarltonsmith.com, Juneau, AK — 1989 - 1998 and 2001 - Present

President / Chief Investment Adviser

Represent corporations, both in-state and nationwide, native and private, in various types of real estate transactions including: sales, commercial leasing, valuations, acquisitions, exchanges, and property management. Coordinate acquisitions for corporate clients with balance sheet equity in excess of *$50M.* Key clients include:

Village Corporations

- **Shee Atika** – Advisor for creation of a real estate policy. Conducted board training. Facilitated *$28M* portfolio of investment-quality lower-48 income properties with returns that outpaced policy guidelines.
- **Shee Atika Fund Endowment** – Identified and secured $7m of property in 2005 within policy guidelines.
- **Goldbelt Inc.** – Profitably sold 2 subdivisions, an office building, and a distressed sand and gravel tract.
- **Kootznoowoo, Inc.** – Established holding company structure and LLCs to own and manage acquisitions. Acquired and managed *$12M* portfolio comprised of NNN and multi-tenanted properties.
- **MTNT Limited** – (5-village corp. consortium). Negotiated favorable purchase of a 75-unit downtown Anchorage apartment building. Developed corporate real estate policy for acquisitions and management/ resale of corporate land owned by 975 shareholders.

Regional Corporations

- **NANA Development Corp.**- Facilitated purchase from Puget Sound Bank of a 41K SF Class A office building in Anchorage as NANA corporate headquarters. Conducted buy/sell analysis of 88 multi-family units and a 17-acres industrial parcel in Kotzebue, AK.
- **CHUGACH** - Provided foreclosure consulting for re-marketing the sale of 2 Anchorage headquarters buildings. Negotiated both sales.

Professional experience (continued)

THE CARLTON SMITH COMPANY – continued

Regional Corporations – continued

- **AHTNA Corporation** - Provide investment analysis and leasing services.
- **Central Council of Tlingit Haida Indian Tribes of Alaska** - Designated leasing broker, CCTHITTA.

Private Corporations

Alaska USA Federal Credit Union; The Salvation Army, Alaska Division; The Church of Jesus Christ of Latterday Saints (National); Federal Express; First Bank of Ketchikan; The Grand Camp of the Alaska Native Brotherhood

MAMMOTH EQUITIES LLC, Mission Viejo, CA 2001 -2004

Vice President, Capital Markets

Raised investment capital from high-net-worth individuals, Native American tribes, and ANCSA corporations. Maintained investor relations for investors nationwide including investment reporting and asset performance.

- **Investor Relations & Capital Growth:** Served a national equities firm with $225M under management. Groomed relationships with new and existing investors, including corporate and high-net-worth individuals. Supervised a $16M portfolio, including asset allocations, distribution policies, and reporting to stakeholders.

KOOTZNOOWOO INCORPORATED 1998 – 2001
TAQUAN AIR SERVICES 1998 – 2001

Chief Executive Officer

Took on challenge of leading and crafting the comprehensive turnaround of an overextended ANCSA native organization and a cash-poor airline subsidiary. Analyzed existing assets, opportunities, organizational strengths and weaknesses, human capital investment and a diverse investment portfolio. Developed and executed a two-prong strategy that instituted cuts and *near-term profits/sufficient cash flow restoration in just 20 months* and overhauled operational/investment practices, creating *ample long-term income* for sustained growth and solvency.

Led leadership team, 22 staff, and 2 field offices. Worked closely with Finance Officer, finance staff, and external auditors to strengthen audit standards, corporate governance, analysis of new investment opportunities, and establishment/monitoring of portfolio performance standards. Used trusts/legal vehicles to avoid foreclosures.

- **Strategic Leadership & Organizational Development**
  - **Redesigned the corporate staffing structure** to better establish direct reporting relationships and accountability for specific corporate functions with new individual position descriptions company-wide.
  - **Brought portfolio management oversight in-house, cutting costs 50% and upping returns.** Promoted the Vice President of Finance to Senior Vice President of Finance to provide direct oversight for Portfolio consultants, money managers, and Real Estate financing and refinancing activities.
  - **Bred accountability: Implemented quarterly/semiannual /annual personnel evaluations.**
  - **Formalized quality service delivery, leading creation of procedures, policies, and manuals.** Structured and led development of personnel manual and office procedures manual for corporate and subsidiary employees, including the addition of updated policies on company security, use of computers, and corporate ethics. Developed job categories/supporting job descriptions for all positions.
- **Financial Management:**
  - **Executed the creation of Kootznoowoo, Inc.'s commercial real estate portfolio,** achieving profitability for the parent corporation in 20 months. Formulated short- and long-term strategies for acquisition, management, and disposition of a real estate portfolio valued at $12 million.
  - **Maintained exceptional returns for a *$10M* portfolio** and slashed overhead costs. Stringently introduced a prudent asset reallocation/balanced investment strategy, replacing former high-risk practices. Established formal investment policy to support Board's strategic vision and mission.
  - **Successfully restructured debt** with Wells Fargo Bank and all major creditors, avoiding foreclosure.

Professional experience (continued)

SMITH STEVENS INSURANCE – Anchorage, AK 1995 - 1999

Chairman of the Board

Led development and profitable operations for Alaska's first MWBE financial services firm. Correctly identified need for a local provider of investment, employee benefit, and HR administrative services that understood the Alaskan community. Served business needs for payroll deduction, life insurance, and employee benefit plans. Acted as local underwriter for major insurers, i.e., Premera Blue Cross, TransAmerica, NY Life, and Principal Financial Group. Primary clients: Alaskan Native Tribes, Village and Regional Corporations and subsidiaries.

Other employment: SEALASKA– Juneau, AK 1980 - 1984 and 1996 - 1998

Assistant Corporate Secretary/Manager, Investor Relations (1980-1984)/ **Boardmember** (1989-1998)

As sole administrative liaison to 18-member Board and 8 standing committees: Researched and provided strategy and planning recommendations, strategic communications, logistics, documentation compilation support, and overall coordination of governance/investment issues. Developed and implemented outreach, annual meetings, communication plans/proxies, and compliance to satisfy the needs of 15,000 shareholders.

As a boardmember charged with portfolio due diligence and policy development: Led creation of first-ever investment policy for a $135M balanced portfolio. Instilled financial discipline, overseeing outside financial consultants and money managers in the development of asset allocation guidelines.

Education & Licenses

B.A., Economics/Political Science - Pre-Law. Stanford University, Palo Alto, CA
Commercial Real Estate Brokers License, State of Alaska #10266
Personal Lines Insurance Brokerage License, State of Alaska

Board and Trustee Positions

CHAIRMAN:	
Kootznoowoo Elders Settlement Trust	2001 – 2007
Southeast ANCSA Presidents Association	1998 – 2001
Alaska Brick Company	1990 – 1998
Sealaska Corporation, Chairman, Finance Comm.	1992 – 1995
Chatham Seafoods Company	1992 – 1998
Fairbanks Sand & Gravel	1992 – 1998
Sealaska Timber Corporation, Vice Chairman	1997 – 1998
Salvation Army, Alaska, State Board Chairman & Director	1993 – 1996
Alaska State Chamber of Commerce, Executive Committee	1998
DIRECTOR:	
SE Regional Council, Boy Scouts of America	1999 – 2002
Sealaska Corporation	1988 – 1998
National Native News	1996 – 1998
Alaska Native Cultural Center Capital Committee	1997 – 1998
Swecker Salmon Farms	1990 – 1991
Big Brothers/ Big Sisters of Southeast and Statewide Merger Board	2007 - 2008
TRUSTEE:	
Kootznoowoo Permanent Fund Settlement Trust	2004 – 2009
SEARHC Foundation	2002 – 2008
SE Tribal College	2001 – 2003
Sealaska Heritage Institute	1981 - 1991
OTHER	
Admiralty Island Alliance — Founding Officer, Vice President & Secretary	1999 - 2001
Alaska State Chamber of Commerce — Executive Committee	1998
Pew Charitable Trust — National Civic Entrepreneur	1998
Sealaska Heritage Foundation 501©(3), Founding Officer, Vice President & Secretary	1981 – 1991

Nancy Bienvenue
PO Box 58221
Fairbanks, Alaska 99711
Residence: 1407 Michael Lane
Fairbanks, Alaska
hm (907) 488-0953 / ofc (907) 455-8201 / cell (907)347-2254
nancyb@carenetfairbanks.com

Objective: To serve on the Alaska State Board of Nursing

Currently employed as CEO of Care Net Pregnancy Center of the Tanana Valley, a faith based, 501(c)(3) pregnancy resource clinic; mission statement: *Serving women, Upholding Life*

Summary of Qualifications:

- Currently licensed as registered nurse in Alaska, license # 17680
- Six years experience as executive director/CEO of Care Net Pregnancy Center
- 15 months experience as peer counselor / Care Net Pregnancy Center
- Has demonstrated leadership / administrative / program development skills,
- Has extensive nursing experience in maternal/child health.
- Easily establishes and maintains rapport with supervisors and coworkers.
- Is a member of Door of Hope Church since its founding; attends regularly and participates with husband in leadership activities such as greeting and leading a cell group in their home.
- Has working knowledge of the major nonprofits, agencies, service providers, and faith-based organizations in the community.

Experience:

April, 2004 – present – CEO of non profit organization, Care Net Pregnancy Center of the Tanana Valley, serving over 1000 women annually. The Center is a pregnancy resource clinic, providing pregnancy confirmation, options counseling, and pregnancy support services for women experiencing unplanned pregnancy.

September 30, 2008 – On behalf of Care Net Pregnancy Center, successfully competed for the Federal CBAE (Community Based Abstinence Education) grant. The five year award of $515,000 per year from the US DHHS, ACF/ACYF/FYSB was received 9/30/08 and has funded the *Step Up Now to Healthy Relationships* program. Step Up Now serves 12 to 18 year old youth in Fairbanks with the message of risk avoidance and healthy relationships.

November, 2002 – April 2004 – volunteered regularly (8-10 hours/weekly) at Care Net Pregnancy Center (then known as Pregnancy Resource Center) as a peer counselor and post abortion healing group facilitator. Served 8 women in 2 groups in 2004-2005 Training includes: Adoption Specialist Training, Care Net Peer Counselor training, Post Abortion Truth for Healing facilitator training. Enjoyed an excellent relationship with the staff and volunteers of the CPC. Became familiar with the structure and function of the CPC by being available for assisting the staff in various tasks.

1998-2002 – Contact person for Door of Hope Church/Love, INC

1998-2000 – Assisted in establishing of Father's House Single Parent Ministry. Facilitated parenting classes for two years for Father's House.

1996-1999 – Employed by the Northwest Medical as home health nurse; duties included equipment rental, CPR instruction, home testing (sleep studies on infants), in-hospital testing of high risk infants.

Dec 1995-Sept 1996 – Volunteered to care for neighbor's infant who required skilled NICU nursing care at home; averaged 3-4 days/week.

Spring 1994-Summer 1995 – Volunteer caseworker for Love, INC

(Moved to Fairbanks, Alaska from San Antonio, Texas in January 1994)

1985-1993 – Humana Women's Hospital, San Antonio, TX – employed as RN – staff nurse labor/delivery, NICU, ante- and post-partum. Also taught childbirth classes, developed curriculum for and taught cesarean classes, and sibling classes.

1984-1989 – San Antonio - employed in OB/BYN office shared by 3 MD's. Was the only licensed nurse; carried out multiple tasks and had numerous responsibilities involving all aspects of patient care, with an emphasis on patient teaching/phone counseling.

1977-1984 – San Antonio - co-director of Alamo Childbirth Training Association, as independent non-profit organization providing childbirth instruction to the community. Was certified as a Lamaze instructor. Taught childbirth classes and cesarean classes. As co-director, was liaison to the professional community. Responsibilities included office reception, arranging classes, handling accounts receivable, light bookkeeping, setting up events such as Professional Division luncheon meetings, which at times involved guest speakers.

Education: Bachelor of Science in Nursing / University of Texas Health Science Center at San Antonio School of Nursing; 1977

Personal – Married to Richard Bienvenue 1993; 5 children, 4 grandchildren. Interests: gardening, sewing/crafts, outdoor activities, traveling

Personal testimony and references available upon request

Wendy S. Hamilton
Box 240674
Douglas, AK 99824
907-209-0023

Education:

Bachelor of Human Services, University of Alaska Anchorage, Magna Cum Laude, 2002
Relevant coursework: Alternative Dispute Resolution; Rural Treatment Strategies; Substance Abuse Counseling; Counseling Skills I-IV; Natives of Alaska; Human Behavior and Diversity; Ethics; Statistics; Fundamentals of Oral Communication and Leadership Skills; and Methods of Written Communication.

Work Experience:

National Council on Alcoholism and Drug Dependence **Dec. 2004-Present**
Therapeutic Court Coordinator – Dec. '04 – Oct. '06 - Initiated and implemented Juneau's first Therapeutic Court; designed forms, wrote policies and procedures and coordinated the therapeutic court team; networked with local community organizations such as State Dept. of Law, City and Borough of Juneau Law Dept., Juneau Police Dept. and Rainforest Recovery Center; wrote grant renewals and quarterly reports; supervised all clients in the Juneau Therapeutic Court, including compliance checks, coordinating adjunctive services and regular home visits.
Tobacco Program Coordinator – Oct. '06 – Present - Coordinate implementation of the State Tobacco Prevention and Control grant; supervise the Teens Against Tobacco Use (TATU) coordinator; create media campaigns about tobacco policy issues; organize the Juneau Clean Air community coalition; work to implement Juneau's Clean Air ordinance.

State of Alaska, Dept. of Corrections, Felony Probation **June 2002-Dec. 2004**
Taught Cognitive Self Change and Victim Impact classes; taught and worked with clients participating in the Driving While Intoxicated Byrne Grant program; conducted group and individual intake orientation sessions reviewing conditions of release; perform individual case management and record keeping; administer risk assessment tools such as the LSI-R and Static 99; interview and counsel victims; provide clerical support to probation officers, writing reentry support groups both at the jail and the halfway house, including topics such as relapse, addictions, staying out and staying free and living in recovery; network with service providers in the community including the Job Center, Tlingit and Haida, JAMHI, individual counselors, child support services and Alaska Legal Services.

Self-employed **1989 - 2002**
Owned and operated yoga studio and bodywork practice; presented stress management classes and seminars for both the public and private sector; facilitated bereavement support groups and individual bereavement counseling.

Internship Experience:

State of Alaska, Dept. of Health & Social Services, Division Public Health, Community Health and EMS **2000 - 2001**

Assisted research analyst in data collection and compilation; interviewed health care providers throughout Alaska; utilized Access and Excel to enter data and print reports; prepared HPSA applications for federal approval.

Additional Training and Conferences:

ACCDPC Chemical Dependency Counselor I Certification; ASAM Criteria Training; Motivational Interviewing for Substance Abuse Counselors; Group Therapy for Substance Abuse Counselors; Cognitive Behavioral Skills training; Sex Offender Treatment Conference; National Conference on Addiction and Criminal Behavior; National Reentry Conference; Critical Incident Stress Management, Basic and Individual; Comprehensive Bereavement Skills.

References:

Available upon request.

RESUME

William W. Resinger, M.D.
P.O. Box 839
Palmer, Alaska 99645

Phone: (907) 745-1763 (home, unlisted)

Married
Wife's name: Edrea
No children

---EDUCATION---

Titusville High School, Titusville, PA - 1961
Seibert Award for highest scholastic average (4.00)

Allegheny College, Meadville, PA - 1965
Phi Beta Kappa (junior year)
Alden Scholar (Dean's List) all four years,
Honors in Chemistry
Magna Cum Laude

University of Pennsylvania School of Medicine, Philadelphia, PA - 1969
Honors in Radiology

Harrisburg Polyclinic Hospital, Harrisburg, PA
Intern (rotating) 1969 - 1970
Resident Radiology 1970 - 1971

Postgraduate Course in Emergency Medicine, Hershey, PA
September 1974, April 1977

University Hospital, University of Michigan
Fellow in Nuclear Medicine 9-78 - 8-79

Oakwood Hospital, Dearborn, MI
Resident Radiology 9-79 - 2-81

Certified American Board of Radiology (ABR)
Diagnostic Radiology with special competence in Nuclear Medicine, 6-4-82

Continuing Medical Education

Average 50 hours or more CME (usually Cat. I) each year since 1981

Twenty Years Experience in Reading Mammograms

Mammography Accreditation by A.C.R. at Valley Hospital 1988-2001

Training in mammography

- 8 weeks during residency (in 1980)
- Stanford Breast Symposium 3-20 - 3-22-86 (13.5 hours)
- Tutorial with Dr. McClure Hall at Virginia Mason Hospital, Seattle, WA 6-5 - 6-6-86 (16 hours)
- (RAD SAT) (ME-SAT) (Videotape Series), Johns Hopkins (Breast Imaging Techniques, 1987) (4 hours)
- RSNA TODAY (Screening Mammography), Vol. 1, No. 1, 1986 (one hour)
- At Least 15 hours Category I every three years to present

---WORK HISTORY---

Oil City Hospital, Oil City, PA
Emergency Physician 1971 - 1978

Mercy Memorial Hospital, Monroe, MI
Staff Radiologist 3-81 - 7-84

Valley Hospital, Palmer, Alaska
Staff Radiologist 8-84 - 12-01
Association Board Member 1992 - 2001

South Peninsula Hospital, Homer, Alaska
Locum Tenens Radiologist 2002,2003

Norton Sound Health Corp., Nome, Alaska
Locum Tenens Radiologist 2002-present

---ACTIVITIES AND ASSOCIATIONS---

ACEP (American College of Emergency Physicians)
Member 1971 - 1979
National Council Member 1973, 1974, 1975, 1977

Pennsylvania Chapter ACEP (American College of Emergency Physicians)
Board of Directors 1972 - 1978

Executive Committee 1973 - 1978
Treasurer 1974 - 1975
Editor of "EPIC" (newsletter) 1973 - 1977
President-elect 1976
President 1977

Community Ambulance Service
Board at large 1973
Board of Directors 1974

Comprehensive Health Planning Council of N.W. Pennsylvania
Member Venango County Task Force on Emergency Health Services
Executive Committee

Pennsylvania Emergency Health Services Council, 1974
Representative for N.W. Pennsylvania
Board of Directors
Subcommittee on Physician Training

Preceptor for Nurse Practitioner Program
Allegheny General Hospital and Oil City Hospital, 8-75 - 2-76

Medical Advisor EMS Council of N.W. Pennsylvania 1977-78

Glacier View Alliance Church, Palmer, Alaska
Elder and board member 1985-present

Pacific NW District of the Christian and Missionary Alliance
Liaison to the District Superintendent for Alaska 1995-present

Board of Trustees at Simpson University, Redding, CA
Member 1996-present, Chairman Student Affairs Committee

Board of Directors Heart Reach Pregnancy Center, Mat-Su Borough
Member 2001-9/2007

Board of Directors of Town and Country Manor, Santa Ana, CA
Member 2002-present, Chairman Benevolence and Health Services Committees

Society Memberships

American Institute of Ultrasound in Medicine -retired
Society of Nuclear Medicine -retired
RSNA (Radiological Society of North America) -active
ACR (American College of Radiology) -retired

---PUBLICATIONS AND ABSTRACTS---

Publications

Weigel, J.A., Resinger, W.W.: Are You in Good Hands? Pennsylvania Medicine 78:53-54, 1975.

Resinger, W.W., Thrall, J.H.: Diagnosis of Ruptured Bladder During a 99mTc-DTPA Renal Study: New Indications for Radionuclide Cystography? Clinical Nuclear Medicine 3:179-180, 1979.

E.A.: Scintigraphic Tomography of the Thyroid. Proceedings of the Eighth International Thyroid Congress Sydney, Australia, February, 1980.

Publications (continued)

Freites, J.E., Fink-Bennett, D.M., Thrall, J.H., Resinger, W.W.: Efficacy of Hepatobiliary Imaging in Acute Abdominal Pain: Concise Communication. Journal of Nuclear Medicine 21:919-924, 1980.

Resinger, W.W., Rose, E.A., Keyes, J.W., Jr., Koral, K.F., Rogers, W.L., Brady, T.J., Kline, R.C., Sisson, J.C., Thrall, J.H.: Tomographic Thyroid Scintigraphy: Comparison with Standard Pinhole Imaging. Journal of Nuclear Medicine 22:638-642,. 1981.

Keyes, J.W., Jr., Kline, R.C., Resinger, W.W., Rose, E.A., Koral, K.F., Rogers, W.L.: Comparison of Observer Performance Reading from a Video CRT vs. Reading from Film Investig. Radiol. 18:298-300, 1983

Abstracts

Annual Meeting, June, 1980.

Scintigraphy: Comparison with Standard Pinhole Imaging. Society of Nuclear Medicine 27th Annual Meeting, June, 1980.

Senator Davis

Alaska State Legislature

Senate

Office of the Secretary

State Capitol, Room 211
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Official Business

Memorandum

for 2-2
Feb 24

TO: Senator Davis, Chair
Health and Social Services Committee

FROM: Kirsten Waid KW
Secretary of the Senate

DATE: February 4, 2010

SUBJECT: Confirmation of Governor's Appointments

Pursuant to AS 39.05.080, the President has referred the following names, with attached resumes, for legislative confirmation to your committee for a hearing, recommendation and report:

Board of Dental Examiners
Dr. Thomas J. Wells - Anchorage
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Marital and Family Therapy
Kennith E. McCarty - Kodiak
Appointed: 3/1/2010 Term Expires: 3/1/2013

Alaska Mental Health Trust Authority Board of Trustees
Laraine L. Derr - Juneau
Appointed: 10/19/2005
Reappointed: 3/1/2010 Term Expires: 3/1/2015

Mary Jane Michael - Anchorage
Appointed: 3/1/2009
Reappointed: 3/1/2010 Term Expires: 3/1/2015

Carlton R. Smith - Juneau
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Certified Direct-Entry Midwives
Jennifer Grimwood - Cordova
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Nursing
Nancy Bienvenue - Fairbanks
Appointed: 3/1/2010 Term Expires: 3/1/2014

Kevin B. Dougherty - Eagle River
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Examiners in Optometry
JoAnne Bell-Graves - Juneau
Appointed: 3/1/2010 Term Expires: 3/1/2014

James C. Graves - Fairbanks
Appointed: 4/3/2006
Reappointed: 3/1/2010 Term Expires: 3/1/2014

Board of Pharmacy
Anne F. Gruening - Juneau
Appointed: 3/1/2010 Term Expires: 3/1/2014

Richard C. Holm - North Pole
Appointed: 3/31/2006
Reappointed: 3/1/2010 Term Expires: 3/1/2014

State Physical Therapy and Occupational Therapy Board
Dr. Darin M. Bell - Seward
Appointed: 6/22/2009
Reappointed: 3/1/2010 Term Expires: 3/1/2012

Judy Bogard - Fairbanks
Appointed: 3/1/2010 Term Expires: 3/1/2014

Mary M. Robinson - Moose Pass
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Professional Counselors
Jennifer Burkholder - Anchorage
Appointed: 4/4/2006
Reappointed: 3/1/2010 Term Expires: 3/1/2014

Emily A. Zimbrich - Haines
Appointed: 4/4/2006
Reappointed: 3/1/2010 Term Expires: 3/1/2014

Board of Psychologist and Psychological Associate Examiners
Dr. Iva Greywolf - Sitka
Appointed: 3/1/2010 Term Expires: 3/1/2014

Board of Social Work Examiners
Jason D. Floyd - Valdez
Appointed: 4/4/2006
Reappointed: 3/1/2010 Term Expires: 3/1/2014

Barbara I. Paddock - Juneau
Appointed: 12/24/2009 Term Expires: 3/1/2011

Laura Thiesen - Glennallen
Appointed: 3/1/2010 Term Expires: 3/1/2014

Attachment: Resumes

KW:sgf
gl#3

CURRICULUM VITAE-2009

Name: Thomas Joseph Wells, DDS,MS.

Age: 65

Marital Status: Married

Number of Children: Five

Education: DDS. Indiana University, 1967
Internship, United States Air Force, 1967-1968
Oral and Maxillofacial Surgery Residency, 1972-1975
Master of Science Degree, University of Texas, 1975-1976

Military Service: Active Duty United States Air Force, 1967-1979

Employment: Private Practice 1979-present

Specialty Board: Diplomate American Board of Oral and Maxillofacial Surgery 1977

Hospital Affiliations: Alaska Regional Hospital, Anchorage, Alaska
Providence Hospital, Anchorage, Alaska
Alaska Surgery Center

Society Memberships: American Dental Association
American Association of Oral & Maxillofacial Surgeons
American College of Oral & Maxillofacial Surgeons
Alaska Dental Society
Western Society of Oral & Maxillofacial Surgeons
South Central District Dental Society
Alaska Society of Oral & Maxillofacial Surgeons

Committee Activities: Past-President South Central District Dental Society
President Alaska Society of Oral & Maxillofacial Surgeons
National Delegate American Society of Oral & Maxillofacial Surgeons 1986-1995, 2000-2002

Credentials Committee: Providence Hospital 1990-1992, 1994 and 1995

Advisory Boards: Dental Hygiene Program UAA 1986-1991
Alaska Surgery Center 1988-1991
Board of Directors & Editor Western Society of Oral & Maxillofacial Surgeons 1992-1996

License: Texas and Alaska

Consultant: Alaska Department of Occupational Licensing 1999-2002

Community Activities: St. Elizabeth School Board 1998-2001
Starboard Cove Homeowners Association Treasurer 1997-2009

Kennith E. McCarty
1423 Simeonof St.
Kodiak, AK 99615
(907) 487-2223

CAREER SUMMARY

Accomplishments as a psycho-therapist, clinical supervisor, administrator, and educator. Demonstrated accomplishments in marriage, family, and child counseling; adolescent treatment; residential treatment; education; substance abuse / dependence treatment; administration; public speaking; wilderness intervention programs; trauma interventions, and working with court referrals (Social Services, Probation, Victims of Crime, and Family Mediations) and agency systems. Demonstrated accomplishments as an educator: director of McCarty's Resource Skills Center, adjunct professor at National University, adjunct professor at Biola University, and teacher in the public and private school setting.

EDUCATION

Master of Arts – MFT (4/1998)
Marriage, Family, and Child Counseling
Western Seminary, Los Gatos, California

Master of Arts (5/1989)
Christian Education/Counseling
Biola University, La Mirada, California

Bachelor of Arts Degree (5/1988)
Christian Education / Recreation Administration
Biola University, La Mirada, California

PROFESSIONAL EXPERIENCE

Private Practice – Licensed Marriage, Family Therapist (LMFT)
Discovery Cove Recovery & Wellness Center - (907) 487-2223
Private Practice, Kodiak, Alaska (3/5/2009 to present)
Owner & Director. Licensed Marriage Family Therapist and Clinical Supervisor in Alaska (MFT #237) and California (MFT37996)

Team Leader of Safe Harbor Program & Counselor
Providence Kodiak Island Counseling Center – Safe Harbor Program, Kodiak, Alaska (11/26/2007 to 3/4/2009)
Administrator, program development, and therapeutic counseling for clients abused by alcohol or drugs. Provide psycho-therapeutic counseling for clients receiving mental health services at PKICC.

Director of McCarty's Resource Skills Center -
Nonpublic School, Redding, California (8/1/2005 to 4/2008)
Administrator of a California State Certified Nonpublic School that serves Special Education and learning disabled students.

Counseling
Private Practice, Redding, California (3/2003 to 11/2007)
Private practice. Clients range from children, adolescents, adults, and couples. Therapeutic treatment include Structural and Systems orientation, EMDR, Dialectic Behavioral Therapy, Adventure therapy, and couples counseling. On the panel of several insurance companies.

Counseling
Victor Treatment Center, Redding, California (3/2001 to 1/31/2005)
Clinician / Team Leader for a RCL 14 treatment Group Home. Therapeutic treatment for adolescent girls and boys. Treatment included individual, group, Horse Therapy, Adventure Therapy, Non-Public School, and alternative health treatment. Treatment interventions included Cognitive / Behavioral, Structural Family Therapy, EMDR, Dialectic Behavioral, and Challenge Activities. Administrative duties involved overseeing staff and residents, administrative meetings, modification and implementation of systems, creation of interventions and assessments, writing proposals, and implementation of treatment activities.

Adjunct Professor
National University, Redding, California (7/2003 to present)
Adjunct professor in the undergraduate psychology department.

Counseling
Siskiyou County Behavioral Health, Yreka, California (9/2000-3/2001)
Youth & Family Division. Individual and family assessments and counseling, Therapeutic Behavioral Services, SOAP (Summer Outdoor Activity Program), Inter-agency collaboration and wrap around services (i.e. CPS, MAPS, Horse Therapy Program, Schools, Adjunctive communities resources, etc). Client(s) are generally from low social-economic or disadvantaged family environments (MediCal).

Counseling
Don Ostendorf Counseling Center, Redding, California (3/2000-3/2001)
Individual and group counseling. Lead therapist for counseling services at an Elementary school for students and families. Steering committee member for Healthy Start programs. Interagency collaboration and wrap around services (i.e. LIFT, probation, CPS, Drug / Alcohol, Churches, Court, Mediations, etc). Client(s) vary in social economic status and background. Most issues regarding children or adolescents involved behavioral problems due to depression, parenting dynamics, or ADHD. Adult issues included most Axis I and some Axis II issues. Referrals came from advertisements, courts, probation, CPS, or schools.

Counseling
Covenant Counseling / Remi Vista Foster Care, Redding, California (11/1998-1/2000)
Individual, group counseling, and case management with community clients and foster children. Contracted to work with Remi Vista Foster Agency. Marriage and family counseling for clients from the community at large. Group leader for issues dealing with drug and alcohol, Independent Living Skills, and Process Issues dealing with being in foster care.

Speakers Bureau for RESPECT
RESPECT PROGRAM, Shasta County, California (1998 to present)
One of several spokes persons for the community and businesses for the RESPECT program, who educate the public about the issues and intervention programs dealing with domestic violence.

Counseling
North State Counseling, Redding, California (9/1996 to 11/1997)
Individual and group counseling with community clients and adolescent in Group Homes. Equestrian group therapy program.

USCG Masters License (25 Ton Vessels) (6/1997)
Mahay's River Service, Talkeetna, Alaska
River boat captain in Alaska.

Mahay's River Boat Water Safety Certification (1996)
Mahay's River Service, Talkeetna, Alaska
River boat captain in Alaska.

Executive Director (11/1994-1/1997)
Mountain Meadows Christian Camp, Shingletown, California
Administrator, program developer, staff developer, financial developer, facilities developer, planning and oversight, marketing and client relations for a resident camp in Northern California.

Teacher
Shasta County Department of Education (1993-1997)
Substitute teacher for Elementary and Secondary education.

Wilderness Instructor – Pacific Crest Outward Bound
Pacific Crest Outward Bound
Instructed two week courses in Oregon and California.

Administrator
Long Beach Chapter of American Red Cross (4/1988-7/1992)
Administrator of Contract Education Health and Safety, and co-chair of the Southern California Safety Council. Health and Safety Instructor. National Disaster Team (assisted with disasters in 1992 including 7.2 Earthquake, floods, and L.A. riots).

Founder and Executive Administrator
Expanded Horizons Ministry (1983-present)
Experiential developmental and self-reflection wilderness program which provides services for adults, youth, leadership, church groups, and individuals.
- Instructor Trainer in White Water Rafting, Canoeing, Rockclimbing, Backpacking, and implementation of challenge activities.

Adjunct Professor
Biola University, La Mirada, California (1986-1992)
Instructor for the Physical Education Department.
- Instructor for Backpacking Classes
- Co-instructor for Rockclimbing Classes

PROFESSIONAL ASSOCIATIONS

AAMFT (American Association of Marriage Family Therapists)
AKMFT (Alaska Division of AAMFT)
AKMFT – Board Member
Alaska Care
Ann Clark Associates (EAP)
CAMFT – Member of California Association of Marriage Family Therapists
EMDR – Eye Movement Desensitization Reprocessing - Advanced Training Certification
Magellan
MHN – Military & Family Life Consultant
Network Provider
- **San Diego County**
- **Shasta County (prior)**
- **Sutter-Yuba Counties**

Redding CAMFT – Member of Redding Chapter of CAMFT
- Redding CAMFT Mental Health Disaster Services Coordinator

Primera – Blue Cross / Blue Shield
TriCare
United Behavioral Health
Wellness 2000

Kennith E. McCarty, M.A., LMFT
1423 Simeonof St. Kodiak, AK 99615
(907) 487-2223

Vitae

Year	Type	Activity
1/15/2010	Board Member	Alaska Division of AAMFT ▪ Elected Board Member
10/13-14/2009	Seminar	ASIST Training – Suicide Intervention ▪ Kodiak Coast Guard – Work Life Program ▪ Intervention Techniques for suicidal clients ▪ 16 Hours
8/1-10/12/2009	Coach	Kodiak High School Tennis Coach ▪ 26 team players and 2 assistant coaches ▪ Inspired tennis team to take a stance against suicide ▪ At least 2 hrs per day four days per week
8/17-18/2009	Seminar	Prime for Life – Instructor Training ▪ Prevention Research Institute / Alaska Department of Behavioral Health ▪ Instructor training for alcohol / drug education program ▪ 11 Hour Seminar
7/2009	Seminar	Supervision Part II ▪ Psych. Seminars ▪ 7 Hour Seminar
5/9/2009	Seminar Presenter	Stress Management Skills in the Health Care Industry ▪ Ken McCarty, M.A, LMFT ▪ 1 Hour Seminar presented to Celebration of Kodiak Nurses
3/30/2009	Seminar	Legal & Ethical ▪ CAMFT ▪ Legal / Ethical Review ▪ 2 Hours
1/9/2009	Seminar	Legal & Ethical ▪ CAMFT ▪ Treatment or Terminate and Refer ▪ 2 Hours
6/9-13/2008	Seminar	Hazeldon – Professionals in Residence Training ▪ 35 Professional Contact Hours
5/5-7/2008	Seminar	Annual School of Addiction ▪ 16 Hours of Seminars
3/3-6/2008	Seminar	Prime for Life Training ▪ Tom Fostman ▪ Risk Reduction - Substance Abuse Education / Treatment Training - Instructor ▪ 32 Hour Seminar
1/9-12/2008	Seminar	State of Alaska Substance Abuse / Behavioral Health Symposium ▪ Various speakers representing State of Alaska offices ▪ 24 Hours of Seminars
1/8/2008	Seminar	Suicide Prevention ▪ Dr. Kinard, Ph.D. ▪ 6 Hour Seminar
3/14/2007	Seminar	Supervision – Legal and Ethical Issues – Parts 1, 2, & 3 ▪ Richard Leslie L.D. ▪ 6 Hour Seminar

Year	Type	Activity
7/13/2006	Seminar Presenter	Axis IV Issues Regarding Clients and their Educational Stressors ▪ Ken McCarty, M.A, LMFT ▪ 1 Hour Seminar presented to Redding CAMFT members
6/19-23/2006	Seminar	Feuerstein's Instrumental Enrichment – Level 1 Training ▪ Dr. Kinard, Ph.D. ▪ 36 Hour Seminar
4/2006	Article	"10 Ways to Build Self-Confidence in your Teenager" ▪ North State Parent Magazine ▪ April 2006
2/11/2006	Seminar	CAMFT – Chapter Leadership Conference ▪ Varied Speakers ▪ 8 Hour Conference ▪ CAMFT Annual Leadership Conference in San Francisco
2/6/2006	Seminar	Assessment & Treatment of Bulimia and B.E.D. ▪ DaLene Forester, PhD., LMFT ▪ 1 Hour Seminar
1/14/2006	Seminar	Hypnosis – Introduction ▪ Patty Bay, MA, MFT ▪ 8 Hour Seminar
1/12/06	Seminar	Autism: Diagnosis & Treatment ▪ Kathryn Ranken, M.A., MFC ▪ 1 Hour Seminar
12/9/2005	Seminar	Bringing Interpersonal Neurobiology into your Mind and Psychotherapy Practice ▪ Daniel Seigel, M.D. ▪ 1 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/9/2005	Seminar	Facilitating Brain Plasticity in Hypnosis and Pschotherapy ▪ Ernest Rossi, Ph.D ▪ 1 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/9/2005	Seminar	The Psychobiology of Change ▪ Ernest Rossi, Ph.D & Daniel Siegel, M.D. ▪ 1 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/10/2005	Seminar	Releasing Emotional Enmeshment ▪ Robert Dilts ▪ 1 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/10/2005	Seminar	Trauma ▪ Bessel van der Kolk, M.D. & Donald Meichenbaum, Ph.D ▪ 1 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/9/2005	Seminar	Advances in Strategic Therapy ▪ Cloe Madanes ▪ 1 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/9/2005	Seminar	Using Experiential Methods to Elicit Change ▪ Jeffrey Zeig, Ph.D ▪ 1 Hour Seminar ▪ Evolution of Psychotherapy Conference

Year	Type	Activity
12/9/2005	Seminar	Supervision of a Few Difficult Cases ▪ Arnold Lazarus, Ph.D ▪ 1 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/9/2005	Seminar	On Shaping Ones Future: The Exercise of Personal and Collective Self Efficacy ▪ Albert Bandura, Ph.D ▪ 1 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/8/2005	Seminar	Ericksonian Therapy: Art and Essence ▪ Jeffrey Zeig, Ph.D ▪ 3 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/8/2005	Seminar	Dialectic Behavior Therapy: Overview and Examples with Suicidal Clients ▪ Marsha Linehan, Ph.D ▪ 3 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/8/2005	Seminar	Psychotherapy as Consciousness Adjustment ▪ Mary Catherine Bateson, Ph.D ▪ 1 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/7/2005	Seminar	Psychoanalytic Psychotherapy of Personality Disorders ▪ Masterson, Ph.D ▪ 3 Hour Seminar ▪ Evolution of Psychotherapy Conference
12/7/2005	Seminar	Treatment of Individuals with Aggressive Behavior: A Life Span Treatment Approach ▪ Donald Meichenbaum, Ph.D ▪ 3 Hour Seminar ▪ Evolution of Psychotherapy Conference
10/13/05	Seminar	Psychosocial Issues with Cancer Patients ▪ Beth Rhodes, MSW ▪ 1 Hour Seminar
7/28/05	Seminar	Depth Psychology ▪ Northern California Catholic Social Service ▪ 1 Hour Seminar
5/12/05	Seminar	Cognitive Therapy for Treatment Resistant Depression ▪ Judith Beck, Ph.D. ▪ 1 Hour Teleconference – United Behavioral Health
5/5/05	Seminar	California's Victim Compensation Program: An Overview ▪ Brian Lew & JoAnn Goodwin ▪ 1 Hour
4/14/05	Seminar	Symbolism of Fairytales in Depth Psychology ▪ Jonathan Young, Ph.D. ▪ 1 Hour – Redding CAMFT
3/25/05	Seminar	ADHD in Children ▪ Russell A. Barkley, Ph.D. ▪ 1 Hour Teleconference – United Behavioral Health
3/24/05	Seminar	ADHD in Adults ▪ Russell A. Barkley, Ph.D. ▪ 1 Hour Teleconference – United Behavioral Health
3/1/05	Seminar	Legal, Ethics, Hippa, and Supervision ▪ Daniel Tauba, JD, Ph.D. ▪ 6 Hours

Year	Type	Activity
3/1/05	Journal	"Making Memories to Remember" – Christian Quarterly ▪ Spring Journal 2005
12/12/04	Seminar	Invoking the Sage ▪ Jonathan Young, Ph.D. ▪ 6 Hours
10/26-11/20/04	Teacher	Introduction to Psychology ▪ National University ▪ Undergraduate level course
8/17-19/04	Seminar	Victor Treatment Centers, Inc. – Conference ▪ 12 Hour Seminar ▪ Aikido Therapy – Donald Saposnek, Ph.D ▪ Psychiatrist Panel
8/12-15/04	Disaster Relief	Mental Health Services for American Red Cross Shelter ▪ Bear Fire Victims ▪ Volunteer
8/13-14/04	Seminar	EMDR Advanced Clinical Applications– Dr. Laurel Parnell ▪ Sponsored by Redding CAMFT ▪ 14 hours
Summer 2004	Journal	"Adventure Therapy" – Christian Quarterly ▪ Summer Journal 2004
5/2/04	Seminar	Neurobiology of Anxiety and Depression – Dr. John Preston ▪ Sponsored by Professional Psych Seminars ▪ 6 hours
5/1/04	Seminar	Dialectic Behavior Therapy – Dr. Michael G. Wetter ▪ Sponsored by Professional Psych Seminars ▪ 6 hours
Spring 2004	Journal	"Balancing Life" – Christian Quarterly ▪ Spring Journal 2004
7/7-8/2/03	Teacher	"Addictive Disorders" ▪ National University – Redding, CA ▪ Undergraduate level course
4/4-6/03	Seminar	Transforming Trauma with EMDR – Part 2 Seminar – Laurel Parnell, Ph.D. • Sponsored by Alliant University • 18 hours
2/21-23/03	Seminar	Transforming Trauma with EMDR – Part 1 Seminar – Laurel Parnell, Ph.D. • Sponsored by Alliant University • 18 hours
8/26-28/02	Seminar	Annual Clinicians and Administrators Conference • Sponsored by Victor Treatment Center • Solution Focused Therapy • 11 hours
11/8/02	Seminar	Clinical Supervision – Patricia Drake, Ph.D. • Sponsored by Shasta County Mental Health • 6 hours
7/1/02	Seminar	Borderline Personality Disorder Study • CEU independent study
7/1/02	Seminar	Clinical Psychopharmacology • CEU independent study
4/03	Presenter	Personality Disorder and Treatment • Presented to the residential treatment staff at Victor Youth Services – Redding, CA

Year	Type	Activity
3/02	Presenter	Personality Disorder and Treatment ▪ Presented to the clinical team at Victor Youth Services – Redding, CA
2/20/02	Seminar	Personality Disorders in Social Work & Health Care Seminar – Gregory Lester, Ph.D • Sponsored by Cross Country University
8/22/01	Seminar	Strength Based Services Seminar ▪ Solution Oriented Therapy ▪ Sponsored by Victor Treatment Center ▪ 12 hours
June 2001	Designed	Mood Charting ▪ Created a Mood Chart which is used by Victor Youth Services and the Director of Psychiatry of Shasta County Mental Health
Fall 2000	Journal	"Stress Management" – Christian Quarterly ▪ Fall Journal 2000
4/9/99	Seminar	Family Violence Seminar – Cloe Madanes • Sponsored by Shasta County Mental Health • 6 hours
5/1/98	Seminar	Foster Parenting for the Year 2000 and Beyond – Laura Carter
4/2/98	Seminar	Assessment and Treatment of HIV/AIDS – Margaret E. Nettles, Ph.D • Sponsored by Shasta County Mental Health • 6 hours
10/18/97	Seminar	Intensive Psychotherapy for Adults Abused as Children: The Self-Trauma Model – John Briere, Ph.D. • Sponsored by Shasta County Mental Health • 7 hours
5/15/97	Seminar	In Quest of Answers – Jacolyn Cott • 7 hours

2 Saddle Pt. Dr. • PO Box 2132 • Cordova AK 99574

907-424-*5586 • chris7grim@ctcak.net

Jennifer Grimwood

objective

To apply for State of Alaska: Board of Direct-Entry Midwives, Public Member

Work of experience

1981-1983, 1988-89 Central KY Re-ed Lexington, KY

Residential treatment center for children with behavior disorders

Houseparent

1983-1986 Youth with a Mission Amsterdam, The Netherlands

Volunteer in half-way house

1986-1988 University of Kentucky, Lexington, KY

Administrative Asst.

1987-1988 Midway College, Midway, KY

Dorm Director

1990 Switzer Home, Kaitaia, New Zealand

Nurse asst.

1991-1992 Youth with a Mission, Fiji Islands

Worked in third world development

1995-1996 Prince William Sound Community College, Cordova, AK

GED, ESL tutor

2000-present, Kiwi Mechanical Plumbing and Heating, Cordova, AK Co-owner

1995-present, Homeschooled 5 children, Cordova, AK

education

1977-81, 1986-89 University of Kentucky, Lexington, KY

BA Technology, Science and Culture, post-grad work in engineering

Volunteer activities

Vacation Bible School Coordinator 2008-present

Children's Church Coordinator 2007-present

Republican Party of Alaska District 5 chair 2001-present

Girl Scout leader 2003-present

Organized and led European travel for Girl Scouts, Cordova 2006, 2010

REFERENCES

On request

Kevin Dougherty
18905 Monastery Rd.
Eagle River, Alaska 99577
(907) 694-5084

Objective: To volunteer on the **Alaska Human Rights Commission** in respect for the mission of the Commission as stated in our Alaska statute, Tittle 18.

PROFESSIONAL QUALIFICATIONS:

ATTORNEY at LAW: Member of the Alaska Bar Association since 1981. Admitted to practice by the Alaska Supreme Court and the U. S. District Court for the District of Alaska.

General Counsel: Served as legal counsel to the Alaska District Council of Laborers for 25 years (1981-2006) full-time, and currently part-time. This position involved the handling of Employment law cases including Employment Discrimination cases in the courts, EEOC, Alaska Human Rights Commission, and the AERC.

Vermont Law School: Juris Doctorate degree awarded 1981.
University of Massachusetts: Bachelors of Science degree awarded in 1978.

Governor's Task Force on Worker Compensation; Served on State of Alaska committee in 2006 to study the administration of the Alaska Worker Compensation law and review draft amendments.

COMMUNITY SERVICE:

PREGNANCY RESOURCE CENTER; Serve as member of the Board of Directors and Treasurer for the Eagle River PRC which assists women in crisis pregnancies, aiding families needing maternity clothing, or clothing and supportive items for newborns through their early childhood years. [2005-present].

LOVE INC of EAGLE RIVER: Serve as Vice President and Board member on organization dedicated to assist all people in need in the Eagle River to Peters Creek region by coordinating volunteer help and support from local Christian churches. [2005-present].

MOUNTAIN VIEW BOYS & GIRLS CLUB: Served on Advisory Board and assisted in fundraising activities for the purpose of supporting the mission of the Club to provide a

positive place for the teens and children of the Mtn. View neighborhood. Also provided free classes to teens on "How to Apply for a Job" to give them the confidence to enter the workforce, tips on filling out job applications, and good presentation at job interviews. [1990's].

CYSA SOCCER COACH: Served as coach for local children's soccer league. [1995-2000's].

References:

Crystal Kennedy--Anchorage School Board member.
Senator Fred Dyson—Alaska Senate/Eagle River dist.
Representaive Bob Lynn—Alaska House of Representatives

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Pharmacy Board
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: JoAnne Belle Graves

Mailing Address: 3319 Park Place

Residence Address: Same

City, State and Zip Code: Juneau, Ak. 99801

Home or Message Telephone: (907) 209-1206 Business Telephone: Same

Fax Number: ✓ Cell Phone: ✓

Email address: ✓

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES _____ NO X

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO X

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
Business Professional 37 yrs. in Alaska

B. List both formal and informal education and training experiences: (Use additional paper if necessary).
college grad.

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.
past president PTA, PTO, site councils HBV + F/D
Current School Board member. Term ends Oct 2010

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).
Self employed, Life the Alaska Business
past Chamber of commerce Board person;
Member S.A.A.

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: __ __ . __ __ SEX: FEMALE X MALE _____

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White ___

MILITARY SERVICE (if applicable, give dates): /

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): _____ Date: 1/20/10

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: JoAnne Bell-Graves Date: 1/20/10

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers / Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
X	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Lane Bell-Grayes (Age): 55 of (Hometown): Sitka
is (Job title/Place of employment): Business owner.
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): owned + operated business past 37 yrs. in S/E Alaska
(Or list relevant experience to the position you are being appointed to)
present School Board member in Juneau

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

ATTN: SUSAN FISCHETTI (Fax) 907-269-7461 Seat

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Optometry, Optometrist Seat
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: James C. Graves, Optometric Physician

Mailing Address: 3455 Rewak Drive, Ste. #102 Fairbanks, Alaska 99709

Residence Address: 750 Knightsbridge Road Fairbanks, Alaska 99708

City, State and Zip Code: _____

Home or Message Telephone: 907-451-0888 Business Telephone: 907-474-8695

Fax Number: 907-474-8727 Cell Phone: _____

Email address: _____ net

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES XXX NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc): _____ _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO XXX if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES XXX NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO XXX

If "YES", explain:

Feb 24 06 02:39p James C. Graves (907)474-8727 p.2

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria: Alaska Optometry License - obtained 07/10/81 (w/ TPA Endorsement)
US Dept. of Labor Bureau of Apprenticeship and Training Registration - obtained 01/30/85
FDA Certification for Corneal Refractive Therapy - obtained 09/18/02

B. List both formal and informal education and training experiences: (Use additional paper if necessary).
- West High School Graduate
- Pacific University, B.S.
- Pacific University College of Optometry - O.D.

Albina Action Center for the Underprivileged
Seattle Indian Health Board
Alaska Native Medical Ctr.

***See addendum

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

Associate Dirctor for the Eye Bank - Div. 49, Served 2 years
Chairman for the Sight and Hearing Saving Committee with the Lion's Club, Served 2 years

D. Employment work history - paid, unpaid or voluntary: (Use additional paper of necessary).

Contracted Optometrist (1981-1982) in Anchorage, Alaska.
Business owner as an Optometrist since 1982 in Fairbanks, Alaska to present.

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will no be used to illegally discriminate against you.

DATE OF BIRTH: _____ SEX: FEMALE _____ MALE XXX

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White ___

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): James C. Graves, O.D. Date: 02/23/06

Dr. James C. Graves 2/23/06

Please attach a current resume with your application.

***ADDENDUM to B: •Yukon Kuskokwim Health Corp. Clinic
•Pennsylvania College of Optometry - Treatment and Management of Disease

REFERENCE BY JEFFERY A. GONNASON, O.D.

Feb 24 06 02:39p James C. Graves (907)474-8727 p.3

Anne F. Gruening
3192 Pioneer Avenue
Juneau, AK 99801
(907) 586-2926

BA in Communications, University of Puget Sound
Community Volunteer

Employment:

1993 – 2000 Juneau School District, Substitute
1987 – 1991 Annie Kaill's, Juneau, AK

Activities:

- Held various positions on the Parent Boards at Glacier Valley Elementary School, Floyd Dryden Middle School and Juneau-Douglas High School.
- Served on Juneau School District committees, including those charged with the responsibility of interviewing candidates for Superintendent and Principal.
- Active in a number of local political campaigns, from writing brochures and advertising to knocking on doors.
- Volunteer with the Alaska Committee, helping to organize, set up and staff Juneau's presence at the Tanana Valley and Palmer State Fairs for the past 10 years.
- Active Board member of PEO, and international organization that raises money for educational scholarships and identified needs within the community.

Biographical Profile

Richard C. Holm, R.Ph., F.A.C.A., F.I.A.C.P., F.A.Ph.A.
167 S. Santa Claus Lane
North Pole, AK 99705
(907) 488-8555 (work)
(907) 488-1776 (home)

907 8035

States Licensed In: Alaska and Wisconsin

Business Activities: (Independent Pharmacist since 1987)

- Owner/Manager- North Pole Prescription Laboratory, Inc. (North Pole, AK)
  - Prescription and Prescription Compounding
  - Veterinary Pharmacy
  - Disease/Drug Management and Consultation Services
  - Home Infusion Services
  - DME
  - Assisted Living Care
  - Alternative Care
  - Drug Allergy Testing
- Owner- Hewitt's Drug (Anchorage, AK)- specializes in:
  - Prescription and Prescription Compounding
  - Long Term Care
  - DME

Current Memberships:

- NCPA
- APhA
- ACA
- IACP
- AKPhA
- Fairbanks PhA
- NHIA.

Offices Held:

1. Alaska Pharmaceutical Association:
   a. Board of Directors 1987-1996
   b. President-1994
2. APhA- APPM:
   a. Section on Ambulatory & Community Practice
      1. Member-At-Large 1996-1998
      2. Chair-Elect- 1999
      3. Chair- 2000
   b. Remington Honor Medal Selection Committee- 1998,1999, 2000
   c. Committees:
      1. Publications- 4 years
      2. Education- 2 years
      3. Grant Review Committee- 2 years
      4. Poster & Podium Review Committee- 3 years
         a. Chair- 1 year
      5. 1995 Graduate CPMP

3. NCPA:
    a. Participant in Annual Legislative Conferences
    b. Gov. Affairs Committee- 1995
    c. Third Party Payors- 1996 to present
    d. Student Roundtable participant- 3 years
    e. NIPCO Diplomate status- earned 1996
4. IACP:
    a. Board of Directors- 1996-2000
    b. Committee Chairs
        1. Compounders on the Hill- 2 years (chair)
        2. Compounding Pharmacist Certification Committee- present chairman

Professional Fellowships:

- IACP- 1997
- APhA- 2001
- ACA- 1996 (Silver Fellowship)

Pharmacist Care Certifications Held:

- Asthma and Respiratory Care (October 1997)
- General and Self Care
- Diabetes, Infectious Disease (May 1993)
- Ostomy and Wound Care (May 1997)
- Coronary and Hypertensive Care (May 1996)
- Women's Health (November 1998)
- Basic and Sterile Compounding (1991, 1994)
- Pain Management/Neuropathic Pain (Nerve Entrapment) (April 2003)
- Nutrition (1998 & 2003)
- Functional Medicine (December 2003)

Professional Honors and Awards:

- NARD Leadership Award- 1994
- McKesson Leadership Award- 1994
- Bristol Myers-Squibb Leadership Award- 1995
- M. George Weber Compounding Pharmacist of the Year Award- 1998
- Innovative Pharmacist Award- 1994
- Preceptor of the Year (2003)- Drake University School of Pharmacy
- APhA/APPM Ambulatory and Community Practice Distinguished Pharmacist of the Year Award (March 2004)
- Bowl of Hygeia Award (2005)

Schools of Pharmacy Faculty Appointments (Clinical Instructor):

- Drake University- 1993 to Present
- University of Colorado- 1999
- University of Kentucky- 2000
- Bernard J. Dunn (Shenandoah University)- 2000 to present
    -Community Residency Site
- Auburn University- 2001
- Creighton University- 2002
- Mercer University- 2000
- Ohio Northern University- 2002
- University of Iowa- 2003
- University of Nevada- 2003

Speaker:

- PCCA Presenter at National Meetings (1993-2001)
- AK State Nursing Annual Meeting
- AK State EMT Meeting
- AK Academy of Physician Assistants
- AK Veterinary Association
- Fairbanks (AK) Veterinary Association
- AKPhA Annual Meetings
- A Women's Affair Convention (Fairbanks, AK)- 2002
- Local lectures:
    - Monthly (HRT classes): 1998-present
    - Pain Management classes: 2003-present
- ACA Annual Meetings
- Published in International Journal of Compounding
- Numerous local civic clubs, etc.

Research: Grant from Ralston-Purina

-Nutrition Research on Working Dogs- 1999 to present

Consultant: Contracted Clinical Consultant- PCCA (1997-present)

Community Organizations:

- Rotary Club International
- Chamber of Commerce
- Borough Economic Development Committee
- Fairbanks Memorial Hospital Pain Committee
- Boy Scouts of America- 35 year veteran
- Loyal Order of Moose- Fellowship Degree (Past Governor- 2 terms; Board of Directors- 10 years; Charter Member- Local (North Pole) Lodge
- SPEBSQSA

Community Awards:

- Scoutmaster National Award of Merit
- Scoutmaster of the Year
- Silver Beaver Award- BSA
- Vigil Honor- BSA

Darin M. Bell, M.D.
417 1st Ave
PO Box 365,
Seward, AK, 99664
H: 907-224-3298
W: 907-224-5205
C: 907-362-1483
Darin.Bell@providence.org

EDUCATION / TRAINING

Residency: Family Medicine, Alaska Family Medicine Residency Program, 2005-2008
M.D. University of Texas Southwestern Medical School at Dallas, 2005
B.S. / B.A. Biology / Psychology, Texas Tech University, 2000; *suma cum laude; with highest honors*

LICENSURE / BOARD CERTIFICATION

American Board of Family Medicine, Board Certified - July 2008

PROFESSIONAL EXPERIENCE

Attending Physician: Family Medicine Clinic / Emergency Room, Providence Seward Medical Center, Seward, AK, 2008-present
Resident Physician: Alaska Family Medicine Residency Program, Providence Alaska Medical Center, Anchorage, AK, 2005-2008

EDUCATIONAL CERTIFICATION

Advanced Cardiovascular Live Support
Advanced Trauma Life Support
Advanced Life Support In Obstetrics
Neonatal Resuscitation Program
Pediatric Advanced Life Support

PROFESSIONAL ORGANIZATIONS

American Academy of Family Physicians, 2003-present
Alaska Academy of Family Physicians, 2005-present

SERVICE

Health and Wellness Lecture Series – Seward Senior Center, 2008-present
Bicycle Rodeo / Children's Bicycle Safety Program volunteer, 2009
Committee member, Domestic Violence / Sexual Assault Advisory Committee – Seaview Community Services, 2009
Resurrection Bay Watershed litter removal volunteer, 2009
Brother Francis Shelter, homeless clinic, 2007
Anchorage School District, sports physicals for low-income children, 2006
Tar-Wars, antismoking lecture series, 2000-2002
SCOPE community outreach clinic for the homeless, 2000-2001
Adopt-a-School, elementary science education program, 2000-2001

HONORS/AWARDS

Doris Duke Charitable Foundation Clinical Research Fellowship, 2003-2004
Howard Hughes Medical Institute Undergraduate Research Fellowship, 1995-2000

RESEARCH EXPERIENCE

1) Doris Duke Clinical Research Fellowship, UT Southwestern Medical Center, 2003-2004, T594M polymorphism and direct ENaC blockade with amiloride as treatment of hypertension in African Americans. PIs: Ronald Victor, M.D., Richard Auchus, M.D., Ph.D.
2) UT Southwestern Summer Research Program, UT Southwestern Medical Center, 2000, Expression of ectopic proteins in Drosophila S2 cells. PI: Marc Mumby, Ph.D.
3) Howard Hughes Medical Institute, Undergraduate Research Fellowship, Texas Tech University, 1995-2000, Molecular systematics of small mammals from the Southwestern United States and Northern Mexico. PI: Robert Bradley, Ph.D.

PUBLICATIONS

1) Genoways, HH, et al. Relationships of the pocket gophers of the genus *Geomys* in Nebraska. In submission, Journal of Mammalogy
2) Holliler JM, et al. Epithelial sodium channel allele T594M is not associated with blood pressure or blood pressure response to amiloride. Hypertension. 2006; 47(3):428-33. Epub 2006 Jan 23.
3) Bell, DM, et al. Patterns of Karyotypic Megaevolution in *Reithrodontomys*: Evidence from a Cytochrome-b Phylogenetic Hypothesis. Journal of Mammalogy. 2001; 82(1):81-91
4) Clary, ML, et al. Checklist of Mammals from Twelve Habitat Types at Fort Bliss Military Base; 1997-1998. Occasional Papers, Museum, Texas Tech University. 1999; 192:1-16
5) Peppers, LL. et al. Distributional Records of Mammals in Texas. Occasional Papers, Museum, Texas Tech University. 1998; 183:1-5

LANGUAGES

English, Spanish (basic spoken and written)

PERSONAL INTERESTS

Running, skiing, biking, kayaking, backpacking, SCUBA, climbing, travel, cooking

REFERENCES

Personal and professional references available upon request

Judy Bogard
652 Goldstreak Rd.
Fairbanks, AK 99712

Work Experience

Sept. 1991 – Present Director of Rehabilitation Services Fairbanks Memorial Hospital, Fairbanks, Alaska. Administrative and daily managerial responsibilities for hospital Physical, Occupational and Speech therapy including inpatient services, two outpatient clinics, long-term care services at Denali Center, home health therapy and certified athletic training services in local high schools and at UAF. Provision of direct supervision to 30 rehabilitation service employees.

March 1987 – Sept. 1991 Director of Rehabilitation Services Bi-County Community Hospital, Warren, Michigan. Administrative and daily managerial responsibilities for hospital Physical, Occupational, and Speech therapy departments. Provision of direct physical therapy services. Direct supervision of 15 employees and management of inpatient and outpatient services for all 3 disciplines.

April 1985 – March 1987 St. Joseph Health Care Corporation, Flint, Michigan. Director of Physical Therapy at Wheelock Hospital, a subsidiary of St. Joseph. Provided physical therapy services and supervised three therapy staff members in small inpatient and predominantly outpatient setting.

January 1984 – April 1985 McLaren Hospital; Flint, Michigan. Staff Physical therapist working primarily with neuro-rehabilitation and orthopedic patients.

May 1982 – January 1984 Professional Therapy Staffing, Birmingham, Michigan. Physical therapy experience in several settings, including Children's Hospital of Michigan, Wayne County Intermediate School District and provision of physical therapy services to four different long-term care facilities.

Dec. 1980 – May 1982 Kenny Michigan Rehabilitation Foundation Pontiac General Hospital, Pontiac, Michigan. Provision of physical therapy services in an acute care inpatient setting and an outpatient clinic. Assistant supervisory experience within physical therapy department.

Education

Dec. 1990	University of Michigan Masters in Public Administration – concentration in health care administration
Dec. 1980	University Michigan Bachelor of Science in Physical Therapy

Curriculum Vita

Mary Melissa Robinson
Residence
35821 Seward Highway
Moose Pass, Alaska 99631

907-240-9935
melissarobinson@att.net
Mailing
1120 E. Huffman Road #347
Anchorage, AK 99517

Education - Post Secondary:

Masters of Arts in Education, Argosy University, Seattle, WA, 2008.
A.A.A., Culinary Arts, Art Institute of Seattle, 2002, Graduated with honors.
Master's Program, Special Education – Rural Specialist, University of Alaska, Anchorage, no degree, 1989 – 1993.
Bachelor of Science, Occupational Therapy, Colorado State University, 1969.

Selected Professional Qualification, Certifications and Accomplishments:

Alaska Occupational Therapy License.
Type "C" Certificate, Alaska Department of Education.
Sensory Integration & Praxis Test, certification.
Southern California Sensory Integration Tests, certification.
Therapeutic Listening, Advanced Training.

Selected Education Related Employment Experience:

Occupational Therapist, self-employed, contracts with Yupiit School District, Akiachak, AK, , Fairbanks North Star Borough School District, Fairbanks, AK, North Slope Borough School District, Barrow, AK, 2003 – present.
Occupational Therapist, Talkabout, Inc. Fairbanks, AK, 2008.
Instructor in Nutrition, Art Institute of Seattle, Seattle, WA, 2004 - 2007.
Occupational Therapist, South East Regional Resource Center, consultation, evaluation, program consultation, and staff training to rural Alaskan schools in 34 villages, 1994 – 2000.
Department Chair, Occupational Therapy, Physical Therapy & Adaptive Physical Education, Anchorage School District, Anchorage, AK, 1980 – 1994.
Occupational Therapist, Anchorage School District, 1979-1980.
Occupational Therapist, Careage North, Long Term Care Facility, Fairbanks, AK 1978-1979
Occupational Therapist, Alaska Psychiatric Institute, Anchorage, AK, 1971-1976

Selected Presentations:

"Written Expression Considerations", In-service Presentation, Fairbanks North Star Borough School District, Fairbanks, AK, January 2008.
"Criteria for Public School Therapy" Council for Exceptional Children Conference, Washington D.C. March 1988.
"Criteria for Public School Therapy" Great Southern Occupational Therapy Conference, New Orleans, LA, October, 1987.

Selected Educational Workshop Participation:

"Communicating Partners – Practical Approach to Building Social and Communication Lives" James Mac Donald, Anchorage, AK, 2008.
"Treating Sensory Modulation Disorders: The S.T.E.P.S.I.-A Clinical Reasoning Tool", Tracy Murnan Stackhouse, and Sharen Trunnell, Anchorage, AK, 2007.
"The Administration and Interpretation of the FirstSTep Screening Test for Evaluating Preschoolers" Juliann Nevells, Anchorage, AK, 2004.
"Therapeutic Listening" Anchorage, AK, 2003.

Representative Awards:

Award of Honor, Alaska Occupational Therapy Association, 1998
Doug Earley Memorial Award, Hope Community Resources, Inc., 2000.

Professional Organization Memberships & Service:

Alaska Occupational Therapy Association, 1971 – present.
[Webmaster, 2003 – present;
Licensure & Legislation Chair, 1991 – 2000;
Membership Committee Chair, 1988 – 2000;
President, 1972 – 1973 & 1986 – 1990;
Secretary, 1980 – 1981;
Secretary-Treasurer, 1971 – 1974.]
American Culinary Federation member, 2001 – 2007
[Washington State Chefs Association, 2001 – 2007;
Sergeant at Arms, Washington State Chefs Association, 2003 – 2007]
American Occupational Therapy Association, 1969 – present.
[Alaska Delegate & Representative, 1974 – 1976 & 1977 – 1980;
Alaska Alternative Representative, 1981 – 1982.]
Counsel of Exceptional Children, 1972 – 1980.
Hope Community Resources, Inc., (Hope Cottages), Board of Directors, 1980 – 2000.
[Programs, Practices and Personnel Committee, Chair, 1985 – 2000;
Properties & Facilities Committee, 1987 – 2000;
Secretary, 1993 – 1994;
Vice President, 1992 – 1993.]

Jennifer Burkholder
4859 Canterbury Way
Anchorage, Alaska 99503
Hm 907-333-1640 Cell 907-360-9936
jen_burkholder@clearwire.net

EDUCATION

MS in Counseling Psychology, Alaska Pacific University, 2000.
BA in Human Services, Western Washington University, 1995.

LICENSURES/ CERTIFICATIONS/ POSITIONS HELD

Alaska Licensed Professional Counselor (LPC)
Alaska Licensed Professional Counselor Board Member
Nationally Certified Counselor (NCC) with National Board of Certified Counselors
Alaska 'C' Certified

PROFESSIONAL EXPERIENCE

Guidance Counselor • Anchorage School District • August 2009 – Present
Establish counseling programs at two elementary schools. Complete thirty-eight classroom presentations monthly. Provide individual and group counseling.

Private Practice Therapist (pt wk) • July 2008 – November 2009
•Behavioral Medicine of Alaska • January 2007 – July 2008
Complete assessments, diagnose disorder, evaluate for appropriate treatment. Provide cognitive behavioral therapy, reality therapy, brief solution focus therapy, and/or play therapy.

Clinician • Southcentral Counseling Center • August 2000 – May 2005
Completed assessments, diagnosed disorders, developed treatment plans, provided individual, family, and group psychotherapy. Discussed progress of goals with client and family. Provided parent education. Monitored development. Evaluated and adjusted treatment. Participated on a multi-disciplinary treatment team. Facilitated teen girls group. Provided crisis intervention.

Clinician (pt contract wk) • Southcentral Counseling Center • April 2002 –November 2002
Completed assessments, diagnosed disorders, developed treatment plans, provided individual therapy for adult clientele. Discussed progress in goals with client. Evaluated and adjusted treatment. Made referrals when necessary.

Substitute Teacher • Anchorage School District • Feb. 1999- May 2000
Taught curriculum to students. Improvised and was creative when necessary. Substituted for special education, emotionally disturbed, and learning disabled.

Counseling Intern • Anchorage School District • August 1999-March 2000
Worked as a mentor and problem-solver with adolescent students who were struggling academically and socially. Taught coping skills and facilitated/co-facilitated grief and anger management groups. Made referrals.

Child Group Recreational Therapist • Alternatives Community Mental Health Center Inc.• 1997-1998
Organized and developed curriculum for adolescent group. Developed individual treatment goals for group members. Co-facilitated daily process group. Worked as part of inter-disciplinary treatment team member. Educated and/or provided feedback on treatment goals to children, parents, therapist, probation officers, social workers, and guardian ad litems. Stabilized children to prevent further acute care.

Youth Activity Technician • Alternatives Community Mental Health Center Inc. • 1996-1997
Participated on a multi-disciplinary team to ensure delivery of wraparound services. Designed and instructed activities that addressed severely emotionally disturbed (SED) clients' treatment team goals. Provided skill-building activities including how to make friends, survival skills in school, dealing with feelings, controlling aggression, and environmental education.

Teacher/Counselor I • Alaska Youth and Parent Foundation • Oct. 1995- Feb. 1996
Co-supervised physically, sexually, and emotionally abused homeless youth in a residential home. Designed daily educational activities. Provided crisis intervention. Communicated with youth, therapists, social workers, probation officers, and police concerning youths' progress and/or defiance of residential rules. Completed formal residential intakes.

Social Worker Intern • Division of Children and Family Services, Washington • Oct. 1994-June 1995
Managed and provided emotional support for multiple children within three foster families. Acted as a liaison between social worker, foster family, and therapist. Facilitated and participated in treatment team meetings. Scheduled and supervised parental visitation with youths in foster care.

Community Resource Center Intern • Opportunity Council, Bellingham, WA. • Oct. 1993-June 1994
Problem-solved with tenants concerning landlord tenant issues. Provided resource counseling for people having disputes. Made referrals.

Recreational Specialist • Municipality of Anchorage Summer Playground Program • Summers 1993, 1994, 1995, 1998
Led and managed youth groups in games and crafts. Supervised and organized indoor/outdoor activities. Co-coordinated special events and field trips.

PUBLICATION
Perham-Burkholder J. Whirlwind: Adolescents Journey through the Grief Process, 2002 (self published).

Emily A. Zimbrich, LPC; CDCII
PO Box 631, Haines, AK. 99827
(907) 766-2788hm (907) 766-2180wk 907 314-0061cell
Mail address: EZimbrich@aptalaska.net

JOB OBJECTIVE
Licensed Professional Counselor Licensing Board

SUMMARY OF AREAS OF CLINICAL EXPERIENCE
- Individual, Family, and Group Therapy
- Chronic and acute mental illness
- Behavioral and emotional difficulties
- Substance abuse
- Crisis intervention
- Documentation and assessments
- Diagnostic impressions in accordance with DSM-IV

SUMMARY OF DUTIES/RESPONSIBILITIES PERFORMED
- Comprehensive intake assessments
- Individual treatment plan
- Crisis assessments/intervention
- File management
- Discharge planning
- Professional consultation
- Family consultation
- Preparing court testimony for ex parte'
- Composing correspondence
- Ability to remain calm and keep a level head when under pressure
- Ability to work effectively as a member of a multi-disciplinary professional team

WORK HISTORY
Currently: Ex. Director Impact Counseling Service Inc.
Currently: Vice Chairman St. of Alaska Board of Professional Counelors.
Currently: Vice Pres./bookkeeper E-Z Mechanical Inc.

Emily A. Zimbrich, LPC; CDC11

2002-2003 Mental Health Clinician Rural AK Community Action Program, Inc. (Contract to do bi annual Mental Health Assessments for local Head Start Program.

2001 to 2002	Mental Health Clinician	Lynn Canal Counseling
2000 to 2001	Counselor	Hns. Christian Center
1998 to 2000	Counselor	Teen Challenge of WY.
1996 to 1998	Counselor	Impact Counseling
1980 to pres.	Bookkeeper	EZ Mechanical Inc
1982 t0 1992	Custodial	EZ Janitorial Serv.
1989 to 1992	Inn Keeper	Skagway Inn, Inc.

EDUCATION

Bachelor of Arts: Clinical Christian Counseling International Bible College and Seminary 1996

Phase I and Phase II Curriculums: National Christian Counselors Association 1996

Master of Arts: Clinical Christian Counseling Cornerstone University 1998

Regional Alcohol & Drug Abuse Counselor Training Program: 2002

Dialectical Behavior Therapy: 2002 & 2004 November, 2004 - October, 2005 DBT Consult Group

Critical Incident Stress Management: basic 2002

National Counselors Exam: January 18, 2003 Passed.

MAC Exam: November 22. 2003 Passed.

SKILLS

Networking with various agencies to coordinate services and community outreach.

Therapeutic Diagnostic Testing

Communicative Skills

Emily A. Zimbrich, LPC; CDC11

Teaching Skills
Computer: Windows 2000/XP; Microsoft Word
Documentation/file management

PROFESSIONAL MEMBERSHIPS

National Christian Counselors Assoc.

CERTIFICATION/LICENSURE

Licensed Professional Counselor: St.of Alaska
Chemical Dependency Counselor 11: St. of Alaska
Temperament Therapist: NCCA
Clinical Christian Therapist: NCCA
NCCA Certification: Adolescent Therapy
Group Therapy

REFERENCES

Stella Howard, Po Box 322, Haines, AK 99827. (907) 766-2810 Family Case Worker 11, Tlingit Haida Central Counsel. Also on the Impact Counseling Board of Directors. showard@ccthita.org

William Stacy, Ret. (Former Dir. Of Lynn Canal Counseling Service)
(907) 766-2286

Rev. Gary Lidholm, PO Box 796, Haines AK. 9927 907 766-3750 Secretary of the Impact Counseling Board of Directors. lidholm@aptalaska.net

IVA GREYWOLF
Cell Phone: 907-738-7604 Fax: 907-747-3453 email: iva@ivagreywolf.com

Highly sought after instructor who is a nationally approved education provider for addiction counselors Possesses the rare blend of high people skills and high technical skills Effectively translates complex ideas into practical application to improve services to clients

License: Psychologist, State of Alaska

Certifications:
Master Addiction Counselor (MAC), NAADAC
Clinical Supervisor of CD Counselors, ACBHC
Administrator II, ACBHC
Approved Education Provider, NAADAC

Trained as a Trainer:
Applied Suicide Intervention Skills (ASIST)
Assessing and Managing Suicide Risk, Core Competencies Curriculum for Mental Health Professionals, Suicide Prevention Resource Center (SPRC) and American Association of Suicidology (AAS)
Alcohol Drug Information School (ADIS), Prime for Life Institute
Alaska Integration Project: Addressing Co-Occurring Disorders
Clinical Supervision, NWF Addiction Technology Transfer Center
Substance Abuse Treatment for Persons with Co-Occurring Disorders

Education:
Ph.D. Professional-Scientific Psychology, USU, Logan, UT, 1991
M.A. Special Education, USD, Vermillion, SD, 1977

Professional Highlights:
Innovative Leader-inclusive respectful style
Advocate of Workforce Development
Proven Manager
Excellent Teacher & Presenter
Service Oriented Provider

Career Experience:

Director SE AHEC (12-08 to present)
SouthEast Area Health Education Center (SE AHEC) hosted by the
SouthEast Alaska Regional Health Consortium (SEARHC), Sitka, AK
Building a brand new program to encourage individuals to serve in a variety of health professions in underserved areas of southeast Alaska. Emphasizing retention through continuing education, recruiting individuals into exploring health careers, supporting students in health professions seeking rotations to complete their education. Support the goals of the program through networking and public speaking, writing grants, grants and program management. Mentoring staff to assume leadership positions. Serving all of southeast Alaska.

Community Family Services Coordinator (01-96 to 07-08)
SouthEast Alaska Regional Health Consortium (SEARHC), Sitka, AK
Efficiently managed a complex multi-site CARF accredited outpatient behavioral health program long range planning, policy setting, training emphases, budget and grant management, providing administrative and clinical supervision and training to staff in several remote southeast Alaska villages. Support the career development of Behavioral Health providers working in remote locations. Network within SEARHC, with Native organizations, with the University system in Alaska and with other agencies. Active on advisory boards promoting career development opportunities. Provided internship supervision and supervision for licensure. Served as a mentor for females going into leadership and management positions.

Assistant Professor of Psychology (08-91 to 12-95)
Concordia College, Moorhead, MN
Responsibilities: Taught three psychology courses per semester, general psychology, educational psychology, developmental and/or cross-cultural psychology. Mentored and advised students on academic matters. Conducted research in my fields of interest. Networked and became involved with the community, through presentations or direct participation on committees, clubs, or boards. Worked closely with the Native American students.

Consultant (1987 to 1997 and 2008 to 2009)
Self-employed part-time
Responsibilities: Provided training and presentations primarily on Native American mental health issues, including substance abuse and suicide, in the United States and internationally. Provided case consultations and training for sexual assault counselors. Conducted a needs assessment in region focusing on Indian mental health. Conducted psychological evaluations. Evaluated grants for the federal government and Headstart programs, specifically the mental health and disabilities components. Gathered data on tribal responses to the Native American Graves Protection & Repatriation Act (NAGPRA) in the Minnesota region.

Therapist (05-88 to 05-90)
Intermountain Sexual Abuse Treatment Center, Logan, Utah
Responsibilities: Provided individual, group and family therapy in the context of "family focused" treatment which supports family members with the required services and provides the support for the victim. Worked with victims of sexual abuse, sexual offenders, parents and siblings of abuse victims and adults who were molested as children. Led time limited focused therapy groups for preschool, young females, pre-adolescent females, and adolescent female victim groups. Co-led an on-going therapy group for young female adolescent victims.

Mental Health Specialist (01-78 to 06-87)
USPHS Indian Health Service, Poplar and Crow Agency Montana
Responsibilities: Provided individual, group, marital, and family therapy. Conducted intake interviews and presented cases for review. Worked with clients with a variety of diagnoses. Led

focused therapy groups on sexual abuse and parenting. Provided educational interactive presentations for children promoting safety. Provided workshops for community meetings and in-service training for staff on children of alcoholics and sexual abuse and other behavioral health issues.

Professional Presentations:

GreyWolf, I. (2009, November). Stepping Into the Light...Community Healing. Hope & Resilience in Suicide Prevention Conference. Presented in Nuuk, Greenland.

GreyWolf, I. (2009, June). Employment Opportunities in Southeast Alaska. American Indian Society of Psychologists (AISP) Convention. Presented in Logan, Utah.

GreyWolf, I. (2009, May). Strategies for Delivering Clinical Supervision. Annual School on Addictions. Presented in Anchorage, Alaska.

GreyWolf, I. (2008, May). Naltrexone Alone and with Sertraline for the Treatment of Alcohol Dependence in Alaska Natives and Non-Natives Residing in Rural Settings: A Randomized Controlled Trial. Summary of research results presented in Sitka, Alaska.

GreyWolf, I. (2008, April). Life Givers & Life Savers (understanding suicide). Southeast Native Women's Conference. Presented in Juneau, Alaska.

GreyWolf, I. (2007, November). Grief, Loss and Bereavement. Presented at End of Life Caregiver Training in Sitka, Alaska.

GreyWolf, I. (2007, May). Assessing and Managing Suicide Risk, Core Competencies for Mental Health Professionals. Presented in Sitka, Alaska.

GreyWolf, I. (2007, February). Assessing and Managing Suicide Risk, Core Competencies for Mental Health Professionals. Sponsored by Suicide Prevention Resource Center (SPRC) and American Association of Suicidology (AAS). Presented in Sitka, Alaska.

GreyWolf, I. (2006, November). Grief and Family of Origin Dynamics. Presented at End of Life Caregiver Training in Sitka, Alaska.

GreyWolf, I. (2005, September). Clinical Supervision for Chemical Dependency Counselors. Presented in Sitka, Alaska.

Didrickson, A., GreyWolf, I, & West, R. (2003, July). Co-Occurring Disorders. Co-presenter in Sitka, Alaska.

GreyWolf, I. (2003, June). Co-Occurring Disorders, State Integration Project. Co-presenter for State of Alaska & Akeela sponsored training in Anchorage, Alaska.

GreyWolf, I. (2003, April). Ethics. Presented in Sitka, Alaska.

GreyWolf, I. & Wellwood, C. (2003, April). Confidentiality/HIPAA & Records Management. Training in Sitka, Alaska.

GreyWolf, I., Wellwood, C., & Strother, M. (2002, December). Clinical Supervision. Training in Sitka, Alaska.

GreyWolf, I. (2002, November). Suicide & Crisis Intervention. Training in Juneau, Alaska.

GreyWolf, I. (2002, June). Culture & Recovery. Keynote address at Native Wellness Conference on Prince of Wales Island, Klawock, Alaska.

GreyWolf, I. (2001, December). Screening for Mental Health & Substance Abuse in Rural Alaska. A breakout session at the 2001 Alaska Health Summit in Anchorage, Alaska.

GreyWolf, I. (2000, June). Delivery of Psychological Services in Rural Indian Country. Keynote

address at the 13th Annual Convention of North American Indians/Native Psychologists and Psychology Graduate Students, Logan, Utah.

Papers and Publications:

O'Malley, S., Robin, R., Levenson, A., GreyWolf, I., Chance, L., Hodgkinson, C., Romano, D., Robinson, J., Meandzija, B., Stillner, V., Wu, R., Goldman, D. (2008, June). Alcoholism: Clinical and Experimental Research. "Naltrexone Alone and with Sertraline for the Treatment of Alcohol Dependence in Alaska Natives and Non-Natives Residing in Rural Settings: A Randomized Controlled Trial." Vol. 32, No. 6

GreyWolf, I. (1998). Service Learning and Cross-Cultural Psychology. With Service in Mind: Concepts and Models for Service-Learning in Psychology. Bringle & Duffy Editors. American Association for Higher Education & American Psychological Association, Washington, D.C.

WICHE Monograph (1996). Developing Culturally Competent State Mental Health Delivery Systems for Ethnically Diverse Adults with Serious Mental Illness. Contributor on Native American issues.

GreyWolf, I. (1995, October). Summer Study Grant. NAGPRA's Effect on Native American Mental Health. Concordia College.

GreyWolf, I., Postema, J., & Lintleman, J. (1995-1996). Bush Foundation Inclusive Issues Grant. Catching Students in a Web of Teaching. Teaching at Concordia, 18-1.

Trottier, I. (1995, March). Bush Inclusive Issues Grant. Classism in the Classroom. Bush Foundation.

Trottier, I. (1993, March). Centennial Summer Research Scholars Program Grant. Psychological Dimensions of Subtle Racism. Bush Foundation.

Dr. GreyWolf has a long history of providing quality trainings, for example:

Serving Native Populations/Cultural Considerations
Working Effectively with Clients with Sexual Abuse Histories
Gender Responsive Services for Female Clients
End of Life Decision-Making
Religious & Spiritual Interventions in Psychotherapy
Trauma Informed Services and Resolving Trauma
Innovations in Addiction Treatment & Behavioral Health Care
Implementing Evidenced-Based Practices for Co-Occurring Disorders
Healing From Psychological Trauma
Clinical Supervision of Chemical Dependency Counselors

Dr. GreyWolf has also provided trainings that support national accreditation, specifically meeting CARF Behavioral Health Standards, covering topics such as: ethics, documentation, vicarious trauma, counseling skills, best practices, evidence based practices, ASAM PPC-2R, Motivational Interviewing (MI), HIV Risk Reduction.

Dr. GreyWolf has specialized training in the following topics:

Treating the Complex Suicidal Client, Utilizing Dialectical Behavioral Therapy (DBT) Strategies
Conducting Suicide Research through Structured Interviews: Suicide Look Back Training
Naltrexone & SSRI Therapy for Alcohol Dependence in Native Americans
Intensive Outpatient Treatment, the Matrix Model
Bereavement Support Group Facilitator Training
Advanced Critical Incident Stress Management
Best Practices in Prevention
Seeking Safety Curriculum for Females with Post-Traumatic Stress Disorder (PTSD) and Substance Use Disorders (SUD)
Integrative Treatment of Complex Trauma (ITCT)

Volunteer Work/ Other Interests:
Chairperson for the Indigenous Women's Committee, as part of The Society for the Psychology of Women, Division 35 of the American Psychological Association. Co-facilitation of grief groups entitled "Making Connections" through the local hospice type of organization, Brave Heart Volunteers. Member of the Crisis Intervention Stress Management team which serves in southeast Alaska. My appreciation of life is expressed through gardening, stained glass design, grandparenting and other art forms. I enjoy scuba diving and travel.

Honors:
Selected as an American Psychological Association Minority Fellow for two years
Selected as one of University of Montana, Billings Campus Outstanding Indian Alumni
Presented three awards from the Federal Government for outstanding work

Membership in Professional Organizations:
American Psychological Association, APA
American Counseling Association, ACA
National Association of Alcoholism and Drug Abuse Counselors, NAADAC

Other Professional Memberships:
Alaska Commission for Behavioral Health Certification, ACBHC, Commissioner
Alaska Technical Preparation Consortium Board, AK Tech Prep Board, Board Member

Professional Resume for:
JASON FLOYD

CONTINUING CAREER OBJECTIVE:

My ideal career places me in a fast paced, dynamic and diverse work environment requiring and recognizing professional excellence, fiscal conservatism and teamwork. I actively seek challenging positions offering opportunities for continual professional growth, development and satisfaction. My long term career objective finds me in ever increasing levels of responsibility, well positioned to positively impact my coworkers, community and the goals of my employer.

IMMEDIATE POSITION OBJECTIVE:

I am seeking appointment to serve the State of Alaska, as a Licensed Baccalaureate Social Worker, to the Social Work Examiner's Board.

RELATED WORK EXPERIENCE:

- **Youth Substance Abuse Counselor/Prevention Specialist**, Drug Free Communities Support Program Coordinator, Providence Valdez Counseling Center (PVCC). Valdez, Alaska, 1/01/2005-Present (First hired to position on 5/24/2004 under Valdez Regional Health Authority). A full-time exempt position under the administrative designation.
  Duties and Essential Functions: Responsible for accurate, timely documentation of program activities, correspondence, client referral and coordination of prevention and treatment planning within PVCC and the community. Maintain strict confidentiality within federally mandated guidelines and maintain professional boundaries with clients and staff. Supervise counselors, volunteers and interns. Perform job duties, independently, with high public contact. Work with agencies and organizations including schools, the court system, juvenile probations, Youth Court, City Parks and Recreation, law enforcement, the Office of Children's Services, school psychologists, the faith community, the general public and other individuals. Coordinate community advocacy efforts, education and awareness campaigns through public meetings, use of print, radio and electronic media, and other prevention-specific programming. Identify and obtain continued funding through federal, state and local agencies, organizations, businesses and individuals through grant-writing, and other fundraising. Required to have a computer proficiency to include familiarity with word processing software.

- **Youth Substance Abuse counselor/prevention Specialist**, Valdez Regional Health Authority (VRHA)Valdez Counseling Center, Valdez, Alaska, 5/24/2004-12/31/2004 (9 months). A full-time nonexempt position eligible for overtime.
  Duties and Essential Functions: Ibid.

- **Social Worker II (CS)**, State of Alaska Department of Health and Social Services, Office of Children's Services (formerly DFYS). Kenai Field Office, Kenai, Alaska, 4/16/2001-5/17/2004 (3 years in Kenai--4 years total). A full-time nonexempt position eligible for overtime.
  Duties and Essential Functions: Worked with at-risk children and families addressing physical and sexual abuse, neglect and harm. Coordinated care and safety/case planning services for at-risk families and children with multiple community providers and entities including the courts, guardian *ad litem*, law enforcement, public behavioral health, public health, substance abuse treatment facilities, public assistance, public housing, the local school district, state representatives and senators, ombudsman, the client's extended family, and other relevant individuals and agencies. Worked independently to manage a high caseload, utilizing skills in crisis management, mediation, negotiation, critical thinking, interpretation, application and enforcement of state policy, statute and federal law. Facilitated coordination of funding, travel logistics and escort for minor children, families, foster parents, and other agency staff. Other duties included: on-call emergency child protection services and crisis response; extensive travel to remote areas; legal contact with the State's Assistant Attorney General, the Public Defender, and Office of Public Advocacy; door-to-door investigation, cold-calling, public relations and education. Required proficiency with Microsoft Office software and with the OCS PROBER program (a proprietary database software).

- **Social Worker I**, State of Alaska Department of Health and Social Services, Division of Family and Youth Services (DFYS). Aniak Field Office, Aniak, Alaska, 3/23/2000-4/13/2001 (1 year). A full-time noncxempt position eligible for overtime.
  Duties and Essential Functions: In addition to the duties listed in the previous section, work with DFYS in the Aniak office required frequent travel to remote locations, in inclement and dangerous weather, often by small aircraft, boat or snowmobile. Other duties required in the Aniak position included: coordination of foster care licensure, home inspection, and investigation; ongoing case planning, management and oversight for families of adjudicated children; extensive travel planning, to include air and ground travel, lodging and board.

ASSETS:

- Team player.
- Self motivated.
- Enthusiastic leader.
- Goal oriented, high achiever.
- Analytical, reflective, and reliable.
- Personable, positive, empathetic and thoughtful of others.

EDUCATION:

Bachelor's of Science Degree, Eastern Oregon University, La Grande OR. 6/12/99.
Major: **Philosophy, Political Science and Economics** (PPE Program).
Minor: **Political Science.**
Cumulative GPA: 3.4
Senior Capstone Project: ***The Economic, Political and Environmental Impacts of the Mexican Maquiladora Industry.***

LICENSES and CERTIFICATION:

- **Licensed Baccalaureate Social Worker**, State of Alaska Department of Economic Development, Division of Occupational Licensing, Alaska License, No. 487, Effective: 6/30/2004. Expires: 6/30/2006.
- **Licensed Baccalaureate Social Worker**, State of Alaska Department of Economic Development, Division of Occupational Licensing, Alaska License, No. 487, Effective: 7/01/2002. Expired: 6/30/2004.
- **Licensed Baccalaureate Social Worker**, State of Alaska Department of Economic Development, Division of Occupational Licensing, Alaska License, No. 487, Effective: 11/20/2001. Expired: 6/30/2002.
- **Awarded Paralegal Certificate**, Eastern Oregon University Small Business Development Department, 3/1999.

MOST RECENT ACCOMPLISHMENT IN ORGANIZATION:

In March of 2006, the Valdez Youth Awareness Coalition (YAC), a Drug-Free Communities Support Program (DFCSP), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), achieved its non-profit status with the State of Alaska.
This success was the result of a year-long effort to organize a discussion-based community council into an action-oriented vehicle for community mobilization around the issues of youth substance-use and other negative risk taking behaviors in the City of Valdez.
As DFCSP Grant Coordinator and *ex officio* representative of the grant's fiscal agent I was able to serve a critical role organizing and facilitating all aspects of YAC's transformation into a coalition and non-profit organization.

HOME ADDRESS:	P.O. Box 1165 Valdez Alaska 99686
Hm:	(907)835-2820
Cell:	(907)831-0706
Wk:	(907)834-1898
E-Mail:	jfloyd@prnvak.org

References are available upon request.

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Social Work Exam (public seat)
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Barbara J. Paddock

Mailing Address: P.O. Box

Residence Address: 5617 Aisek St

City, State and Zip Code: Juneau AK 99801

Home or Message Telephone: _____ Business Telephone: _____

Fax Number: — Cell Phone: 602-885-0744

Email address: —

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO _____ Voter Registration Number (Optional) _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.) —

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO ✓ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES _____ NO ✓

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO ✓

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria: NA Real Estate Licensed

B List both formal and informal education and training experiences: (Use additional paper if necessary).
14 years formal education. Many informal training through my 33 years as a federal Employee.

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.
Numerous awards received throughout my 33 years as a Federal Employee. Recipient of the American Spirit Medallion Degree of the American Fire. Lifetime Member

D. Employment work history - paid, unpaid or voluntary: (Use additional paper if necessary). 14 years Edu
33 years Fed. Govt. Duty Penance; Regional Manager. 19 years VA approx 8 Juneau & 5 in Anchorage Balance of in Wash/Mail Dept worked as CSR Health Clinic 1997-2007 Juneau/Las Vegas
Present Retired 3rd Class 2/29/2007.

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH ____ SEX: FEMALE ____ MALE ____

ETHNICITY.
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White ___

MILITARY SERVICE (if applicable, give dates). ____

CERTIFICATION I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Barbara Underhill Date. 10-

Please attach a current resume with your application

Retired Sept 1993.
Retired 2/29/2007.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: BARBARA T. PADDOCK Date: 10-12-2009

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/ Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/ Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
✓	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
✓	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): ~~Barbara T. Paddock~~ 72 of (Hometown): Juneau
is (Job title/Place of employment): RETIRED
(Name) holds (Listing of earned degrees like bachelor's, master's, ect): N/A **

(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

** Served 33 years and retired from U.S. Forest Svc. 1993. Served 18 years in Alaska; will be Nelsons Administrator 14 yrs. Juneau / and Balance U.S. Forest Svc / Alaska Power admin / U.S. Forest Svc
Recently retired from Alaska Airlines as a Customer Svc. Agent 2/29/2007.

LAURA THIESEN, MSW
laurathiesen@yahoo.com

PO Box 247
Glennallen, AK 99588
907-822-3220 (Home)
907-822-3203 (Work)
907-980-9660 (Cell)

OBJECTIVE: I am interested in serving on the Alaska State Board of Social Work Examiners.

SUMMARY: Experience in the area of cognitive-behavioral psychotherapy with individuals including those with substance abuse and dual diagnoses, hospital social work, grief and loss, and domestic violence.

EDUCATION:

Master of Social Work, May, 1997
New Mexico Highlands University, Las Vegas, New Mexico
Concentration in Gerontology
Thesis: *Observation of a Validation Therapy Group at Las Vegas Medical Center*

Bachelor of Science in Social Work May 1996
University of Nevada, Reno, Nevada
Minor in Addiction Treatment
Practicum with a domestic violence program in conjunction with Parent's United.

EXPERIENCE:

Social Worker/Behavioral Health Clinician, March, 2008 to March, 2009
Cross Road Medical Center
Glennallen, AK 99588

- Case Management
- Medicare, Medicaid, Denali Kid Care, VA assistance
- Patient Assistance Programs
- Durable Medical Equipment
- Member of CQI Committee
- Member of Local Emergency Planning Committee
- Local Red Cross Representative
- Behavioral Health
    - Prime for Life
    - Celebrate Recovery

Behavioral Health Clinician, July, 2006 to February, 2008
Cordova Community Medical Center/Sound Alternatives
Cordova, AK

- Behavioral Health Assessments
- DENS ASI Assessments
- Developed Treatment Plans
- Documentation in AKAIMS
- Individual, Family, and Group Counseling
- Community Outreach
- Crisis Intervention, including on-call ER coverage

Hospital Social Worker, July, 2006 to March, 2007
Cordova Community Medical Center
Cordova, AK

- Responsible for effective case management, discharge planning, referrals, and financial needs of patients in the long term care facility
- Assisted patients and families in the acute care setting with social service needs
- Morgue duties (i.e. Visitation, death certificates, burial arrangements, and transportation)
- Marketing for long term care unit

Lead Clinician (Adolescent Treatment Program), December, 2005 to July, 2006
Yukon Kuskokwim Healthcare Corporation
Bethel, AK

- Responsible for developing a grant funded adolescent treatment program
- Treated youth and families with mental, emotional, and/or substance abuse problems
- Duties included individual psychotherapy, group therapy, case management, crisis intervention, advocacy, prevention, and education

Medical Social Worker/Case Manager, March, 2005 to December, 2005
Yukon Kuskokwim Healthcare Corporation
Bethel, AK

- Responsible for psychosocial needs of patients on the Obstetrical unit
- Morgue duties (i.e. Visitation, death certificates, final arrangements, and transportation)
- Responsible for psychosocial needs of patients in outpatient clinics
- Responsible for providing persons, families, or vulnerable populations with the psychosocial support needed to cope with chromic, acute, or terminal illnesses, such as Alzheimer's disease, cancer, and HIV/AIDS

- Services included counseling and advising patients, families, and caregivers
- Managed further referrals and durable medical equipment needs

Medical Social Worker, June, 2004 to February, 2005
Manor Care Health Services
Reno, NV

- Responsible for effective case management, discharge
- Responsible for providing persons, families, or vulnerable populations with the psychosocial support needed to cope with chromic, acute, or terminal illnesses, such as Alzheimer's disease, cancer, and AIDS

Medical Social Worker, November, 1999 to June, 2004
Davita Dialysis
Reno, NV

- Member of a management team on a dialysis unit
- Responsible for admission's case management, advocacy, education, crisis intervention, and counseling
- Participated and led quality improvement projects, locally and regionally
- Organized and led facility projects

Medical Social Worker, September, 1998 to November, 1999
Vistacare Hospice
Reno, Nevada

- Provide psychosocial support to terminally ill patients and their families and/or significant others
- Provided referrals, assisted with advance directives and final arrangements
- Effectively coordinated nursing home placements and transfers through EMS
- Provided crisis intervention and grief counseling

Medical Social Worker, March, 1998 to September, 1998
Reno Healthcare
Reno, NV

- Director of Social Services.
- Responsible for effective case management, discharge planning referrals, and financial needs in long term care facility.
- Responsible for providing persons, families, or vulnerable populations
- Assist with the psychosocial support needed to cope with chromic, acute, or terminal illnesses, such as Alzheimer's disease, cancer, and AIDS.

Medical Social Worker, August, 1998 to March, 1999
Tahoe Pacific Hospital
Sparks, NV

- Provided case management including psychosocial assessments, referrals, advocacy, education, and discharge planning in a long term, acute care facility.

CERTIFICATIONS:

- Master of Social Work License, State of Alaska, expires June, 2010
- Prime for Life Instructor
- Certificate of Aging
- Case Management
- Emergency Trauma Technician
- Red Cross Training – Client Services, Shelter Operations

ACTIVITIES:

- Member of National Association of Social Workers
- Member of Mercy Medical Team, Kenya, July, 2009
- Committee Member, Sobriety Celebration, Cordova, AK 2006, 2007
- Participated in Sobriety Week Celebration 2006, 2007
- Assisted in Brain Wise Training, Cordova, AK 2006
- Volunteer Court Appointed Special Advocate, 1995 -1997
- Volunteer, swimming official

Wendy S. Hamilton
Box 240674
Douglas, AK 99824
907-209-0023

Education:

Bachelor of Human Services, University of Alaska Anchorage, Magna Cum Laude, 2002
Relevant coursework: Alternative Dispute Resolution; Rural Treatment Strategies; Substance Abuse Counseling; Counseling Skills I-IV; Natives of Alaska; Human Behavior and Diversity; Ethics; Statistics; Fundamentals of Oral Communication and Leadership Skills; and Methods of Written Communication.

Work Experience:

National Council on Alcoholism and Drug Dependence **Dec. 2004-Present**
Therapeutic Court Coordinator – Dec. '04 – Oct. '06 - Initiated and implemented Juneau's first Therapeutic Court; designed forms, wrote policies and procedures and coordinated the therapeutic court team; networked with local community organizations such as State Dept. of Law, City and Borough of Juneau Law Dept., Juneau Police Dept. and Rainforest Recovery Center; wrote grant renewals and quarterly reports; supervised all clients in the Juneau Therapeutic Court, including compliance checks, coordinating adjunctive services and regular home visits.
Tobacco Program Coordinator – Oct. '06 – Present - Coordinate implementation of the State Tobacco Prevention and Control grant; supervise the Teens Against Tobacco Use (TATU) coordinator; create media campaigns about tobacco policy issues; organize the Juneau Clean Air community coalition; work to implement Juneau's Clean Air ordinance.

State of Alaska, Dept. of Corrections, Felony Probation **June 2002-Dec. 2004**
Taught Cognitive Self Change and Victim Impact classes; taught and worked with clients participating in the Driving While Intoxicated Byrne Grant program; conducted group and individual intake orientation sessions reviewing conditions of release; perform individual case management and record keeping; administer risk assessment tools such as the LSI-R and Static 99; interview and counsel victims; provide clerical support to probation officers, writing reentry support groups both at the jail and the halfway house, including topics such as relapse, addictions, staying out and staying free and living in recovery; network with service providers in the community including the Job Center, Tlingit and Haida, JAMHI, individual counselors, child support services and Alaska Legal Services.

Self-employed **1989 - 2002**
Owned and operated yoga studio and bodywork practice; presented stress management classes and seminars for both the public and private sector; facilitated bereavement support groups and individual bereavement counseling.

Internship Experience:

State of Alaska, Dept. of Health & Social Services, Division Public Health, Community Health and EMS **2000 - 2001**

Assisted research analyst in data collection and compilation; interviewed health care providers throughout Alaska; utilized Access and Excel to enter data and print reports; prepared HPSA applications for federal approval.

Additional Training and Conferences:

ACCDPC Chemical Dependency Counselor I Certification; ASAM Criteria Training; Motivational Interviewing for Substance Abuse Counselors; Group Therapy for Substance Abuse Counselors; Cognitive Behavioral Skills training; Sex Offender Treatment Conference; National Conference on Addiction and Criminal Behavior; National Reentry Conference; Critical Incident Stress Management, Basic and Individual; Comprehensive Bereavement Skills.

References:

Available upon request.

RESUME

William W. Resinger, M.D.
P.O. Box 839
Palmer, Alaska 99645

Phone: (907) 745-1763 (home, unlisted)

Married
Wife's name: Edrea
No children

---EDUCATION---

Titusville High School, Titusville, PA - 1961
Seibert Award for highest scholastic average (4.00)

Allegheny College, Meadville, PA - 1965
Phi Beta Kappa (junior year)
Alden Scholar (Dean's List) all four years,
Honors in Chemistry
Magna Cum Laude

University of Pennsylvania School of Medicine, Philadelphia, PA - 1969
Honors in Radiology

Harrisburg Polyclinic Hospital, Harrisburg, PA
Intern (rotating) 1969 - 1970
Resident Radiology 1970 - 1971

Postgraduate Course in Emergency Medicine, Hershey, PA
September 1974, April 1977

University Hospital, University of Michigan
Fellow in Nuclear Medicine 9-78 - 8-79

Oakwood Hospital, Dearborn, MI
Resident Radiology 9-79 - 2-81

Certified American Board of Radiology (ABR)
Diagnostic Radiology with special competence in Nuclear Medicine, 6-4-82

Continuing Medical Education

2898

Average 50 hours or more CME (usually Cat. I) each year since 1981

Twenty Years Experience in Reading Mammograms

Mammography Accreditation by A.C.R. at Valley Hospital 1988-2001

Training in mammography

- 8 weeks during residency (in 1980)
- Stanford Breast Symposium 3-20 - 3-22-86 (13.5 hours)
- Tutorial with Dr. McClure Hall at Virginia Mason Hospital, Seattle, WA 6-5 - 6-6-86 (16 hours)
- (RAD SAT) (ME-SAT) (Videotape Series), Johns Hopkins (Breast Imaging Techniques, 1987) (4 hours)
- RSNA TODAY (Screening Mammography), Vol. 1, No. 1, 1986 (one hour)
- At Least 15 hours Category I every three years to present

---WORK HISTORY---

Oil City Hospital, Oil City, PA
Emergency Physician 1971 - 1978

Mercy Memorial Hospital, Monroe, MI
Staff Radiologist 3-81 - 7-84

Valley Hospital, Palmer, Alaska
Staff Radiologist 8-84 - 12-01
Association Board Member 1992 - 2001

South Peninsula Hospital, Homer, Alaska
Locum Tenens Radiologist 2002,2003

Norton Sound Health Corp., Nome, Alaska
Locum Tenens Radiologist 2002-present

---ACTIVITIES AND ASSOCIATIONS---

ACEP (American College of Emergency Physicians)
Member 1971 - 1979
National Council Member 1973, 1974, 1975, 1977

Pennsylvania Chapter ACEP (American College of Emergency Physicians)
Board of Directors 1972 - 1978

Executive Committee 1973 - 1978
Treasurer 1974 - 1975
Editor of "EPIC" (newsletter) 1973 - 1977
President-elect 1976
President 1977

Community Ambulance Service
Board at large 1973
Board of Directors 1974

Comprehensive Health Planning Council of N.W. Pennsylvania
Member Venango County Task Force on Emergency Health Services
Executive Committee

Pennsylvania Emergency Health Services Council, 1974
Representative for N.W. Pennsylvania
Board of Directors
Subcommittee on Physician Training

Preceptor for Nurse Practitioner Program
Allegheny General Hospital and Oil City Hospital, 8-75 - 2-76

Medical Advisor EMS Council of N.W. Pennsylvania 1977-78

Glacier View Alliance Church, Palmer, Alaska
Elder and board member 1985-present

Pacific NW District of the Christian and Missionary Alliance
Liaison to the District Superintendent for Alaska 1995-present

Board of Trustees at Simpson University, Redding, CA
Member 1996-present, Chairman Student Affairs Committee

Board of Directors Heart Reach Pregnancy Center, Mat-Su Borough
Member 2001-9/2007

Board of Directors of Town and Country Manor, Santa Ana, CA
Member 2002-present, Chairman Benevolence and Health Services Committees

Society Memberships

American Institute of Ultrasound in Medicine -retired
Society of Nuclear Medicine -retired
RSNA (Radiological Society of North America) -active
ACR (American College of Radiology) -retired

---PUBLICATIONS AND ABSTRACTS---

Publications

Weigel, J.A., Resinger, W.W.: Are You in Good Hands? Pennsylvania Medicine 78:53-54, 1975.

Resinger, W.W., Thrall, J.H.: Diagnosis of Ruptured Bladder During a 99mTc-DTPA Renal Study: New Indications for Radionuclide Cystography? Clinical Nuclear Medicine 3:179-180, 1979.

E.A.: Scintigraphic Tomography of the Thyroid. Proceedings of the Eighth International Thyroid Congress Sydney, Australia, February, 1980.

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Freites, J.E., Fink-Bennett, D.M., Thrall, J.H., Resinger, W.W.: Efficacy of Hepatobiliary Imaging in Acute Abdominal Pain: Concise Communication. Journal of Nuclear Medicine 21:919-924, 1980.

Resinger, W.W., Rose, E.A., Keyes, J.W., Jr., Koral, K.F., Rogers, W.L., Brady, T.J., Kline, R.C., Sisson, J.C., Thrall, J.H.: Tomographic Thyroid Scintigraphy: Comparison with Standard Pinhole Imaging. Journal of Nuclear Medicine 22:638-642, 1981.

Keyes, J.W., Jr., Kline, R.C., Resinger, W.W., Rose, E.A., Koral, K.F., Rogers, W.L.: Comparison of Observer Performance Reading from a Video CRT vs. Reading from Film Investig. Radiol. 18:298-300, 1983

Abstracts

Annual Meeting, June, 1980.

Scintigraphy: Comparison with Standard Pinhole Imaging. Society of Nuclear Medicine 27th Annual Meeting, June, 1980.

PARENTAL CONSENT LAWS FOR ADOLES-CENT...

Planned Parenthood® of the Great Northwest

FAX

Date: 4/3/09
Pages including cover: ~~2~~ 4

To: Sen. Davis
Attn: Don & Linda
Phone: (907) 465-3822
Fax: (907) 465-3758
CC:

From: Bethany Goodnight
Phone: 907-770-9916
Fax: 907-565-7529
CC:

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___ Reply ASAP
___ Please comment
✓ For your review

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Don & Linda —
As things heat up w/ Notice & Consent bills I thought this article could provide good talking points.
I will email you our draft points on notice momentarily. Thank you BOTH SO much!
Bethany

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Parental Consent Laws for Adolescent Reproductive Health Care: What Does the Psychological Research Say?

Psychological research has found that most adolescents seek parental or other adult guidance in decisions about contraceptive use and abortion, and that adolescents are generally competent to make such decisions. Given the overall lack of empirical support for parental notification and consent laws for adolescent reproductive health care, resources need to be directed to teen pregnancy prevention efforts, including family support, education, and psychosocial services.

ARE ADOLESCENTS COMPETENT TO MAKE DECISIONS REGARDING REPRODUCTIVE HEALTH SERVICES?

Psychological theory and research on cognitive, social, and moral development support the finding that adolescents, as a group, are able to understand, reason, and make decisions about important life situations.

- Research on pregnancy-related decision-making abilities, and more general studies on cognitive and social development, support the view that by middle adolescence (ages 14 to 15) minors have developed many adult-like intellectual and social capacities (Ambuel, 1995; Ambuel & Rappaport, 1992; Lewis, 1987; Mann et al., 1989). These capacities include the specific abilities necessary for understanding treatment alternatives, considering risks and benefits, and giving legally competent consent. It is important to note that the ability to make a legally competent decision is not equivalent to making an intelligent, mature, or right decision (O'Keefe & Jones, 1990). Adults, like adolescents, can make decisions that are not in their best interests or are considered immature by others.

- When comparing adolescents to adults, research has found that adolescents who considered abortion were generally as competent as legal adults in their decision-making; however, adolescents under age 15 who did not consider abortion were generally found to be less competent in their decision-making than adults (Ambuel & Rappaport, 1992).

- It is also noteworthy that almost all adolescents who exercise the judicial bypass option provided in parental consent/notification laws governing abortion are successful in obtaining court permission to forgo parental involvement (Ambuel, 1995; Crosby & English, 1991; Ptiner & Yates, 1992). Nearly 90 percent of the minors who use judicial bypass procedures are ages 16 and 17; and in those cases where minors were considered immature, the courts have almost always decided that the abortion was in the minor's best interest (O'Keefe & Jones, 1990) . Research on sociodemographic and economic factors has found that adolescents who choose to obtain abortions tend to be relatively well-educated, white, unmarried residents of the northeast or west, and either in school or working (Stevans et al., 1992). There is also evidence to suggest that adolescents who choose abortion are more mature and competent than those who decide to carry the pregnancy to term (Ambuel & Rappaport, 1992).

DO ADOLESCENTS SEEK ADULT GUIDANCE WHEN MAKING DECISIONS ABOUT REPRODUCTIVE HEALTH SERVICES?

Empirical studies have found that the majority of adolescents consult a parent or other adult about reproductive health care. Family characteristics that facilitate parent-child communication include openness and adaptability.

- Without any legal compulsion, over 50 percent of adolescents consult a parent about contraceptive use (Pistella & Bonati, 1998) and abortion decisions (Ambuel, 1995; Ambuel & Rappaport, 1992; Crosby & English, 1991; Griffin-Carlson & Mackin, 1993). Studies have also found that adolescents consult adult, nonparental relatives about reproductive health care (Pistella & Bonati, 1998) and abortion-related decisions (Resnick et al., 1994). Moreover, younger adolescents (age 13 and 14) are most likely to notify their parents about abortion decisions (Resnic, et al., 1994).

- Adolescent girls report feeling more free to talk about sex and birth control with their mothers than with any other single person (Griffin-Carlson & Schwanenflugel, 1998). They regard their mothers and male partners as most helpful in their abortion decision-making process, followed by friends and counseling services (Resnick et al., 1994).

- Adolescents who describe the communication in their family as generally open were more likely to involve their parents in their decision whether to have an abortion (Griffin-Carlson & Mackin, 1993). Family adaptability (parents' ability to change their interactions with their children in age-appropriate ways) has been found to influence the quality of parental involvement in an adolescent's abortion decision (Griffin-Carlson & Schwanenflugel, 1998). Parents who are adaptable are more likely to be approachable, and provide the necessary guidance, understanding, and support to an adolescent faced with an unwanted pregnancy. Yet, even adolescents in adaptable families with open communication may still refrain from seeking parental consent for fear of disappointing their parents about the pregnancy.

- A disproportionate number of young adolescents who become pregnant live in severely unstable families (Ambuel, 1995). Thus, adolescents most at risk for pregnancy are also those most likely to come from violent and/or chaotic homes where they may not be able to seek guidance from their parents. Moreover, nearly half of pregnant adolescents with a history of physical assault report being hit during their pregnancy, most often by a family member (Berenson et al., 1992). These at-risk teens may suffer the most from mandatory parental consent laws, because they are confronted with having to seek permission from an abusive parent or are forced to delay medical care until they obtain a judicial bypass. Alternatively, these teens may choose to become young parents or may seek

dangerous, extralegal methods of abortion.

WHAT ARE THE EFFECTS OF PARENTAL INVOLVEMENT LAWS ON ADOLESCENTS?

Parental notification and consent laws can have harmful psychological and health consequences for the minors affected by these laws. By restricting adolescent access to confidential contraceptive services, these laws can result in an increased number of unintended pregnancies.

These laws often have the following additional unintended effects:

- Delayed timing of contraceptive services and/or abortion, which increases health risks and expenses (Ambuel, 1995; Lieberman & Felerman, 1999; Melton, 1987; Pfiner & Yates, 1992)
- Stress, fear, and anxiety for those adolescents who go to court to obtain a judicial bypass for an abortion (Crosby & English, 1991; O'Keefe & Jones, 1990)
- Intrafamilial conflict in abusive homes (Ambuel, 1995; Melton, 1987; O'Keefe & Jones, 1990)
- Restriction of adolescent access to abortion resulting in teenage parenthood or the use of dangerous extralegal methods of abortion (Crosby & English, 1991; O'Keefe & Jones, 1990).

WHAT IS NEEDED?

First, there needs to be general consensus that adolescent health is of paramount importance in discussions of contraceptive use and abortion. Next, strategies need to be identified to safeguard and promote adolescent health. Such strategies include the widespread dissemination and implementation of provenly effective adolescent pregnancy prevention programs, such as school-based curricula (e.g., Arnold et al., 1999); community-based initiatives (e.g., Lewis et al., 1999); family support programs (e.g., Solomon & Liefeld, 1998); peer support/counseling programs (e.g., Ferguson, 1998); and skills training (e.g., Hovell et al., 1998). Concurrently, concerted efforts need to be undertaken to promote open, meaningful communication between parents and their adolescent children. In the absence of such communication (e.g., as in the case of abusive families), parental notification and consent laws place the health of adolescents in jeopardy. Yet, psychological research has shown that most adolescents consult their parents or other adult relatives about contraceptive use and abortion and are generally competent to make such decisions. Taken as a whole, these findings call into question the value of parental notification and consent laws and point to the general ability of adolescents to exercise control over their own reproductive health care.

For more information, please contact Lori Valencia Greene in APA's Public Policy Office at (202) 336-6062.

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February 2000

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SB

10

Alaska State Legislature

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Senator Bettye Davis

SB 10 26-LS0073\A

"An Act requiring health care insurers to provide insurance coverage for medical care received by a patient during certain approved clinical trials designed to test and improve prevention, diagnosis, treatment, or palliation of cancer; directing the Department of Health an Social Services to provide Medicaid services to persons who participate in clinical trials; relating to experimental procedures under a state plan offered by the Comprehensive Health Insurance Association; and providing for an effective date."

SPONSOR STATEMENT

Clinical trials are research studies that test how well new medical approaches work in patients. Each study answers scientific questions and tries to find better ways to prevent, screen for, diagnose, or treat disease. Patients who take part in cancer clinical trials have an opportunity to contribute to the knowledge of, and progress against cancer. They also receive state-of-the art treatment from experts in the field. The National Cancer Institute, as part of the U.S. National Institutes of Health, reports 6,000 cancer trials in the United States any one time. They include trials in prevention, screening, diagnosis, treatment, quality-of-life, and genetic studies.

SB 10 removes important barriers to the participation of patients in cancer clinical trials in Alaska. It requires that applicable health care plans, including Medicaid, cover routine patient care costs for patients enrolled in all phases of clinical trials, including prevention, detection, treatment, and palliation (supportive care) of cancer. Currently Alaska health plans may exclude coverage for routine patient-care costs while a patient with cancer is enrolled in a clinical trial. Providers of health care plans often conclude that money is saved by excluding care while patients participate in clinical trials. But these patients, if not enrolled in clinical trials, will continue to receive conventional therapy at roughly the same or slightly increased costs in the short-run.

Studies have shown that only 2-3 percent of eligible adult patients enroll in clinical trials with a 6.5% increase in costs for clinical trial participants compared to nonparticipants. (National Conference of State Legislatures, www.ncsl.org/programs/health/clinicaltrials.htm, accessed 2/27/08) Without in-state facilities and support of clinical trials participants in Alaska currently have to travel out of state, increasing the cost of non-emergency transportation which is about 3% of total Medicaid costs.

In FY 2007 an estimated 4,600 patients received cancer treatments through Alaska's Medicaid program at a cost of $21.5 million. The average payment per beneficiary was about $4,675. **The federal government reimburses the state at about 50% of the total costs.** Based on an estimated 2.5% participation rate per above, about 115 patients are expected to participate in clinical trials each year. A 6.5% average increase for 115 persons would add $35.00 per year to Medicaid for cancer treatments. Non-emergency transportation costs for the same group are estimated to add another $15.00 per year. Medicaid insurance cost for cancer clinical trials is estimated to increase $50,000 with the federal government paying half of this.

Twenty-three or more states have passed legislation or instituted special agreements requiring health plans to pay the cost of routine medical care patients receive while participating in clinical trials. Passage of SB 10 will result in more successful outcomes in cancer treatments in Alaska, increase retention of patients in Alaska for their cancer care, and also, after full implementation, result in cost savings in the short and long term.

A description of "The Access to Cancer Clinical Trials Act of 2009" (Rep. Sue Myrick) per "The Hill's Congress Blog" January 30, 2009 sums up to a large extent what SB 10 is attempting to do:

"Clinical trials are so critical for patients and or medical research, yet many patients find that their health insurance won't cover the rest of their routine cancer treatment if they decide to enroll in clinical trials. We're not asking insurance companies to pay for clinical trials. This bill simply states that insurers must continue to pay for routine treatments — that they would be paying for regardless — if patients enroll in a clinical trial.

No patient should ever have to fear exploring all treatment options at the cost of losing coverage. We should be encouraging participation in clinical trials, not discouraging it by removing coverage for routine care. Were it not for patients who have enrolled in past trials, the medial advancements we've experienced toward finding a cure for cancer would not be possible.

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Senator Bettye Davis

CS for Senate Bill 10( ) 26-LS0073\E

"An Act requiring health care insurers to provide insurance coverage for medical care received by a patient during certain approved clinical trials designed to test and improve prevention, diagnosis, treatment, or palliation of cancer; directing the Department of Health an Social Services to provide Medicaid services to persons who participate in clinical trials; relating to experimental procedures under a state plan offered by the Comprehensive Health Insurance Association; and providing for an effective date."

EXPLANATION OF COMMITTEE SUBSTITUTE

The Committee Substitute for Senate Bill 10( ) makes several **substantive definitional changes in the body of the bill** itself **to clarify sections in the original bill** outlined below and it reorganizes the bill in accordance with requirements of the Drafting Manual by Legislative Counsel:

1) "**Approved clinical trial related to cancer**" (AS 21.42.410(1)(e)(1) means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure use in the prevention, diagnosis, treatment, or palliative care of cancer if the study is approved by....
2) "**Routine patient costs**" (AS 21.42.410(1)(e)(2) means costs incurred for medical care for an approved clinical trial related to cancer that would otherwise be covered under a health care insurance plan if the medical care was not in connection with an approved clinical trial related to cancer, including: coverage for items or services needed for reasonable and necessary care arising form the provision of an investigational item or service, including the diagnosis or treatment of complications; and transportation for the patient that is primarily for and essential to the medical care.
3) "**Coverage for approved and non-approved drugs and devices**"(AS 21.42.410(1)(e)(2) (off-label use) includes coverage for routine patient care costs incurred for drugs and devices that have been approved by the Food and drug Administration (FDA), whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device. This shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial.

26-LS0073\E
Bailey
2/3/09

CS FOR SENATE BILL NO. 10( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

"An Act requiring health care insurers to provide insurance coverage for medical care received by a patient during certain approved clinical trials designed to test and improve prevention, diagnosis, treatment, or palliation of cancer; directing the Department of Health and Social Services to provide Medicaid services to persons who participate in those clinical trials; relating to experimental procedures under a state plan offered by the Comprehensive Health Insurance Association; and providing for an effective date."

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

*** Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.410. Coverage for clinical trials related to cancer. (a) A health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in the state shall cover routine patient care costs incurred by a patient enrolled in an approved clinical trial related to cancer, including leukemia, lymphoma, and bone

marrow stem cell disorders.

(b) The health care insurer is required to provide coverage under this section only if the patient's treating physician determines that

(1) there is no clearly superior noninvestigational treatment alternative; and

(2) available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as efficacious as any noninvestigational alternative.

(c) The coverage to be provided under (a) of this section must include payment for the costs of

(1) prevention, diagnosis, treatment, and palliative care of cancer;

(2) medical care for an approved clinical trial related to cancer that would otherwise be covered under a health care insurance plan if the medical care were not in connection with an approved clinical trial related to cancer;

(3) items or services necessary to provide an investigational item or service;

(4) the diagnosis or treatment of complications;

(5) a drug or device approved by the United States Food and Drug Administration without regard to whether the United States Food and Drug Administration approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device;

(6) services necessary to administer a drug or device under evaluation in the clinical trial; and

(7) transportation for the patient that is primarily for and essential to the medical care.

(d) The coverage to be provided under (a) of this section may not include the cost of

(1) a drug or device that is associated with the clinical trial that has not been approved by the United States Food and Drug Administration;

(2) housing, companion expenses, or other nonclinical expenses

associated with the clinical trial;

(3) an item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;

(4) an item or service excluded from coverage under the patient's health care insurance plan; and

(5) an item or service paid for or customarily paid for through grants or other funding.

(e) The coverage required by this section is subject to the standard policy provisions applicable to other benefits, including deductible, coinsurance, or copayment provisions.

(f) This section does not apply to a fraternal benefit society.

(g) In this section, "approved clinical trial" means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care of a subject, if the study is approved by

(1) an institutional review board that complies with 45 CFR Part 46; and

(2) one or more of the following:

(A) the United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers;

(B) the United States Department of Health and Human Services, United States Food and Drug Administration;

(C) the United States Department of Defense;

(D) the United States Department of Veterans' Affairs; or

(E) a nongovernmental research entity abiding by current National Institute of Health guidelines.

*** Sec. 2.** AS 21.55.140(a) is amended to read:

(a) A state plan may not provide benefits for charges for the following:

(1) care for an injury or disease either

(A) arising out of and in the course of an employment subject

to a workers' compensation or similar law or where the benefit is available to be provided under a workers' compensation policy or equivalent self-insurance to a sole proprietor, business partner, or corporation officer; or

(B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in a motor vehicle or other liability insurance policy or equivalent self-insurance;

(2) treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered or for replacement of an anatomic structure removed during treatment of tumors;

(3) travel, other than transportation covered under AS 21.55.110(17);

(4) private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room;

(5) services or articles to the extent that the charge exceeds the reasonable charge in the locality for the service;

(6) services or articles that are determined not to be medically necessary, except for the fabrication or placement of the prosthesis as specified in AS 21.55.110(12) and (2) of this subsection;

(7) services or articles that are not within the scope of the license or certificate of the institution or individual rendering the services or articles;

(8) services or articles furnished, paid for, or reimbursed directly by or under any law of a government, except as otherwise provided in this chapter;

(9) services or articles for custodial care or designed primarily to assist an individual in the activities of daily living;

(10) service charges that would not have been made if no insurance existed or that the covered individual is not legally obligated to pay;

(11) eyeglasses, contact lenses, or hearing aids or the fitting of them;

(12) dental care not specifically covered by this chapter;

(13) services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse;

(14) experimental procedures**, except during an approved clinical**

trial; in this paragraph, "approved clinical trial" has the meaning given in AS 21.42.410; and

(15) services and supplies for which the patient was not charged.

* **Sec. 3.** AS 47.07.030 is amended by adding a new subsection to read:

(e) The department shall provide the services set out in (a) and (b) of this section to an eligible person, notwithstanding the person's participation in an approved clinical trial. In this subsection, "approved clinical trial" has the meaning given in AS 21.42.410.

* **Sec. 4.** This Act takes effect January 1, 2010.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 2, 2009

SUBJECT: Mandatory insurance for clinical trials for cancer, sectional summary (SB 10; Work Order No. 26-LS0073\A)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Dennis C. Bailey
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. Requires health care insurers to cover approved clinical trials for cancer if there is no clearly superior noninvestigational treatment alternative, and available clinical or preclinical data provide a reasonable expectation that the treatment in the clinical trial will be at least as efficacious as any noninvestigational alternative; makes coverage for clinical trials subject to standard policy provisions that are applicable to other benefits; and defines covered clinical trials and patient costs.

Section 2. Requires the state health insurance plan provided by the Comprehensive Health Care Insurance Association to include clinical trials related to cancer in its minimum standard benefits.

Section 3. Requires the state Medicaid program to cover clinical trials related to cancer.

Section 4. Gives the Act a January 1, 2010, effective date.

DCB:lmb
09-011.lmb

SENATE BILL NO. 10

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY SENATOR DAVIS

Introduced: 1/9/09
Referred: Prefiled

A BILL

FOR AN ACT ENTITLED

"An Act requiring health care insurers to provide insurance coverage for medical care received by a patient during certain approved clinical trials designed to test and improve prevention, diagnosis, treatment, or palliation of cancer; directing the Department of Health and Social Services to provide Medicaid services to persons who participate in those clinical trials; relating to experimental procedures under a state plan offered by the Comprehensive Health Insurance Association; and providing for an effective date."

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

*** Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.410. Coverage for clinical trials related to cancer. (a) A health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in the state shall cover routine patient care costs incurred by a patient enrolled in an approved clinical trial related to cancer. The coverage provided must include the

costs of prevention, diagnosis, treatment, and palliative care of cancer. The health care insurer is required to provide coverage under this section only if the patient's treating physician determines that

(1) there is no clearly superior noninvestigational treatment alternative; and

(2) available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as efficacious as any noninvestigational alternative.

(b) The coverage to be provided under (a) of this section must include leukemia, lymphoma, and bone marrow stem cell disorders.

(c) The coverage required by this section is subject to the standard policy provisions applicable to other benefits, including deductible or copayment provisions.

(d) This section does not apply to a fraternal benefit society.

(e) In this section,

(1) "approved clinical trial related to cancer" means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the treatment of cancer if the study is approved by

(A) an institutional review board that complies with 45 CFR Part 46; and

(B) one or more of the following:

(i) the United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers;

(ii) the United States Department of Health and Human Services, United States Food and Drug Administration;

(iii) the United States Department of Defense;

(iv) the United States Department of Veterans' Affairs; or

(v) a nongovernmental research entity abiding by current National Institute of Health guidelines;

(2) "routine patient care costs"

(A) means the costs incurred for medical care for an approved clinical trial related to cancer that would otherwise be covered under a health care insurance plan if the medical care was not in connection with an approved clinical trial related to cancer, including transportation for the patient that is primarily for and essential to the medical care;

(B) does not include the cost for

(i) a drug or device that is associated with the clinical trial that has not been approved by the United States Food and Drug Administration;

(ii) housing, companion expenses, or other nonclinical expenses associated with the clinical trial;

(iii) an item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;

(iv) an item or service excluded from coverage under the patient's health care insurance plan; and

(v) an item or service paid for or customarily paid for through grants or other funding.

* **Sec. 2.** AS 21.55.140(a) is amended to read:

(a) A state plan may not provide benefits for charges for the following:

(1) care for an injury or disease either

(A) arising out of and in the course of an employment subject to a workers' compensation or similar law or where the benefit is available to be provided under a workers' compensation policy or equivalent self-insurance to a sole proprietor, business partner, or corporation officer; or

(B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in a motor vehicle or other liability insurance policy or equivalent self-insurance;

(2) treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered or for replacement of an anatomic structure removed during treatment of tumors;

(3) travel, other than transportation covered under AS 21.55.110(17);

(4) private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room;

(5) services or articles to the extent that the charge exceeds the reasonable charge in the locality for the service;

(6) services or articles that are determined not to be medically necessary, except for the fabrication or placement of the prosthesis as specified in AS 21.55.110(12) and (2) of this subsection;

(7) services or articles that are not within the scope of the license or certificate of the institution or individual rendering the services or articles;

(8) services or articles furnished, paid for, or reimbursed directly by or under any law of a government, except as otherwise provided in this chapter;

(9) services or articles for custodial care or designed primarily to assist an individual in the activities of daily living;

(10) service charges that would not have been made if no insurance existed or that the covered individual is not legally obligated to pay;

(11) eyeglasses, contact lenses, or hearing aids or the fitting of them;

(12) dental care not specifically covered by this chapter;

(13) services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse;

(14) experimental procedures**, except during an approved clinical trial related to cancer; in this paragraph, "approved clinical trial related to cancer" has the meaning given in AS 21.42.410**; and

(15) services and supplies for which the patient was not charged.

* **Sec. 3.** AS 47.07.030 is amended by adding a new subsection to read:

(e) The department shall provide the services set out in (a) and (b) of this section to an eligible person, notwithstanding the person's participation in an approved clinical trial related to cancer. In this subsection, "approved clinical trial related to cancer" has the meaning given in AS 21.42.410.

* **Sec. 4.** This Act takes effect January 1, 2010.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 010
() Publish Date:

Identifier (file name): SB010-DHSS-MS-02-11-09
Dept. Affected: Health & Social Services
Title: Medicaid/Insurance For Cancer Clinical Trials
RDU: Health Care Services
Component: Medicaid Services
Sponsor: Davis
Requester: Senate HSS
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 010 amends the Medicaid statute (AS 47.07.030) to add a new subsection (e) that requires the program to pay for Medicaid covered services for Medicaid recipients even when provided as part of an approved clinical trial related to cancer.

The bill would be effective on January 1, 2010. It is not expected to result in an increase in Medicaid expenditures as Medicaid already covers these services.

Prepared by: William J. Streur, Deputy Commissioner
Phone 907-269-7827
Division: Health Care Services
Date/Time 2/10/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/11/2009
DHSS Finance Management Services

Alaska State Legislature

Senator Bettye Davis, Chair
State Capitol, Room 30
Juneau, Alaska 99801
Phone: (907) 465-3822
Fax: (907) 465-3756

Committee Members:
Senator Johnny Ellis
Senator Joe Thomas
Senator Joe Paskvan
Senator Fred Dyson

Senate Health & Social Services Committee

MEMORANDUM

Date: 2/11/09

To: Senate Secretary's Office

From: Senator Bettye Davis BD

Re: Notice of Meeting

Monday Feburary 16th, Capital Building
Butrovich Room #205
1:30 p.m. to 3:00 p.m

State Holiday – no meeting scheduled

Tuesday, Feburary 17th, Capital Building
Room # 106
3:00 p.m. to 5:00 p.m.

Joint House & Senate H&SS committee meeting
+Presentation by U.S. Preventative Medicine

Wednesday Feburary 18th, Capital Building
Butrovich Room #205
1:30 p.m. to 3:00 p.m.

+SB 10 Medicaid/Ins For Cancer Clinical Trials
+BPH

Friday, Feburary 20th, Capital Building
Butrovich Room # 205
1:30 p.m. to 3:00 p.m.

+Presentation by Alaska Native Tribal Health Consortium
+ BPH

tentative
SB 52, "Salvia Divinorum as Controlled Substance"

2922

Thomas Obermeyer

From: Thomas Obermeyer

Sent: Friday, February 13, 2009 9:21 AM

To: 'Jeanne Anderson'; Emily.Nenon@cancer.org; Tammy@hotsheet.com; Latha Subramanian; mstewartonc@yahoo.com; Doug Debenham; muffz326@aol.com; Wooley, Beverly K (HSS); Rangitsch, Krista

Cc: Sen. Bettye Davis; Lynda Zaugg; Don Burrell; Richard Benavides

Subject: RE: CS for SB 10 and memo

Dr. Anderson,

Linda Zaugg, Senate HSS Committee Aide to Senator Davis, Linda_Zaugg@legis.state.ak.us, would appreciate knowing in advance those doctors and others who wish to testify on Wednesday, February 18, 2009 at 1:30-3:00 pm. All Senate HSS meetings are from 1:30-3:00 pm. The hearing schedule is already posted on "BASIS," on the Legislature web site. SB 10 is the first bill to be heard and likely will be given as much time as needed, although there may be another item on the agenda as well. If the hearing runs over, it could be continued to another day.

If you wish to have the physicians testify first, e-mail the request to Linda Zaugg, Linda_Zaugg@legis.state.ak.us, who will ask Senator Davis to accommodate this request. They can call in after 1:30, and a communications person at the hearing will receive notice by computer of people on the phone and hand a new list to Linda who will forward their presence to Senator Davis. Be sure when physicians call in they identify themselves as doctors. When called upon to testify, they will be asked their name and affiliation or organization.

Senator Davis often asks to the Department (DHSS) to comment before testimony of constituents, but physicians, as experts may wish to testify both before and after Departmental comments, or stay on line to explain misunderstandings in the bill. This testimony will be recorded and useful in the next hearings in Labor & Commerce and Finance. So the best effort is needed in this first hearing if possible.

Keep in mind that rather than a teleconference call to 888-295-4546, physicians and/or patients or parties of interest who wish to testify in Anchorage could meet at the Legislative Information Office (LIO) in Anchorage at 716 W. 4th Avenue, 2nd floor conference room, which is already set up with microphones and aides to assist in communications. Make sure you understand operation and use of the on/off buttons on the microphones. The LIO phone number is 269-0111. Parking is available at the Legislature parking lot on 4th & H, and parking permits are available either by the guard at the front door or at the LIO office on the 2nd floor.

As a last comment, it would be helpful to have one or two doctors and/or others testify in person at the hearing on the 2nd floor of the Capitol, Room 205. This adds weight and urgency to the need for cancer clinical trials. You may also want to have contacts from your oncology and cancer society organizations, or peers from other states which conduct cancer clinical trials testify telephonically.

Tom Obermeyer
Thomas_Obermeyer@legis.state.ak.us

Phone: 465-3762

From: Jeanne Anderson [mailto:JeanneAnderson@katmaioncology.com]
Sent: Thursday, February 12, 2009 1:09 PM
To: Thomas Obermeyer; Emily.Nenon@cancer.org; Tammy@hotsheet.com; Latha Subramanian; mstewartonc@yahoo.com; Doug Debenham; muffz326@aol.com; Wooley, Beverly K (HSS); Rangitsch, Krista
Subject: RE: CS for SB 10 and memo

Tom-
A few questions about the logistics of the hearing:

1. Do you need a list, in advance, of names of people who are going to call in?
2. Can we have the physicians who call in testify first (or at the time they call, if they call later than 1:30)? I think we may have 4 physicians calling in (I don't think they will be in person).
3. How long do you expect the hearing to last?
-Jeanne

Jeanne E. Anderson, M.D.
Katmai Oncology Group, LLC
3851 Piper Street, Suite U340
Anchorage, AK 99508-4627
tel (907) 562-0321
fax (907) 562-2683
jea@katmaioncology.com

From: Thomas Obermeyer [mailto:Thomas_Obermeyer@legis.state.ak.us]
Sent: Monday, February 09, 2009 8:55 AM
To: Jeanne Anderson; Emily.Nenon@cancer.org; Tammy@hotsheet.com; Latha Subramanian; mstewartonc@yahoo.com; Doug Debenham; muffz326@aol.com; Wooley, Beverly K (HSS)
Subject: RE: CS for SB 10 and memo

Dr. Anderson,

I would prefer to have currently dated letters or written testimony, even if from last year, and if from professional offices, on letterhead if possible. This helps show the earnest interest of the parties and their affiliations. However, if I do not receive currently dated letters or written testimony, I will use last year's. Please be sure to have people testify by teleconference or in person if they are in Juneau. The call-in number is 888-295-4546.

Tom Obermeyer
Office of Senator Bettye Davis, Chair
Senate HSS Committee
465-3762
Thomas_Obermeyer@legis.state.ak.us

State Capitol, Suite 30
Juneau, AK 99801-1182
465-3822
465-3756 fax

From: Jeanne Anderson [mailto:JeanneAnderson@katmaioncology.com]
Sent: Monday, February 09, 2009 8:38 AM
To: Emily.Nenon@cancer.org; Tammy@hotsheet.com; Latha Subramanian; mstewartonc@yahoo.com; Doug Debenham; muffz326@aol.com; Wooley, Beverly K (HSS)
Cc: Thomas Obermeyer
Subject: FW: CS for SB 10 and memo

To all involved-
Here is the latest draft of the bill. It looks fine to me.

Note the date, time and instructions for the first hearing, given below.

Please forward to anyone else who may want to participate.

Mr. Obermeyer-
Will the written testimony that was submitted last year be included in this year's hearings? Or, should we re-submit testimony, even if identical to last year's?
-Jeanne

Jeanne E. Anderson, M.D.
Katmai Oncology Group, LLC
3851 Piper Street, Suite U340
Anchorage, AK 99508-4627
tel (907) 562-0321
fax (907) 562-2683
jea@katmaioncology.com

From: Thomas Obermeyer [mailto:Thomas_Obermeyer@legis.state.ak.us]
Sent: Wednesday, February 04, 2009 8:08 PM
To: Jeanne Anderson
Cc: Lynda Zaugg; Sen. Bettye Davis
Subject: RE: CS for SB 10 and memo

February 4, 2009

Dr. Anderson,

Attached is the latest draft of the clinical trials bill, a **Committee Substitute for Senate Bill 10, 26-LS0073\E**, and an accompanying memo from our Legislative Counsel. The drafter incorporated your requested changes with substantive terms in the body of the bill itself instead of including them in a definition section in accordance with the requirements of the Drafting Manual.

We will be unable to make further changes before the Senate HSS hearing scheduled February 18 at 1:30 pm, but your suggestions and comments are welcome any time in writing. The teleconference number on the date of the hearing is 888-295-4546.

Your help in organizing support at the hearing is most important.
Please notify your peers, local and national organizations, and patients of the hearing and have them call or write in to support the bill or appear in person to testify. If you testify in person or telephonically and provide written copies for the record, please provide the written copies in advance on letterhead, if available, to me and Lynda Zaugg, Senate HSS Committee Aide to Senator Davis. Our fax machine produces a poor quality copy, so I suggest you mail or e-mail written documents, if possible.

Tom Obermeyer
Office of Senator Bettye Davis
907-465-3822 office
907-465-3756 fax
465-3762 direct line
Thomas_Obermeyer@legis.state.ak.us

Lynda Zaugg
465-4906 direct line
Lynda_Zaugg@legis.state.ak.us

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 3, 2009

SUBJECT: Insurance coverage for clinical trials (CSSB 10( );
Work Order No. 26-LS0073\E)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Dennis C. Bailey
Legislative Counsel

This memo accompanies the blank draft CS you requested and explains the changes made to your request.

You will notice that I have reworked the bill to avoid incorporating substantive terms in the definitions section in accordance with the Drafting Manual. While making these drafting changes, I did not intend to make substantive changes to the bill other than those you requested. Please review the new draft closely to be sure that it reads as intended.

AS 01.10.040(b) provides: "(b) When the words 'includes' or 'including' are used in a law, they shall be construed as though followed by the phrase 'but not limited to.'" Therefore, the change in Item 4 of your request is not necessary.

If I may be of further assistance, please advise.

DCB:ljw
09-065.ljw

Enclosure

26-LS0073\E
Bailey
2/4/09

CS FOR SENATE BILL NO. 10( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

"An Act requiring health care insurers to provide insurance coverage for medical care received by a patient during certain approved clinical trials designed to test and improve prevention, diagnosis, treatment, or palliation of cancer; directing the Department of Health and Social Services to provide Medicaid services to persons who participate in those clinical trials; relating to experimental procedures under a state plan offered by the Comprehensive Health Insurance Association; and providing for an effective date."

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

*** Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.410. Coverage for clinical trials related to cancer. (a) A health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in the state shall cover routine patient care costs incurred by a patient enrolled in an approved clinical trial related to cancer, including leukemia, lymphoma, and bone

marrow stem cell disorders.

(b) The health care insurer is required to provide coverage under this section only if the patient's treating physician determines that

(1) there is no clearly superior noninvestigational treatment alternative; and

(2) available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as efficacious as any noninvestigational alternative.

(c) The coverage to be provided under (a) of this section must include payment for the costs of

(1) prevention, diagnosis, treatment, and palliative care of cancer;

(2) medical care for an approved clinical trial related to cancer that would otherwise be covered under a health care insurance plan if the medical care were not in connection with an approved clinical trial related to cancer;

(3) items or services necessary to provide an investigational item or service;

(4) the diagnosis or treatment of complications;

(5) a drug or device approved by the United States Food and Drug Administration without regard to whether the United States Food and Drug Administration approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device;

(6) services necessary to administer a drug or device under evaluation in the clinical trial; and

(7) transportation for the patient that is primarily for and essential to the medical care.

(d) The coverage to be provided under (a) of this section may not include the cost of

(1) a drug or device that is associated with the clinical trial that has not been approved by the United States Food and Drug Administration;

(2) housing, companion expenses, or other nonclinical expenses

associated with the clinical trial;

(3) an item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;

(4) an item or service excluded from coverage under the patient's health care insurance plan; and

(5) an item or service paid for or customarily paid for through grants or other funding.

(e) The coverage required by this section is subject to the standard policy provisions applicable to other benefits, including deductible, coinsurance, or copayment provisions.

(f) This section does not apply to a fraternal benefit society.

(g) In this section, "approved clinical trial" means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care of a subject, if the study is approved by

(1) an institutional review board that complies with 45 CFR Part 46; and

(2) one or more of the following:

(A) the United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers;

(B) the United States Department of Health and Human Services, United States Food and Drug Administration;

(C) the United States Department of Defense;

(D) the United States Department of Veterans' Affairs; or

(E) a nongovernmental research entity abiding by current National Institute of Health guidelines.

*** Sec. 2.** AS 21.55.140(a) is amended to read:

(a) A state plan may not provide benefits for charges for the following:

(1) care for an injury or disease either

(A) arising out of and in the course of an employment subject

to a workers' compensation or similar law or where the benefit is available to be provided under a workers' compensation policy or equivalent self-insurance to a sole proprietor, business partner, or corporation officer; or

(B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in a motor vehicle or other liability insurance policy or equivalent self-insurance;

(2) treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered or for replacement of an anatomic structure removed during treatment of tumors;

(3) travel, other than transportation covered under AS 21.55.110(17);

(4) private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room;

(5) services or articles to the extent that the charge exceeds the reasonable charge in the locality for the service;

(6) services or articles that are determined not to be medically necessary, except for the fabrication or placement of the prosthesis as specified in AS 21.55.110(12) and (2) of this subsection;

(7) services or articles that are not within the scope of the license or certificate of the institution or individual rendering the services or articles;

(8) services or articles furnished, paid for, or reimbursed directly by or under any law of a government, except as otherwise provided in this chapter;

(9) services or articles for custodial care or designed primarily to assist an individual in the activities of daily living;

(10) service charges that would not have been made if no insurance existed or that the covered individual is not legally obligated to pay;

(11) eyeglasses, contact lenses, or hearing aids or the fitting of them;

(12) dental care not specifically covered by this chapter;

(13) services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse;

(14) experimental procedures**, except during an approved clinical**

trial; in this paragraph, "approved clinical trial" has the meaning given in AS 21.42.410; and

(15) services and supplies for which the patient was not charged.

*** Sec. 3.** AS 47.07.030 is amended by adding a new subsection to read:

(e) The department shall provide the services set out in (a) and (b) of this section to an eligible person, notwithstanding the person's participation in an approved clinical trial. In this subsection, "approved clinical trial" has the meaning given in AS 21.42.410.

*** Sec. 4.** This Act takes effect January 1, 2010.

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Wednesday, February 18, 2009 12:02 PM
To: Lynda Zaugg; Fick, Tyson C (CED)
Cc: Sherwood, Jon (HSS)
Subject: Senate HSS SB 10 hearing

This is to let you know that Jon Sherwood, DHSS medical assistance administrator, will be at today's Senate HSS hearing on SB 10 to answer questions if needed. He will not have a statement.

Let me know if you need anything else from me.
w.

Dept. HSS
– for questions.
– will not have a statement –

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Labor and Commerce
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/20/09

Health and Social Services Committee considered SENATE BILL NO. 10

SB 10 MEDICAID/INS FOR CANCER CLINICAL TRIALS

"An Act requiring health care insurers to provide insurance coverage for medical care received by a patient during certain approved clinical trials designed to test and improve prevention, diagnosis, treatment, or palliation of cancer; directing the Department of Health and Social Services to provide Medicaid services to persons who participate in those clinical trials; relating to experimental procedures under a state plan offered by the Comprehensive Health Insurance Association; and providing for an effective date."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 10 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[✓] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS	2/11			✓	
CED	2/11			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	✓			
	THOMAS	✓			
	PASKVAN	X			
CHAIR: Betty Davis	DAVIS	X			

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB10
() Publish Date:

Identifier (file name): SB10-CED-INS-2-4-09
Dept. Affected: DCCED
Title: Medicaid/Insurance for cancer clinical trials
RDU: Insurance (116)
Component: Insurance
Sponsor: Senator Davis
Requester: Senate Health and Social Services
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill requires companies that offer health care insurance in Alaska cover routine patient care costs incurred by a patient enrolled in an approved clinical trial related to cancer. The coverage provided must include the costs of prevention, diagnosis, treatment, and palliative care of cancer. The health care insurer is required to provide coverage under this section only if the patient's treating physician determines that there is no clearly superior non-investigational treatment alternative; and available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as efficacious as any non-investigational alternative.

Prepared by: Linda S. Hall, Director — Phone 907-269-7900
Division: Insurance — Date/Time 2/4/09 10:48 AM
Approved by: Emil R. Notti, Commissioner — Date 2/4/2009
Commerce, Community, and Economic Development

(Revised 9/10/2008 OMB)

Lynda Zaugg

From: mary stewart [mstewartonc@yahoo.com]
Sent: Friday, February 13, 2009 1:08 PM
To: Jeanne Anderson; Emily.Nenon@cancer.org; Tammy@hotsheet.com; Latha Subramanian; Doug Debenham; muffz326@aol.com; Wooley, Beverly K (HSS); Rangitsch, Krista; Thomas Obermeyer
Cc: Sen. Bettye Davis; Lynda Zaugg; Don Burrell; Richard Benavides
Subject: RE: CS for SB 10 and memo

Mr Obermeyer,
I have committments from Dr Michael O'Connell of NSABP (National Surgical Adjuvant Breast Project) to speak at the hearing next week. Also, from our national professional oncology society, ASCO, the president-elect, Dr Doug Blayney, of the University of Michigan, will call in. I have told them both that the meeting starts at 1:30 our time, and I expect they will be calling in at about that time. I can email them to call a little later if you like. Two survivers, Angela Verploeg and Paula Call will testify. I will be phoning in as well, but will not be able to listen to the proceedings continuously.
Mary Stewart

--- On Fri, 2/13/09, Thomas Obermeyer <Thomas_Obermeyer@legis.state.ak.us> wrote:

> From: Thomas Obermeyer <Thomas_Obermeyer@legis.state.ak.us>
> Subject: RE: CS for SB 10 and memo
> To: "Jeanne Anderson" <JeanneAnderson@katmaioncology.com>,
> "Emily.Nenon@cancer.org" <Emily.Nenon@cancer.org>,
> "Tammy@hotsheet.com" <Tammy@hotsheet.com>, "Latha Subramanian"
> <2006anch@gmail.com>, "mstewartonc@yahoo.com" <mstewartonc@yahoo.com>,
> "Doug Debenham" <dougdebenham@excite.com>, "muffz326@aol.com"
> <muffz326@aol.com>, "Wooley, Beverly K (HSS)"
> <beverly.wooley@alaska.gov>, "Rangitsch, Krista"
> <Krista.Rangitsch@providence.org>
> Cc: "Sen. Bettye Davis" <Senator_Bettye_Davis@legis.state.ak.us>,
> "Lynda Zaugg" <Lynda_Zaugg@legis.state.ak.us>, "Don Burrell"
> <Don_Burrell@legis.state.ak.us>, "Richard Benavides"
> <Richard_Benavides@legis.state.ak.us>
> Date: Friday, February 13, 2009, 9:20 AM Dr. Anderson,
>
> Linda Zaugg, Senate HSS Committee Aide to Senator Davis,
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> to testify on Wednesday, February 18, 2009 at
> 1:30-3:00 pm. All Senate HSS meetings are from 1:30-3:00
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> to explain misunderstandings in the bill. This testimony will be recorded and useful in the next hearings in Labor & Commerce and Finance. So the best effort is needed in this first hearing if possible.
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> Keep in mind that rather than a teleconference call to 888-295-4546, physicians and/or patients or parties of interest who wish to testify in Anchorage could meet at the Legislative Information Office (LIO) in Anchorage at 716 W.
> 4th Avenue, 2nd floor conference room, which is already set up with microphones and aides to assist in communications.
> Make sure you understand operation and use of the on/off buttons on the microphones. The LIO phone number is 269-0111. Parking is available at the Legislature parking lot on 4th & H, and parking permits are available either by the guard at the front door or at the LIO office on the 2nd floor.
>
> As a last comment, it would be helpful to have one or two doctors and/or others testify in person at the hearing on the 2nd floor of the Capitol, Room 205. This adds weight and urgency to the need for cancer clinical trials. You may also want to have contacts from your oncology and cancer society organizations, or peers from other states which conduct cancer clinical trials testify telephonically.
>
> Tom Obermeyer
> Thomas_Obermeyer@legis.state.ak.us<mailto:Thomas_Obermeyer@legis.state.ak.us>
>
> Phone: 465-3762
>
> _____
> From: Jeanne Anderson
> [mailto:JeanneAnderson@katmaioncology.com]
> Sent: Thursday, February 12, 2009 1:09 PM
> To: Thomas Obermeyer; Emily.Nenon@cancer.org; Tammy@hotsheet.com; Latha Subramanian; mstewartonc@yahoo.com; Doug Debenham; muffz326@aol.com; Wooley, Beverly K (HSS); Rangitsch, Krista
> Subject: RE: CS for SB 10 and memo
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> Tom-
> A few questions about the logistics of the hearing:
> 1. Do you need a list, in advance, of names of people who are going to call in?
> 2. Can we have the physicians who call in testify first (or at the time they call, if they call later than 1:30)? I think we may have 4 physicians calling in (I don't think they will be in person).
> 3. How long do you expect the hearing to last?
> -Jeanne
>
> Jeanne E. Anderson, M.D.
> Katmai Oncology Group, LLC
> 3851 Piper Street, Suite U340
> Anchorage, AK 99508-4627
> tel (907) 562-0321
> fax (907) 562-2683
> jea@katmaioncology.com<mailto:jea@katmaioncology.com>
> _____
> From: Thomas Obermeyer
> [mailto:Thomas_Obermeyer@legis.state.ak.us]
> Sent: Monday, February 09, 2009 8:55 AM
> To: Jeanne Anderson; Emily.Nenon@cancer.org; Tammy@hotsheet.com; Latha Subramanian; mstewartonc@yahoo.com; Doug Debenham; muffz326@aol.com; Wooley, Beverly K (HSS)
> Subject: RE: CS for SB 10 and memo
>
> Dr. Anderson,
>

> I would prefer to have currently dated letters or written testimony,
> even if from last year, and if from professional offices, on
> letterhead if possible. This helps show the earnest interest of the
> parties and their affiliations.
> However, if I do not receive currently dated letters or
> written testimony, I will use last year's. Please be
> sure to have people testify by teleconference or in person if they are
> in Juneau. The call-in number is 888-295-4546.
>
> Tom Obermeyer
> Office of Senator Bettye Davis, Chair
> Senate HSS Committee
> 465-3762
> Thomas_Obermeyer@legis.state.ak.us<mailto:Thomas_Obermeyer@legis.state
> .ak.us>
>
> State Capitol, Suite 30
> Juneau, AK 99801-1182
> 465-3822
> 465-3756 fax
>
>
> _____
> From: Jeanne Anderson
> [mailto:JeanneAnderson@katmaioncology.com]
> Sent: Monday, February 09, 2009 8:38 AM
> To: Emily.Nenon@cancer.org; Tammy@hotsheet.com; Latha Subramanian;
> mstewartonc@yahoo.com; Doug Debenham; muffz326@aol.com; Wooley,
> Beverly K (HSS)
> Cc: Thomas Obermeyer
> Subject: FW: CS for SB 10 and memo
>
> To all involved-
> Here is the latest draft of the bill. It looks fine to me.
>
> Note the date, time and instructions for the first hearing, given
> below.
>
> Please forward to anyone else who may want to participate.
>
> Mr. Obermeyer-
> Will the written testimony that was submitted last year be included in
> this year's hearings? Or, should we re-submit testimony, even if
> identical to last year's?
> -Jeanne
>
> Jeanne E. Anderson, M.D.
> Katmai Oncology Group, LLC
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> jea@katmaioncology.com<mailto:jea@katmaioncology.com>
> _____
> From: Thomas Obermeyer
> [mailto:Thomas_Obermeyer@legis.state.ak.us]
> Sent: Wednesday, February 04, 2009 8:08 PM
> To: Jeanne Anderson
> Cc: Lynda Zaugg; Sen. Bettye Davis
> Subject: RE: CS for SB 10 and memo
>
> February 4, 2009
>
> Dr. Anderson,
>
> Attached is the latest draft of the clinical trials bill, a Committee
> Substitute for Senate Bill 10, 26-LS0073\E,

SB 10

Lynda Zaugg

From: Jeanne Anderson [JeanneAnderson@katmaioncology.com]
Sent: Sunday, February 15, 2009 7:15 AM
To: Thomas Obermeyer
Cc: Lynda Zaugg; Sen. Bettye Davis
Subject: RE: CS for SB 10 and memo

Tom-
I also want you and Senator Davis to know that, although I cannot attend in person, I will be on the phone during the entire hearing. So, I will be available to help answer questions and clarify issues during the hearing, if any arise.

Thank you, again, for your support.
-Jeanne

Jeanne E. Anderson, M.D.
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3851 Piper Street, Suite U340
Anchorage, AK 99508-4627
tel (907) 562-0321
fax (907) 562-2683
jea@katmaioncology.com

From: Thomas Obermeyer [mailto:Thomas_Obermeyer@legis.state.ak.us]
Sent: Saturday, February 14, 2009 3:53 PM
To: Jeanne Anderson
Cc: Lynda Zaugg; Sen. Bettye Davis
Subject: RE: CS for SB 10 and memo

Dr. Ancerson,
Thank you for the written testimony. It is very important and detailed. I will ask Lynda Zaugg to include it in the committee packages or hand it out to committee members at the hearing.

Tom Obermeyer

From: Jeanne Anderson [mailto:JeanneAnderson@katmaioncology.com]
Sent: Saturday, February 14, 2009 11:29 AM
To: Thomas Obermeyer
Cc: Sen. Bettye Davis; Lynda Zaugg; Don Burrell; Richard Benavides; mstewartonc@yahoo.com; Rangitsch, Krista
Subject: RE: CS for SB 10 and memo

I have attached the written testimony that I will be giving by phone on Wed, 2/18. Unfortunately, I cannot attend in person.

I have also attached an update of the position paper from the Denali Oncology Group regarding the bill. Can you please use this document as written testimony also?

In addition to the names of people that Dr. Mary Stewart sent to Linda Zaugg yesterday, I expect there will be a few additional patients who call in, although I don't have an exact list. A research nurse, Krista Rangitsch will be calling in, too.

Jeanne E. Anderson, M.D.
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Cc: Sen. Bettye Davis; Lynda Zaugg; Don Burrell; Richard Benavides
Subject: RE: CS for SB 10 and memo

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Tom Obermeyer
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Phone: 465-3762

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To: Thomas Obermeyer
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Subject: RE: CS for SB 10 and memo
Attachments: SB 10 Testimony 2-18-09.doc; Proposal for insurance coverage clnical trials 2-14-09.doc

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Thomas_Obermeyer@legis.state.ak.us

Phone: 465-3762

Lynda Zaugg

SB 10

From: mary stewart [mstewartonc@yahoo.com]
Sent: Friday, February 13, 2009 5:18 PM
To: Thomas Obermeyer
Cc: Lynda Zaugg; Sen. Bettye Davis; Don Burrell
Subject: RE: CS for SB 10 and memo

Dear Mr Obermeyer,
Dr Verneeda Spencer will also be calling in to give testimony re SB 10.
Thenks for all your work.
Mary Stewart, MD

--- On Fri, 2/13/09, Thomas Obermeyer <Thomas_Obermeyer@legis.state.ak.us> wrote:

> From: Thomas Obermeyer <Thomas_Obermeyer@legis.state.ak.us>
> Subject: RE: CS for SB 10 and memo
> To: "mstewartonc@yahoo.com" <mstewartonc@yahoo.com>
> Cc: "Lynda Zaugg" <Lynda_Zaugg@legis.state.ak.us>, "Sen. Bettye Davis"
> <Senator_Bettye_Davis@legis.state.ak.us>, "Don Burrell"
> <Don_Burrell@legis.state.ak.us>
> Date: Friday, February 13, 2009, 1:37 PM Dear Dr. Stewart,
>
> Thank you for this information. I am forwarding this information to
> Lynda Zaugg, and hope that Lynda, as Committee Aide organizing the
> hearing, will be kept apprised of any additional testimony as well.
> In my view, the more people testifying on behalf of SB 10 the better.
> Their knowledge and experience is very valuable.
>
> Tom Obermeyer
> Legislative Assistant
> Office of Senator Davis
>
>
> -----Original Message-----
> From: mary stewart [mailto:mstewartonc@yahoo.com]
> Sent: Friday, February 13, 2009 1:08 PM
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> Rangitsch, Krista; Thomas Obermeyer
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> "Emily.Nenon@cancer.org"
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> "Tammy@hotsheet.com" <Tammy@hotsheet.com>, "Latha Subramanian"
> <2006anch@gmail.com>, "mstewartonc@yahoo.com"
> <mstewartonc@yahoo.com>, "Doug Debenham"
> <dougdebenham@excite.com>,
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> <beverly.wooley@alaska.gov>, "Rangitsch, Krista"
> <Krista.Rangitsch@providence.org>
> > Cc: "Sen. Bettye Davis"
> <Senator_Bettye_Davis@legis.state.ak.us>, "Lynda Zaugg"
> <Lynda_Zaugg@legis.state.ak.us>, "Don Burrell"
> <Don_Burrell@legis.state.ak.us>, "Richard Benavides"
> <Richard_Benavides@legis.state.ak.us>
> > Date: Friday, February 13, 2009, 9:20 AM Dr. Anderson,
> >
> > Linda Zaugg, Senate HSS Committee Aide to Senator
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> I
> > think we may have 4 physicians calling in (I don't
> think
> > they will be in person).

> > 3. How long do you expect the hearing to last?
> > -Jeanne
> >
> > Jeanne E. Anderson, M.D.
> > Katmai Oncology Group, LLC
> > 3851 Piper Street, Suite U340
> > Anchorage, AK 99508-4627
> > tel (907) 562-0321
> > fax (907) 562-2683
> >
> jea@katmaioncology.com<mailto:jea@katmaioncology.com>
> > _____
> > From: Thomas Obermeyer
> > [mailto:Thomas_Obermeyer@legis.state.ak.us]
> > Sent: Monday, February 09, 2009 8:55 AM
> > To: Jeanne Anderson; Emily.Nenon@cancer.org; Tammy@hotsheet.com;
> > Latha Subramanian; mstewartonc@yahoo.com; Doug Debenham;
> muffz326@aol.com;
> > Wooley, Beverly K (HSS)
> > Subject: RE: CS for SB 10 and memo
> >
> > Dr. Anderson,
> >
> > I would prefer to have currently dated letters or
> written
> > testimony, even if from last year, and if from
> professional
> > offices, on letterhead if possible. This helps show
> the
> > earnest interest of the parties and their
> affiliations.
> > However, if I do not receive currently dated letters
> or
> > written testimony, I will use last year's.
> Please be
> > sure to have people testify by teleconference or in
> person
> > if they are in Juneau. The call-in number is
> 888-295-4546.
> >
> > Tom Obermeyer
> > Office of Senator Bettye Davis, Chair Senate HSS Committee
> > 465-3762
> >
> Thomas_Obermeyer@legis.state.ak.us<mailto:Thomas_Obermeyer@legis.state
> .ak.us>
> >
> > State Capitol, Suite 30
> > Juneau, AK 99801-1182
> > 465-3822
> > 465-3756 fax
> >
> >
> > _____
> > From: Jeanne Anderson
> > [mailto:JeanneAnderson@katmaioncology.com]
> > Sent: Monday, February 09, 2009 8:38 AM
> > To: Emily.Nenon@cancer.org; Tammy@hotsheet.com; Latha Subramanian;
> > mstewartonc@yahoo.com; Doug Debenham; muffz326@aol.com; Wooley,
> > Beverly K (HSS)
> > Cc: Thomas Obermeyer
> > Subject: FW: CS for SB 10 and memo
> >
> > To all involved-
> > Here is the latest draft of the bill. It looks fine
> to me.
> >

> > Note the date, time and instructions for the first
> hearing,
> > given below.
> >
> > Please forward to anyone else who may want to
> participate.
> >
> > Mr. Obermeyer-
> > Will the written testimony that was submitted last
> year be
> > included in this year's hearings? Or, should we re-submit
> > testimony, even if identical to last
> year's?
> > -Jeanne
> >
> > Jeanne E. Anderson, M.D.
> > Katmai Oncology Group, LLC
> > 3851 Piper Street, Suite U340
> > Anchorage, AK 99508-4627
> > tel (907) 562-0321
> > fax (907) 562-2683
> >
> jea@katmaioncology.com<mailto:jea@katmaioncology.com>
> > _____
> > From: Thomas Obermeyer
> > [mailto:Thomas_Obermeyer@legis.state.ak.us]
> > Sent: Wednesday, February 04, 2009 8:08 PM
> > To: Jeanne Anderson
> > Cc: Lynda Zaugg; Sen. Bettye Davis
> > Subject: RE: CS for SB 10 and memo
> >
> > February 4, 2009
> >
> > Dr. Anderson,
> >
> > Attached is the latest draft of the clinical trials
> bill, a
> > Committee Substitute for Senate Bill 10,
> 26-LS0073\E,
> > and an accompanying memo from our Legislative Counsel.
> The
> > drafter incorporated your requested changes with substantive terms
> > in the body of the bill itself
> instead of
> > including them in a definition section in accordance
> with
> > the requirements of the Drafting Manual.
> >
> > We will be unable to make further changes before the
> Senate
> > HSS hearing scheduled February 18 at 1:30 pm, but your suggestions
> > and comments are welcome any time in
> writing.
> > The teleconference number on the date of the hearing
> is
> > 888-295-4546.
> >
> > Your help in organizing support at the hearing is most important.
> > Please notify your peers, local and national
> organizations,
> > and patients of the hearing and have them call or
> write in
> > to support the bill or appear in person to testify.
> If you
> > testify in person or telephonically and provide
> written
> > copies for the record, please provide the written

> copies in
> > advance on letterhead, if available, to me and Lynda
> Zaugg,
> > Senate HSS Committee Aide to Senator Davis. Our fax
> machine
> > produces a poor quality copy, so I suggest you mail or e-mail
> > written documents, if possible.
> >
> > Tom Obermeyer
> > Office of Senator Bettye Davis
> > 907-465-3822 office
> > 907-465-3756 fax
> > 465-3762 direct line
> >
> Thomas_Obermeyer@legis.state.ak.us<mailto:Thomas_Obermeyer@legis.state
> .ak.us>
> >
> > Lynda Zaugg
> > 465-4906 direct line
> >
> Lynda_Zaugg@legis.state.ak.us<mailto:Lynda_Zaugg@legis.state.ak.us>

Lynda Zaugg

From: Thomas Obermeyer
Sent: Wednesday, February 18, 2009 9:46 AM
To: Lynda Zaugg
Cc: Sen. Bettye Davis; Don Burrell
Subject: drafter Bailey will be available in person on on-line per Sen.Davis's Request

Lynda,

I have confirmed that Dennis Bailey, drafter and legal counsel, will be on line to handle drafting and legal questions at hearing today regarding SB 10.

Please also REMIND SENATOR DAVIS THAT WE WANT TO ADOPT THE COMMITTEE SUBSTITUTE for SB 10, 26-LS0073\E, the "E" version, not the "A" version which was initially read across and available to the public.

Tom

Lynda Zaugg

From: Apache [apache@wwwjnu02.legis.state.ak.us]
Sent: Monday, February 16, 2009 1:04 PM
To: LIO Juneau; Peg Warren; Lynda Zaugg
Subject: Teleconference Order Form

Meeting: new

Sponsor and/or Committee Name: Sen H&SS

Date of Teleconference: 2/18/09

Start Time: 1:30

End Time: 3:00

Chairing Site: Capital Building

Juneau Room: Butrovich Rom #205

Testimony: yes

Testimony Time Limit: no time limit

Executive Session: no

Contact Person: Lynda Zaugg

Telephone Number: 907-465-4906

Email Address: lynda_zaugg@legis.state.ak.us

LIO Sites:

anchorage
fairbanks

Other sites may add: yes

Offnet Name(s):

Subject of meeting and/or Bills on Agenda:

SB 10 \"Medicaid/Ins For Cancer Clinical Trials\"

CANCER CLINICAL TRIALS FAST FACTS
DENALI ONCOLOGY GROUP, October 28, 2007

Frequently Asked Questions (FAQ)

1. **What is a clinical trial?** A clinical trial is a scientific way of studying a new treatment for a specific disease that may be better and/or safer than existing treatments.
2. **Why are clinical trials necessary?** Without these studies, we can not determine whether a new treatment is safe, effective, and better than existing options.
3. **What types of cancer clinical trials exist?** Trials may be for prevention, early detection, diagnosis, or treatment of cancer. There are also trials for reducing symptoms and improving quality-of-life.
4. **Why would a cancer patient consider participating in a clinical trial?**
   a. Treatment given on the clinical trial offers the potential for better outcome (e.g. longer life or higher cure rate) than the standard treatment.
   b. Results of the trial will help improve treatment for future patients.
5. **Is it risky to be on a clinical trial?** There are risks with any type of cancer treatment. Side effects that occur in patients on a clinical trial are monitored very closely and described in paperwork that patients receive (i.e., consent form).
6. **Are clinical trials available in Alaska?** Yes, more than 50 cancer clinical trials are open in Alaska for patients to receive treatment in-state.
7. **Do doctors or patients gain financially from participating in clinical trials?** We only support the conduct of studies where there is no financial gain for patients or physicians. Support is provided by the sponsor of the study to help pay for costs associated with the trial, such as research personnel and regulatory requirements.

Myths

1. **"I may receive placebo."** Placebo is rarely used in cancer clinical trials because there is usually an acceptable standard treatment. However, if the standard is to offer no treatment, then the new treatment under investigation will be compared to no treatment (i.e., placebo). Patients will always be informed of the potential to receive placebo.
2. **"I will be a guinea pig."** Patients on clinical trials are treated with respect, receive informed consent, and have all questions answered. They have the right to withdraw from the study at any time without compromising their future care.
3. **"I'm not sick enough for a clinical trial."** Many trials are studying ways to prevent cancer in healthy people at risk for cancer. Other trials are studying ways to improve upon the most common types of treatment used when patients are first diagnosed with cancer.

POSITION PAPER ON HEALTH PLAN COVERAGE FOR PATIENT CARE COSTS IN CANCER CLINICAL TRIALS

Sponsored by the Denali Oncology Group, the Alaska State Affiliate of the American Society of Clinical Oncology

February 24, 2008

BACKGROUND:

1. Clinical trials for cancer patients provide state-of-the-art treatment for patients with life-threatening diseases. Cancer patients and their physicians typically look to clinical trials as an option when the investigational treatment offers as much or more benefit than standard treatment.
2. Currently, in Alaska, health plans can exclude coverage for routine patient care costs while a patient with cancer is enrolled on a clinical trial.
3. Since 2000, Medicare has provided coverage for beneficiaries for routine costs associated with cancer clinical trial enrollment.
4. Twenty-three states in the United States have passed legislation or instituted special agreements requiring health plans to pay the cost of routine medical care a patient receives while participating in a clinical trial.
5. Health plans mistakenly think that money is saved by excluding care while patients participate in clinical trials. However, if not enrolled on a clinical trial, these patients will continue to receive conventional therapy. Studies have shown that there are not differences in cost of care for patients enrolled on clinical trials compared with patients on conventional therapy.
6. Results of clinical trials lead to more rational use of cancer treatment and more successful outcomes, resulting in short-term and long-term cost savings.

PROPOSED LEGISLATION:

We propose that the Senate and House of the State of Alaska pass a bill requiring that all health care plans, including Medicaid, cover routine patient care costs for patients enrolled in all phases of clinical trials, including prevention, detection, treatment and palliation (supportive care) of cancer.

BENEFITS:

1. Passage of this bill will remove an important barrier to the participation of patients in cancer clinical trials. It will result in physicians more often recommending patient participation and in patients having greater desire to enroll in clinical trials.
2. Greater participation by Alaskans in cancer clinical trials will result in improved care of our patients in the short- and long-term, improved doctor-patient relationship, increased patient satisfaction with treatment, and increased retention of patients in Alaska for their cancer care.
3. Alaska will be in the forefront in making meaningful progress in providing care for cancer and other life threatening conditions.

REFERENCES:

1. States That Require Health Plans to Cover Patient Care Costs in Clinical Trials http://www.cancer.gov/clinicaltrials/learning/laws-about-clinical-trial-costs
2. Clinical Trials and Insurance Coverage - A Resource Guide http://www.cancer.gov/clinicaltrials/learning/insurance-coverage/page1
3. Coverage of Routine Patient Care Costs in Clinical Trials Position Statement http://www.asco.org/asco/downloads/patient_care_costs_3.05.pdf
4. American Society of Clinical Oncology Response to CMS Town Hall Meeting "The Effect of Coverage and Payment on Clinical Research Study Participation and Retention" September 10, 2007
5. Harris Interactive. *Health Care News.* Vol 1, Issue 3. January 22,200 1.
6. Lara PN, et al: Prospective evaluation of cancer clinical trial accrual patterns: identifying potential barriers to enrollment. *Journal of Clinical Oncology.* 19: 1728-1733,200 1.
7. Lara PN, et al: Evaluation of factors affecting awareness of and willingness to participate in cancer clinical trials. *Journal of Clinical Oncology.* 23:9282-9289,2005.
8. Goldman DP, et al: Incremental treatment costs in National Cancer Institute-sponsored clinical trials. *JAMA.* 289:2970-2977, 2003.
9. Bennett CL, et al: Evaluating the financial impact of clinical trials in oncology: results from a pilot study from the Association of American Cancer Institutes/Northwestern University Clinical Trials Costs and Charges Project. *Journal of Clinical Oncology.* 18:2805-28 10, 2000.
10. Fireman BH: Cost of care for patients in cancer clinical trials. *Journal of the National Cancer Institute.* 92: 136-142, 2000.
11. Wagner JL, et al: Incremental costs of enrolling cancer patients in clinical trials: a population-based study. *Journal of the National Cancer Institute.* 9 1947-853, 1999.
12. Quirk J, et al: Clinical trial costs are similar to and may be less than standard care and inpatient (InPT) charges at an academic medical center (AMC) are similar to major, minor, and non-teaching hospitals. *Proc American Society Clinical Oncology.* 19:433a, (abstr. 1696), 2000.
13. Bennett C L, et al: Evaluating the financial impact of clinical trials in oncology: Results from a pilot study from the Association of American Cancer Institutes/Northwestern University Clinical Trials Costs and Charges Project. *Journal of Clinical Oncology.* 18:2805-10, 2000 .

Coverage of Routine Patient Care Costs in Clinical Trials
Position Statement
Approved by the ASCO Board of Directors, March 2005

For people with serious or life-threatening illness, like cancer, completely satisfactory or curative treatment often is not available. Those patients are nevertheless able to receive state-of-the-art therapy through high-quality clinical trials, offering not only an important treatment option but an opportunity to advance medical knowledge.

Cancer patients face a number of obstacles to clinical trials enrollment. One of the barriers is the potential denial of third party payment for the routine patient care costs for those enrolled in clinical trials. Historically, payers have denied coverage for care provided in a clinical trial, arguing that such care is "experimental" and therefore not a covered benefit.

Current Clinical Trials Coverage

The American Society of Clinical Oncology (ASCO) and its partners in the patient advocacy community have sought, over the course of more than a decade, to reform clinical trials payment policy in public and private health plans. These efforts have resulted in reforms in Medicare payment policy and in enactment of legislation to ensure clinical trials coverage in more than 20 states.

In 2000, in response to Congressional pressure and cancer community advocacy, the Clinton Administration issued an Executive Memorandum setting a policy for coverage of the routine patient care costs for Medicare beneficiaries enrolled in clinical trials for all diseases.

In addition to action by Medicare, a number of states have enacted legislation that would ensure coverage of routine patient care costs in clinical trials (coverage ranges from cancer clinical trials only to trials for all diseases) by those health plans that are regulated by the state. Some of those states have adopted, either in statute or in implementing regulations, the coverage standards of the Medicare program. In several states without clinical trials coverage mandates, third party payers have entered into voluntary agreements to cover routine costs in clinical trials. States continue to engage in efforts to improve coverage in state plans.

ASCO Position

These federal, state, and private sector initiatives reflect widespread recognition of clinical trials coverage as a critical element of quality cancer care. However, not all of the initiatives meet the standards for coverage endorsed by ASCO, and a significant number of cancer patients remain beyond the reach of these reimbursement reforms. ASCO recommends that every cancer patient should have access to clinical trials under the criteria defined below.

Standards for Clinical Trials Coverage

The following ASCO standards should remain the standard for Medicare coverage and should serve as the model for state legislative initiatives, including provisions governing coverage under state-funded programs like Medicaid, as well as mandates for private insurance and managed care plans.

The cost of medical care provided when a patient with serious or life-threatening disease is entered on a Phase I, II, III, or IV (post-marketing) clinical trial – including hospital, physician, and other health care items and services as well as the cost of approved drugs for labeled or unlabeled uses which might be part of the regimen[1] – should not be denied coverage when all of the following are demonstrated:

- Treatment is provided with a therapeutic intent[2];
- Treatment is being provided pursuant to a clinical trial approved by one of the National Institutes of Health (NIH), an NIH cooperative group or an NIH center; the Food and Drug Administration (FDA) in the form of an investigational new drug (IND) or new device (IDE) exemption; the Department of Defense; the Department of Veterans Affairs; or a qualified non-governmental research entity as identified in National Cancer Institute guidelines or center support grants;
- The trial is conducted according to a written protocol, which includes the following elements: trial design and scientific justification, criteria for inclusion and exclusion, outcome measures, statistical analysis plan, conflicts and other ethical controls, and publication policy;
- The protocol has undergone scientific review by a group of independent and qualified experts;
- The clinical trial has been reviewed and approved by a qualified institutional review board (IRB);
- The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training;
- There is no non-investigational therapy that is clearly superior to the protocol treatment; and
- The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as non-investigational therapy.[3]

Originally adopted February 1993
As amended June 1994 and March 2005

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[1] Items and services required by the design of the trial should be covered, except those items or services normally paid for by other funding sources such as the cost of certain investigational drugs, the costs of any non-health services that might be required for a person to receive the treatment, and the costs of managing the research.

[2] Treatment with therapeutic intent may be aimed at improving patient outcome relative to either survival or quality of life.

[3] While these standards refer to clinical trials involving "treatment" or "therapy", the same principles would apply equally to trials of interventions to prevent, rather than treat, diseases.

Bob Boerner

From: "Dick Cauchi" <dick.cauchi@ncsl.org>
To: "Bob Boerner" <bob.boerner@ncsl.org>
Sent: Thursday, April 03, 2008 2:58 PM
Subject: Clinical Trials What are States Doing 2008

Although it is not possible to provide this live by phone today, the NCSL report provided below is our best information on this topic. Next week Karmen Hanson, our author and expert, may be able to provide additional information or insights.
The online version is located at: http://www.ncsl.org/programs/health/clinicaltrials.htm

NCSL Health Program

Clinical Trials: What are States Doing?
April 2008 Update

What is a Clinical Trial?

A clinical trial is a research study on human patients to test the safety and effectiveness of new treatments. These trials offer patients access to new and potentially life saving drugs and cures.

The dramatic progress made in treating childhood cancers in recent years, is attributable, in part, to clinical trials, because 60 percent of all children with cancer are enrolled in some kind of trial. A ten percent drop in breast cancer mortality for women under the age of 50 is said to be the result of clinical trials research conducted in the 1970's.

Who Enrolls in Clinical Trials?

Only two to three percent of eligible adult patients enroll in clinical trials. For cancer patients, clinical trials are often the last resort after exhausting all other approved means of treatment.

Insurance Coverage for Clinical Trials

Typically, when a patient enrolls in a clinical trial, the cost of tests, procedures, drugs and any research activity directly associated with the investigation, are covered by the group sponsoring the trial, such as a pharmaceutical company or the National Cancer Institute. However, because some health plans define clinical trials as "experimental" or "investigational," health insurance coverage may or may not include some or all of the costs of "routine patient care," such as the doctor visits, hospital stays, tests and x-rays, that a patient would normally receive whether or not they were enrolled in a trial.

Nevertheless, a growing number of states have passed legislation or instituted special agreements requiring health plans to pay the cost of the routine medical care a patient receives as a participant in a clinical trial.

Advantages:

For cancer patients, properly designed and conducted clinical trials represent an important therapeutic option, as well as a critical means of advancing medical knowledge. Lack of insurance coverage is a barrier to patients who might otherwise participate. Sixty percent of patients in one survey cited fear of insurance denial as a major reason for not participating in clinical trials. And finally, a recent study found only a slight increase in treatment costs for adult clinical trial patients compared to nonparticipants--$35,418 versus $33,248.

Disadvantages:

Even though the same recent study found only a slight increase in treatment costs, the 6.5 percent increase between participants and nonparticipants in clinical trials translated into an additional $16 million in 1999 spent on treatment costs for the 19,000 adult patients enrolled in National Cancer Institute-sponsored clinical trials. These additional insurance costs, like other mandated benefits and services, may result in higher insurance premium rates, which are often cost-shifted onto workers in the form of higher deductibles and copayments.

Definitions of Phases:

A clinical trial study is conducted in four phases.

Phase I: Research is conducted on a small group of volunteers (20 to 80 people) for the first time to evaluate its safety, determine a safe dosage range and identify side effects.

Phase II: The experimental drug or treatment is given to or a procedure is performed on a larger group of people (100 to 300 individuals) to further measure its effectiveness and safety.

Phase III: Further research is conducted to confirm the effectiveness of the drug, treatment or procedure, monitor the side effects, compare commonly used treatments and collect information on safe use. Phase III trials are typically conducted on 1,000 to 3,000 individuals.

Phase IV: After the drug, treatment or medical procedure is marketed, investigators continue testing to determine the effects on various populations and whether there are side effects associated with long-term use.

Summary of State Laws

Table One provides a summary of the **20 states** that have enacted laws regarding mandated coverage of clinical trials.

Table One
Clinical Trials Laws
April 2006

State Year of Enactment Bill Number and/or Citation	Who is Required to Pay?	What Services or Benefits are Covered?	Other Key Criteria:
Arizona (2000) Senate Bill 1213 20-2328	Hospital or medical service corporations, benefit insurers, health care service organizations, disability insurers, group disability insurers and accountable health plans	Patient costs associated with participation in Phase I through IV cancer clinical trials.	Trail must be reviewed by an Institutions Review Board in AZ. Health professional must agree to accept reimbursement from insurer as payment in full. Only covers trial when no clearly superior nonivestigational treatment exists. Trail must be in AZ.
California (2000) Senate Bill 37	All California insurers, including Medicaid and other medical assistance programs	Routine patient care costs associated with Phase I through IV cancer clinical trials.	May restrict coverage to services in CA.
Connecticut (2001) Senate Bill 325	Private insurers, individual and group health plans	Routine patient care costs associated with cancer clinical trials.	Prevention trials are covered only in Phase III and only if involve therapeutic intervention.

Public Act 01-171			Insurer may require documentation of the likelihood of therapeutic benefit, informed consent, protocol information and/or summary of costs.
Delaware (2001)Senate Bill 181	Every group of blanket policy, including policies or contracts issued by health service corporations	Routine patient care costs for covered persons engaging in clinical trials for the treatment of life threatening diseases under specified conditions.	Trial must have therapeutic intent and enroll individuals diagnosed with the disease. Trial must not be designed exclusively to test toxicity or disease pathophysiology.
Georgia* (1998) 33-24-59.1	Insurers and the state health plan	Routine patient costs incurred in Phase II and III of prescription drug clinical trial programs for the treatment of children's cancer.	For the treatment of cancer that generally first manifests itself in children under the age of 19.
Illinois (1999) House Bill 1622 (amended 2004) Senate Bill 2339 Public Act No. 93-1000 20 ILCS 1405/56.3**	HMOs and individual/group insurance policies to offer coverage to the applicant or policyholder (2004 amendment: Plans may not be canceled or non renewed based on an individual's participation in a qualified clinical trial)	Routine patient care if the individual participates in an approved Phase II through IV cancer research trial.	Coverage benefit can have annual limit of $10,000. Trial must be conducted at multiple sites in state. Primary care MD must be involved in coordination of care. Researchers must submit results of trial for publication in nationally recognized scientific literature.
Louisiana (1999) RS 22:230.4	HMOs, PPOs, State Employee Benefits Program and other specified insurers	Patient costs incurred in Phase II through IV cancer clinical trials.	Only covers costs when no clearly superior, noninvestigational approach exists. Available data must support reasonable expectation that the treatment will be as effective as the noninvestigational alternative. Patient must sign an Institutional Review Board-approved consent form.
Maine (2000) 24-A-4310	Managed care organizations and private insurers	Routine patient care costs associated with clinical trial.	Participation must offer meaningful potential for significant clinical benefit. Referring physician must conclude that trial participation is appropriate.
Maryland*** (1998) Chap 146-15-827	Private insurers and other specified managed care organizations.	Patient costs for Phase I through IV cancer treatment, supportive care, early detection, and prevention trials. Phase II through IV for other life-threatening conditions, with Phase I considered on a case-by-case basis.	There is no clearly superior, nonivestigational alternative. The data provide a reasonable expectation that the treatment will be as least as effective as the alternative.
Massachusetts (2002)	All health plans issued or renewed after Jan. 1,	Patient care services associated with all phases of qualified cancer clinical	Insurers must provide payment for services that are consistent with the

Chap 176A Sec 8X	2003	trials.	usual and customary standard of care provided under the trial's protocol and that would be covered if the patient did not participate in the trial.
Missouri (2002) 376.429 (2006)- Phase II SB 567 & 792	All health benefit plans operating in the state	Routine patient care costs as the result of Phase II, III or IV clinical trials for the prevention, early detection, or treatment of cancer.	There must be identical or superior nonivestigational treatment alternatives available before providing clinical trial treatment, and there must be a reasonable expectation that the trial will be superior to the alternatives. Requires coverage of FDA-approved drugs and devices even if they have not be approved for use in treatment of patient's particular condition.
New Hampshire (2000) 415:18	Private insurers and specified managed care plans	Medically necessary routine patient care costs incurred as a result of a treatment for Phase I through IV cancer clinical trial or trial for a life-threatening disease.	Coverage for Phases I or II decided on case-by-case basis. Coverage is required for services needed to administer drug or device under evaluation. Coverage is required for routine patient care associated with drugs or devices which are not subject of trial, as long as they have been approved by FDA.
Nevada (2003) (amended 2005) SB 29 NRS 695G.173	All health insurance insurers, medical service corporations, HMOs and managed care organizations	Patient costs associated with Phase I through IV cancer or chronic fatigue clinical trial	Healthcare facility and personnel must have experience and training to provide the treatment in a capable manner. There must be no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial. There must be a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment. Amendment revises type of medical treatment covered.
New Mexico (2002) (amended 2004 to delay repeal until July 1, 2009) 59A-22-43	A health insurer; a nonprofit health service provider; a HMO; a managed care organization; a provider service organization; or the state's medical	Routine patient care costs incurred as a result of the patient's participation in a phase II, III or IV cancer clinical trial.	Must be undertaken for the purposes of the prevention of reoccurrence of cancer, early detection or treatment of cancer for which no equally or more effective standard cancer treatment exists. Must not be designed exclusively to

	assistance program.		test toxicity or disease pathophysiology and it has a therapeutic intent. Must be provided as part of a scientific study of a new therapy or intervention and is for the prevention of reoccurrence, early detection, treatment or palliation of cancer in humans and in which includes specific provisions of scientific study.
New Mexico (2001) 59A-22-43	Private insurers, specified managed care plans, and Medicaid and other state medical assistance programs	Routine patient care costs incurred as result of Phase I through IV cancer clinical trial.	Effective through July 1, 2004. Trial must have therapeutic intent. Reasonable expectation that investigational treatment will be at least as effective as standard treatment.
North Carolina (2001) ? 58-3-255	All health insurance plans and teachers' and state employees' comprehensive major medical plan.	Medically necessary costs of health care services associated with Phase II through IV of covered clinical trials.	Patients suffering from a life-threatening disease or chronic condition may designate a specialist who is capable of coordinating their health care needs.
Rhode Island (1994, 1997) 94-S 2623B 97-S 1A am	Private insurers and specified managed care plans	Coverage for new cancer therapies if treatment is provided under Phase II through IV cancer clinical trial.	
Tennessee (2005) HB 837	All health benefit plans	Routine patient care costs related to Phase I through IV cancer clinical trial.	Treatment must involve drug that is exempt under federal regulations from a new drug application, or approved by: NIH, FDA in form of new drug application, DOD, or VA.
Vermont (2001) (amended 2005 to remove March 1, 2005 sunset provision) Chap 107 ? 4088b HB 6	All health insurance policies and health benefit plans, including Medicaid	Routine patient care costs incurred during the participation in a cancer clinical trial.	Providers and insurers required to participate in a cost analysis to determine impact of the program on health insurance premiums. Amended law allows for participation in trial outside of Vermont if patient notifies health benefit plan prior to participation, and no clinical trial is available at Vermont or New Hampshire cancer care providers.
Virginia (1999) ? 38.2-3418.8	Private insurers, specified managed care plans, and public employee health plans	Patient costs incurred during the participation in Phase II through IV cancer clinical trials. Coverage provided on a case-by-case basis for Phase I.	There must be no clearly superior, nonivestigational alternative. Data must provide a reasonable expectation that the treatment will be at least as effective as the alternative.
West Virginia (2003) ?9-2-12	Individual and group insurers, health service corporations, health care corporations,	Patient costs associated with the participation in Phase II through IV clinical trial for treatment of life-threatening condition or the	Facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients

	HMOs, public employees insurance agency, Medicaid and the children's health insurance program	prevention, early detection and treatment of cancer.	treated to maintain expertise. There must be no clearly superior, noninvestigational treatment alternative. Data provide a reasonable expectation that the treatment will be more effective than the noninvestigational treatment alternative.
Wisconsin AB 617 (2006) Act 194	Any health insurance plan offered by the state, any self-insured plans	Routine patient care costs incurred during the participation in all phases of a cancer clinical trial. No policy, plan, or contract may exclude coverage for the cost of any routine patient care that is administered to an insured in a cancer clinical trial satisfying the criteria under par. (c) and that would be covered under the policy, plan, or contract if the insured were not enrolled in a cancer clinical trial.	Trial must meet all criteria: 1. The purpose is to test whether the intervention potentially improves the trial participant's health outcomes. 2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes. 3. The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology. 4. The trial does one of the following: a. Tests how to administer a health care service, item, or drug for the treatment of cancer. b. Tests responses to a health care service, item, or drug for the treatment of cancer. c. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer. d. Studies new uses of health care services, items, or drugs for the treatment of cancer. 5. The trial is approved by one of the following: a. A National Institute of Health, or one of its cooperative groups or centers, under the federal department of health and human services; federal food and drug administration; federal department of defense; federal department of veterans affairs.
Wyoming SF 024 (2008 budget	All health insurance policies, contracts, and certificates providing	Routine patient care for a person enrolled in a Phases II- IV clinical trial. Includes a medical service or	Trial must also be approved by NIH, FDA, Dept. of Defense, or Dept. of Veterans Affairs. The medical

session)	coverage to any resident of this state.	treatment that is a benefit under a health plan that would be covered if the patient were receiving standard cancer treatment; or a drug provided to a patient during a cancer clinical trial, other than the drug that is the subject of the clinical trial, if the drug has been approved by the federal food and drug administration for use in treating the patient's particular condition.	treatment must be provided by a licensed health care provider operating within the scope of his/her license in a facility whose personnel has the experience and training necessary to provide the treatment in a competent manner. The clinical trial participant must have signed an informed consent document prior to starting the trial.

*In 2002, all major insurers in Georgia agreed to cover routine patient care costs associated with Phase I, II, III, or IV cancer clinical trials. Trials include those that involve a drug that is currently exempt under federal regulations from a new drug application or those that are approved by specified federal agencies or a local institutional review board. The agreement also provides for the coverage of cancer screens and examinations in accordance with the most recently published guidelines and recommendations established by any nationally recognized health care organization (see below).

**Illinois Executive Branch Administrative Code (20 ILCS 1405/1405-20) required the Department of Insurance to conduct an analysis and study of costs and benefits derived from the implementation of the coverage requirements for investigational cancer treatments. The study covered the years 2000 through 2002 and included an analysis of the effect of the coverage requirements on the cost of insurance and health care, the results of the treatments to patients, the mortality rate among cancer patients, any improvements in care of patients, and any improvements in the quality of life of patients.

***A 2003 Maryland law (S 128) repealed a reporting requirement for insurers, nonprofit health service plans, and HMOs to submit a report that described the trials covered during the previous year.

Sources: National Cancer Institute, Health Policy Tracking Service.

Summary of Other Actions

Table Two summarizes the special agreements some states have arranged with insurance companies to voluntarily provide coverage for clinical trials.

Table Two
Special Agreements

State (Year Agreement Became Effective) Web Address of Agreement	Who is Required to Pay?	What Services or Benefits are Covered?	Other Key Criteria:
Georgia (2002) Georgia Cancer Coalition	All major insurers	Routine patient care costs associated with Phase I through IV cancer clinical trials.	Trials include those that involve a drug that is currently exempt under federal regulations from a new drug application or those that are approved by specified federal agencies or a local institutional review board. Provides for the coverage of cancer screens and examinations in accordance with the most recently published guidelines and recommendations established

			by any nationally recognized health care organization.
Michigan (2002) Michigan Consensus Agreement	Private insurance plans, HMOs and Medicaid	Routine patient care costs associated with Phase II and III cancer clinical trials.	Coverage for Phase I trials is under consideration.
New Jersey (1999) New Jersey Consensus Agreement	All insurers	Routine patient care costs associated with all phases of cancer clinical trials.	
Ohio (1999) Ohio Med Plan	State employees on Ohio Med Plan	Routine patient care costs associated with Phase II and III cancer treatment clinical trials.	Preauthorization is required for clinical trial participation.

Federal Activity

In 2000, Medicare began covering beneficiaries patient care costs in clinical trials. While many state Medicaid programs have no legal requirements to cover clinical trials costs, many do cover all or some of the costs.

To legislators and legislative staff: For more information please contact Karmen Hanson at health-info@ncsl.org

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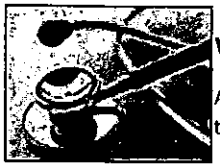
Clinical Trials: What are States Doing?
February 2009 Update



What is a Clinical Trial?

A clinical trial is a research study on human patients to test the safety and effectiveness of new treatments. These trials offer patients access to new and potentially life saving drugs and cures.

The dramatic progress made in treating childhood cancers in recent years, is attributable, in part, to clinical trials, because 60 percent of all children with cancer are enrolled in some kind of trial. A ten percent drop in breast cancer mortality for women under the age of 50 is said to be the result of clinical trials research conducted in the 1970's.

Who Enrolls in Clinical Trials?

Only two to three percent of eligible adult patients enroll in clinical trials. For cancer patients, clinical trials are often the last resort after exhausting all other approved means of treatment.
Only a small percentage (approximately 20%) of cancer patients are eligible to participate in a clinical trial and very few (approximately 3% of cancer patients and less than 0.5% of Medicare patients) currently enroll. Even if enrollment was increased to the full 20 percent, it is unlikely that these numbers will significantly impact overall costs to health plans;[1]

Insurance Coverage for Clinical Trials

Typically, when a patient enrolls in a clinical trial, the cost of tests, procedures, drugs and any research activity directly associated with the investigation, are covered by the group sponsoring the trial, such as a pharmaceutical company or the National Cancer Institute. However, because some health plans define clinical trials as "experimental" or "investigational," health insurance coverage may or may not include some or all of the costs of "routine patient care," such as the doctor visits, hospital stays, tests and x-rays, that a patient would normally receive whether or not they were enrolled in a trial.

A growing number of states have passed legislation or instituted special agreements requiring health plans to pay the cost of the routine medical care a patient receives as a participant in a clinical trial.

Advantages:

For cancer patients, properly designed and conducted clinical trials represent an important therapeutic option, as well as a critical means of advancing medical knowledge. Lack of insurance coverage is a barrier to patients who might otherwise participate. Sixty percent of patients in one survey cited fear of insurance denial as a major reason for not participating in clinical trials. And finally, a recent study found only a slight increase in treatment costs for adult clinical trial patients compared to nonparticipants--$35,418 versus $33,248.[2]

Some large HMOs have computed costs associated with patients in clinical trials. Kaiser Permanente discovered the cost of medical care for enrollees in clinical trials that haven't had bone marrow transplant were no higher than for patients who were not enrolled in a trial. The Kaiser report further states, "Kaiser has been participating in cancer clinical trials without substantial increases in the direct costs of medical care."[3]

Researchers at the Mayo Clinic found that patient care costs for those enrolled in clinical trials is only slightly more than for patients who received standard therapy protocols.[4]

The Institutes of Medicine has also found the following:
-The reimbursement costs are limited to the cost of "standard care" which would be covered if the patient were not enrolled in the trial;[1]

-Only a small percentage (approximately 20%) of cancer patients are eligible to participate in a clinical trial and very few (approximately 3% of cancer patients and less than 0.5% of Medicare patients) currently enroll. Even if enrollment was increased to the full 20 percent, it is unlikely that these numbers will significantly impact overall costs to health plans;[1]

-Through clinical trials, we will be able to identify ineffective treatments, which could save health plans money and will benefit the nation as a whole.[1]

Disadvantages:

Even though the same recent study found only a slight increase in treatment costs, the 6.5 percent increase between participants and

nonparticipants in clinical trials translated into an additional $16 million in 1999 spent on treatment costs for the 19,000 adult patients enrolled in National Cancer Institute-sponsored clinical trials.[2] These additional insurance costs, like other mandated benefits and services, may result in higher insurance premium rates, which are often cost-shifted onto workers in the form of higher deductibles and copayments.

For states without insurance mandates, it is possible that some physicians may enroll patients in clinical trials but not inform the patients' insurance companies, bypassing the reimbursement issue for the patient and potentially the physician.[5]

It may also be possible to encourage participation in clinical trials by working within networks of health care providers and industry, research facilities, patient groups, as well as major media outlets, without enacting a state wide insurance mandate.

Sources:

1. Aaron HJ, Gelband H, editors. Extending Medicare reimbursement in clinical trials. Washington, DC: National Academy Press; 2000. p 13.

2. Goldman DP, Berry SH, McCabe M, et al. Incremental Treatment Costs in National Cancer Institute-Sponsored Clinical Trials. JAMA. 2003;289(22):2970-2977 (doi:10.1001/jama.289.22.2970) http://jama.ama-assn.org/cgi/reprint/289/22/2970.pdf

3. Fireman BH, Fehrenbacher L, Gruskin EP, Ray GT. Cost of care for patients in cancer clinical trials. *J Natl Cancer Inst* 2000;92:136-42.

4. Wagner JL, Alberts SR, Sloan JA, *et al.* Incremental costs of enrolling cancer patients in clinical trials: a population-based study. *J Natl Cancer Inst* 1999;91:847-53.

5. McBride G, More States Mandate Coverage of Clinical Trial Costs, But Does It Make a Difference?, JNCI Journal of the National Cancer Institute 2003 95(17):1268-1269; doi:10.1093/jnci/95.17.1268

Definitions of Phases:

A clinical trial study is conducted in four phases.

Phase I: Research is conducted on a small group of volunteers (20 to 80 people) for the first time to evaluate its safety, determine a safe dosage range and identify side effects.

Phase II: The experimental drug or treatment is given to or a procedure is performed on a larger group of people (100 to 300 individuals) to further measure its effectiveness and safety.

Phase III: Further research is conducted to confirm the effectiveness of the drug, treatment or procedure, monitor the side effects, compare commonly used treatments and collect information on safe use. Phase III trials are typically conducted on 1,000 to 3,000 individuals.

Phase IV: After the drug, treatment or medical procedure is marketed, investigators continue testing to determine the effects on various populations and whether there are side effects associated with long-term use.

Summary of State Laws as of December 2008

Table One provides a summary of the **23 states and District of Columbia** that have enacted laws regarding mandated coverage of clinical trials.

Table One
Clinical Trials Laws

State Year of Enactment Bill Number and/or Citation	Who is Required to Pay?	What Services or Benefits are Covered?	Other Key Criteria:
Arizona (2000) Senate Bill 1213 20-2328	Hospital or medical service corporations, benefit insurers, health care service organizations, disability insurers, group disability insurers and accountable health plans	Patient costs associated with participation in Phase I through IV cancer clinical trials.	Trail must be reviewed by an Institutions Review Board in AZ. Health professional must agree to accept reimbursement from insurer as payment in full. Only covers trial when no clearly superior nonivestigational treatment exists. Trail must be in AZ.

California (2000) Senate Bill 37	All California insurers, including Medicaid and other medical assistance programs	Routine patient care costs associated with Phase I through IV cancer clinical trials.	May restrict coverage to services in CA.
Connecticut (2001) Senate Bill 325 Public Act 01-171	Private insurers, individual and group health plans	Routine patient care costs associated with cancer clinical trials.	Prevention trials are covered only in Phase III and only if involve therapeutic intervention. Insurer may require documentation of the likelihood of therapeutic benefit, informed consent, protocol information and/or summary of costs.
Delaware (2001) Senate Bill 181	Every group of blanket policy, including policies or contracts issued by health service corporations	Routine patient care costs for covered persons engaging in clinical trials for the treatment of life threatening diseases under specified conditions.	Trial must have therapeutic intent and enroll individuals diagnosed with the disease. Trial must not be designed exclusively to test toxicity or disease pathophysiology.
District of Columbia (2008) Bill 17-469 (D.C. Law 17-166)	All insurers in the District	Routine patient care costs for people in clinical trials undertaken for prevention, early detection, treatment, or monitoring of cancer and approved or funded in full or in part by one of the following: National Institutes of Health or one of its cooperative groups or centers, Centers for Disease Control and Prevention, Agency for Health Care Research and Quality, Centers for Medicare and Medicaid Services, U.S. Food and Drug Administration (FDA), U.S. Department of Defense, U.S. Department of Veterans Affairs, U.S. Department of Energy, nongovernmental research entity that has been awarded a National Cancer Institute support grant.	Routine patient care costs shall not include tests or measurements conducted primarily for the purpose of the clinical trial involved. services or products provided solely for data collection and analysis purposes. services or products customarily provided free of charge to trial participants by the research sponsors.
Georgia* (1998) 33-24-59.1	Insurers and the state health plan	Routine patient costs incurred in Phase II and III of prescription drug clinical trial programs for the treatment of children's cancer.	For the treatment of cancer that generally first manifests itself in children under the age of 19.
Illinois (1999) House Bill 1622 (amended 2004) Senate Bill 2339 Public Act No. 93-1000 20 ILCS 1405/56.3**	HMOs and individual/group insurance policies to offer coverage to the applicant or policyholder (2004 amendment: Plans may not be canceled or non renewed based on an individual's participation in a qualified clinical trial)	Routine patient care if the individual participates in an approved Phase II through IV cancer research trial.	Coverage benefit can have annual limit of $10,000. Trial must be conducted at multiple sites in state. Primary care MD must be involved in coordination of care. Researchers must submit results of trial for publication in nationally recognized scientific literature.
Louisiana (1999) RS 22:230.4	HMOs, PPOs, State Employee Benefits Program and other specified insurers	Patient costs incurred in Phase II through IV cancer clinical trials.	Only covers costs when no clearly superior, noninvestigational approach exists. Available data must support reasonable expectation that the treatment will be as effective as the noninvestigational alternative. Patient must sign an Institutional Review Board-approved consent form.
Maine (2000) 24-A-4310	Managed care organizations and private insurers	Routine patient care costs associated with clinical trial.	Participation must offer meaningful potential for significant clinical benefit. Referring physician must conclude that trial participation is appropriate.

Maryland*** (1998) Chap 146-15-827	Private insurers and other specified managed care organizations.	Patient costs for Phase I through IV cancer treatment, supportive care, early detection, and prevention trials. Phase II through IV for other life-threatening conditions, with Phase I considered on a case-by-case basis.	There is no clearly superior, nonivestigational alternative. The data provide a reasonable expectation that the treatment will be as least as effective as the alternative.
Massachusetts (2002) Chap 176A Sec 8X	All health plans issued or renewed after Jan. 1, 2003	Patient care services associated with all phases of qualified cancer clinical trials.	Insurers must provide payment for services that are consistent with the usual and customary standard of care provided under the trial's protocol and that would be covered if the patient did not participate in the trial.
Missouri (2002) 376.429 (2006)- Phase II SB 567 & 792	All health benefit plans operating in the state	Routine patient care costs as the result of Phase II, III or IV clinical trials for the prevention, early detection, or treatment of cancer.	There must be identical or superior nonivestigational treatment alternatives available before providing clinical trial treatment, and there must be a reasonable expectation that the trial will be superior to the alternatives. Requires coverage of FDA-approved drugs and devices even if they have not be approved for use in treatment of patient's particular condition.
New Hampshire (2000) 415:18	Private insurers and specified managed care plans	Medically necessary routine patient care costs incurred as a result of a treatment for Phase I through IV cancer clinical trial or trial for a life-threatening disease.	Coverage for Phases I or II decided on case-by-case basis. Coverage is required for services needed to administer drug or device under evaluation. Coverage is required for routine patient care associated with drugs or devices which are not subject of trial, as long as they have been approved by FDA.
Nevada (2003) (amended 2005) SB 29 NRS 695G.173	All health insurance insurers, medical service corporations, HMOs and managed care organizations	Patient costs associated with Phase I through IV cancer or chronic fatigue clinical trial	Healthcare facility and personnel must have experience and training to provide the treatment in a capable manner. There must be no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial. There must be a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment. Amendment revises type of medical treatment covered.
New Mexico (2002) (amended 2004 to delay repeal until July 1, 2009) 59A-22-43	A health insurer; a nonprofit health service provider; a HMO; a managed care organization; a provider service organization; or the state's medical assistance program.	Routine patient care costs incurred as a result of the patient's participation in a phase II, III or IV cancer clinical trial.	Must be undertaken for the purposes of the prevention of reoccurrence of cancer, early detection or treatment of cancer for which no equally or more effective standard cancer treatment exists. Must not be designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent. Must be provided as part of a scientific study of a new therapy or intervention and is for the prevention of reoccurrence, early detection, treatment or palliation of cancer in humans and in which includes specific provisions of scientific study.
New Mexico	Private insurers,	Routine patient care costs incurred as result of	Effective through July 1, 2004.

(2001) 59A-22-43	specified managed care plans, and Medicaid and other state medical assistance programs	Phase I through IV cancer clinical trial.	Trial must have therapeutic intent. Reasonable expectation that investigational treatment will be at least as effective as standard treatment.
North Carolina (2001) ? 58-3-255	All health insurance plans and teachers' and state employees' comprehensive major medical plan.	Medically necessary costs of health care services associated with Phase II through IV of covered clinical trials.	Patients suffering from a life-threatening disease or chronic condition may designate a specialist who is capable of coordinating their health care needs.
Ohio (2008) ORC Ann. 1751.01 (2008)	All health benefit plans including those for public employees.	Medically necessary costs of health care services associated with any stage of clinical trial.	Trial must be approved by NIH or another group under HHS, FDA, DOD or VA. May exclude coverage for service or product that is part of the investigative trial, item or procedure used only for data collection for the trial, item not approved by FDA, and transportation, lodging and food related to travel for participation in the trial.
Rhode Island (1994, 1997) 94-S 2623B 97-S 1A am	Private insurers and specified managed care plans	Coverage for new cancer therapies if treatment is provided under Phase II through IV cancer clinical trial.	
Tennessee (2005) HB 837	All health benefit plans	Routine patient care costs related to Phase I through IV cancer clinical trial.	Treatment must involve drug that is exempt under federal regulations from a new drug application, or approved by: NIH, FDA in form of new drug application, DOD, or VA.
Vermont (2001) (amended 2005 to remove March 1, 2005 sunset provision) Chap 107 ? 4088b HB 6	All health insurance policies and health benefit plans, including Medicaid	Routine patient care costs incurred during the participation in a cancer clinical trial.	Providers and insurers required to participate in a cost analysis to determine impact of the program on health insurance premiums. Amended law allows for participation in trial outside of Vermont if patient notifies health benefit plan prior to participation, and no clinical trial is available at Vermont or New Hampshire cancer care providers.
Virginia (1999) ? 38.2-3418.8	Private insurers, specified managed care plans, and public employee health plans	Patient costs incurred during the participation in Phase II through IV cancer clinical trials. Coverage provided on a case-by-case basis for Phase I.	There must be no clearly superior, nonivestigational alternative. Data must provide a reasonable expectation that the treatment will be at least as effective as the alternative.
West Virginia (2003) ?9-2-12	Individual and group insurers, health service corporations, health care corporations, HMOs, public employees insurance agency, Medicaid and the children's health insurance program	Patient costs associated with the participation in Phase II through IV clinical trial for treatment of life-threatening condition or the prevention, early detection and treatment of cancer.	Facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise. There must be no clearly superior, noninvestigational treatment alternative. Data provide a reasonable expectation that the treatment will be more effective than the noninvestigational treatment alternative.
Wisconsin AB 617 (2006) Act 194	Any health insurance plan offered by the state, any self-insured plans	Routine patient care costs incurred during the participation in all phases of a cancer clinical trial. No policy, plan, or contract may exclude coverage for the cost of any routine patient care that is administered to an insured in a cancer	Trial must meet all criteria: 1. The purpose is to test whether the intervention potentially improves the trial participant's health outcomes. 2. The treatment provided as part of the trial is given with the intention of

		clinical trial satisfying the criteria under par. (c) and that would be covered under the policy, plan, or contract if the insured were not enrolled in a cancer clinical trial.	improving the trial participant's health outcomes. 3. The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology. 4. The trial does one of the following: a. Tests how to administer a health care service, item, or drug for the treatment of cancer. b. Tests responses to a health care service, item, or drug for the treatment of cancer. c. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer. d. Studies new uses of health care services, items, or drugs for the treatment of cancer. 5. The trial is approved by one of the following: a. A National Institute of Health, or one of its cooperative groups or centers, under the federal department of health and human services; federal food and drug administration; federal department of defense; federal department of veterans affairs.
Wyoming SF 024 (2008 budget session)	All health insurance policies, contracts, and certificates providing coverage to any resident of this state.	Routine patient care for a person enrolled in a Phases II- IV clinical trial. Includes a medical service or treatment that is a benefit under a health plan that would be covered if the patient were receiving standard cancer treatment; or a drug provided to a patient during a cancer clinical trial, other than the drug that is the subject of the clinical trial, if the drug has been approved by the federal food and drug administration for use in treating the patient's particular condition.	Trial must also be approved by NIH, FDA, Dept. of Defense, or Dept. of Veterans Affairs. The medical treatment must be provided by a licensed health care provider operating within the scope of his/her license in a facility whose personnel has the experience and training necessary to provide the treatment in a competent manner. The clinical trial participant must have signed an informed consent document prior to starting the trial.

*In 2002, all major insurers in Georgia agreed to cover routine patient care costs associated with Phase I, II, III, or IV cancer clinical trials. Trials include those that involve a drug that is currently exempt under federal regulations from a new drug application or those that are approved by specified federal agencies or a local institutional review board. The agreement also provides for the coverage of cancer screens and examinations in accordance with the most recently published guidelines and recommendations established by any nationally recognized health care organization (see below).

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***A 2003 Maryland law (S 128) repealed a reporting requirement for insurers, nonprofit health service plans, and HMOs to submit a report that described the trials covered during the previous year.

Sources: National Cancer Institute, Health Policy Tracking Service.

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clinical trials.

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Michigan (2002) Michigan Consensus Agreement	Private insurance plans, HMOs and Medicaid	Routine patient care costs associated with Phase II and III cancer clinical trials.	Coverage for Phase I trials is under consideration.
New Jersey (1999) New Jersey Consensus Agreement	All insurers	Routine patient care costs associated with all phases of cancer clinical trials.	
Ohio (1999) Ohio Med Plan	State employees on Ohio Med Plan	Routine patient care costs associated with Phase II and III cancer treatment clinical trials.	Preauthorization is required for clinical trial participation.

Federal Activity

In 2000, Medicare began covering beneficiaries patient care costs in clinical trials. While many state Medicaid programs have no legal requirements to cover clinical trials costs, many do cover all or some of the costs.

Additional Resources

American Cancer Society, National Government Relations memo on Clinical Trials.
http://www.indianacancer.org/documents/factsheet_ACS_clinical%20trials.pdf

National Cancer Institue, States That Require Health Plans to Cover Patient Care Costs in Clinical Trials. Information and Overview: http://www.cancer.gov/clinicaltrials/ctlaws-home

To legislators and legislative staff: For more information please contact Karmen Hanson at health-info@ncsl.org

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January 27, 2009

Medicare Widens Drugs It Accepts for Cancer

By REED ABELSON and ANDREW POLLACK

Medicare, with little public debate, has expanded its coverage of drugs for cancer treatments not approved by the Food and Drug Administration.

Cancer doctors had clamored for the changes, saying that some of these treatments, known as off-label uses, were essential if patients were to receive the most up-to-date care. But for many such uses there is scant clinical evidence that the drugs are effective, despite costing as much as $10,000 a month. Because the drugs may represent a patient's last hope, though, doctors are often willing to try them.

The new Medicare rules are the latest twist in a protracted debate over federal spending on off-label drugs — drugs prescribed for uses other than those for which they have been specifically approved.

Proponents of the changes say such spending not only helps patients, but can also enhance medical understanding of which treatments work against various forms of cancer.

But opponents argue that the new approach may waste money and needlessly expose patients to the side effects of drugs that may not help them. They also raise the possibility of conflicts of interest, because the rules rely on reference guides that in some cases are linked to drug makers.

The new policy, which took effect in November, makes it much easier to get even questionable treatments paid for, critics of the changes say. Medicare is providing "carte blanche in treatment for cancers," said Steven Findlay, a health policy analyst for Consumers Union. He said overly expansive coverage encourages doctors to use patients as guinea pigs for unproved therapies.

Because Medicare officials canceled a cost analysis of the changes, it is hard to predict how much spending will increase beyond the $2.4 billion Medicare paid in 2007 for cancer drugs. But cancer doctors and other experts say the new policies, adopted in the final months of the Bush administration, seem almost certain to raise the federal drug bill, while making it more difficult for the new administration to rein in spending on unproven medical treatments.

Although President Obama has made a goal of controlling health care costs, a spokesman for the Obama administration declined to comment on the Medicare changes.

One of the many drugs whose use is likely to expand is the Eli Lilly product Gemzar, which costs $2,500 to $5,000 a month. The F.D.A. has approved it to treat only four types of cancer. But the new rules will virtually guarantee that Medicare will pay for its use for about a dozen other cancers, including advanced cervical cancer — even though the evidence supporting Gemzar for that use is "inconclusive," according to one of the reference guides Medicare will now be consulting.

In the case of Genentech's Avastin, one of the world's most expensive and widely used cancer drugs, Medicare

rejected in 2007 nearly all of the estimated $16 million in requests from doctors' offices to cover its off-label use for ovarian cancer, according to claims specialists who work with Medicare data but declined to be identified because of the controversy over the topic. Under the new rules, Avastin will be routinely covered for ovarian cancer — as will at least some other off-label uses, including for brain and kidney cancer.

It is unclear how much precedent Medicare's new rules might have on private insurers, which often follow the agency's lead on paying for drugs.

Medicare officials defend the new policies, saying they respond to cancer doctors' concerns that the agency has been too slow to recognize promising new off-label treatments. Dr. Steve Phurrough, who has overseen coverage for the agency since 2003, noted that a 1993 federal law gave Medicare specific authorization to cover some unapproved uses of cancer drugs.

"Congress wanted a lesser level of evidence," Dr. Phurrough said. The question of what is adequate evidence is "not a line in the sand," he said. "It's a broad stripe in the sand."

The American Society of Clinical Oncology, which represents cancer doctors, has hailed the new rules, saying they will ensure that the appropriate off-label uses are covered.

But some specialists say that being able to offer off-label drugs can also let physicians avoid hard discussions with patients about a grim prognosis.

"It makes it easier to give drug after drug," said Dr. Andrew Berchuck, director of gynecologic oncology at Duke University, "and keep the fantasy alive."

The new rules expand the number of reference guides — or compendiums — that Medicare relies on for determining which off-label uses of cancer drugs to cover. The writers and editors of these compendiums, who work completely outside the federal government, scan the medical literature and evaluate the evidence in making their recommendations.

In 1993, Congress had authorized three compendiums for Medicare, all published by not-for-profit organizations. But by 2007 two had stopped publishing, leaving Medicare with a single compendium. Having selected three additional guides last year, the agency plans to review its choice of guides every year.

Under the old rules, Medicare representatives were supposed to consult the compendiums but also use their own discretion in interpreting the guides' recommendations. The new rules essentially delegate the decision to guides Medicare has selected, even when there is little clinical evidence behind a particular recommendation. As long as at least one of them recommends a cancer treatment, Medicare is essentially obliged to pay for it — unless one of the other guides specifically advises against it.

And some of these new compendiums have close financial ties to the drug industry, according to the draft of a report Medicare commissioned last year after Congress raised questions about possible conflicts of interest. The draft was completed in October, with a final version to be released soon.

The draft criticizes the new rules for essentially taking most decisions about off-label cancer drugs out of Medicare's hands, even when the agency is aware of potential conflicts. The guide's recommendation, the report says, "becomes the final word."

For some experts, the bigger concern about using some cancer drugs off-label without adequate evidence is that they may not only be useless — they may cause dangerous side effects.

"We have very little faith that those indications that make it into the compendia are safe, let alone effective," said Dr. Allan M. Korn, the chief medical officer for the Blue Cross and Blue Shield Association, who added that Medicare should cover off-label drugs only if the results of their use are carefully tracked afterward. There is no such requirement in the new Medicare guidelines.

There have been three different top Medicare administrators since the off-label rule changes were set in motion a few years ago. The second of them, Leslie V. Norwalk, chose to select the compendiums through a streamlined and internal administrative process, instead of the more elaborate and public process that Medicare often uses for broad coverage decisions.

"I did not see it as a significant step in coverage," said Ms. Norwalk, who left Medicare in 2007.

Drug makers say they welcome the Medicare changes. A spokesman for the Pharmaceutical Research and Manufacturers of America, the industry's main trade group, said the new rules ensured "that cancer patients have access to the treatments they need."

Many oncologists say they needed greater flexibility in using cancer drugs because it can take months or years for a new use to be approved by the F.D.A. They cite the example of Celgene's drug thalidomide, now a mainstay treatment for multiple myeloma, which was prescribed only off-label for years before the F.D.A. formally approved it for that use.

And in the case of rare types of cancer, there may be so few potential patients that companies have little financial incentive to undergo the formal F.D.A. process for approving a drug for expanded use. Only two drugs have been approved by the F.D.A. for brain cancer, for example, and cancer doctors say they need the ability to try other drugs or other combinations of treatments.

"To arbitrarily stop after two drugs to me is ludicrous," especially for younger patients, said Dr. Virginia Stark-Vance, a solo practitioner in Dallas and Fort Worth. She said one of her brain cancer patients had been kept alive for 10 years by off-label use of irinotecan, a colon cancer drug that was the ninth drug the patient tried.

Medicare seems to have ignored some concerns raised by a group of outside researchers whom the agency had asked to survey a half-dozen compendiums, including the four that Medicare has now adopted. That report, completed in 2007, found that the six guides "cited very little of the available evidence," said Dr. Amy P. Abernethy, a Duke oncologist who led the study.

The study also found great variability among the guides, in terms of what uses were recommended — or discussed at all.

Despite her study's findings, Dr. Abernethy says she does not oppose Medicare's new rules.

"I think the addition of the new compendia this year is an important increase in the bandwidth," she said.

Critics say the agency also seems to have played down the potential financial conflicts of interests between the drug industry and the producers of the compendiums. The draft study that was completed in October notes that one of the new guides is published by the National Comprehensive Cancer Network, a group of 21 leading

cancer centers that routinely employs experts who have financial ties to the drug industry.

William T. McGivney, the network's chief executive, said each committee of reviewers had 20 to 30 members, which "diminishes the opportunity for dominance of one person's opinion," regardless of any ties to drug makers.

Then there is the American Hospital Formulary compendium, the one that Medicare was using before the November changes and will continue to consult. It has long been published by the nonprofit American Society of Health-System Pharmacists. But last year the society forged a financial relationship with a foundation linked to drug companies and some cancer doctors' private practices.

A drug company can apply to that foundation, the Foundation for Evidence-Based Medicine, and pay a $50,000 fee to have new uses of its drug reviewed by the compendium within 90 days. The foundation was started in 2007 by the Association of Community Cancer Centers, which represents oncology practices, and says it received about $200,000 in initial funding from drug makers.

Gerald K. McEvoy, the guide's editor in chief, said the application fee was meant to raise money to pay for additional researchers, to address previous criticism that the publication was too slow to vet new evidence. The foundation insulates the guide's staff from industry pressure, he said, and fewer than one-third of the reviews under the new arrangement have resulted in a positive recommendation in the compendium.

Medicare officials acknowledge that some of the potential conflicts need to be addressed. But they say they have confidence in the guides they have chosen. "We had significant conversations with all the companies," Dr. Phurrough said.

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The Costs of Routine Care Provided in a Clinical Trial are comparable to the Costs of Standard Therapy

The evidence from numerous studies has overwhelmingly shown that patient care in clinical trials costs approximately the same as care delivered in standard therapy. In some cases, because the third-party payer is not billed for the drug or treatment under investigation, the costs associated with care in a clinical trial can actually be less than the care delivered in standard therapy.

Several studies specifically focused on the costs of cancer clinical trials have recently been published in highly respected peer-reviewed publications.

- A pilot study conducted by the American Association of Cancer Institutes (AACI) showed that the total mean direct medical charges for patients enrolled in a clinical trial *were less than the charges for patients receiving standard therapy.*[1]
- A December, 2001 article similarly found that some clinical trials may actually result in *lower* patient care costs. In addition, in cases where trials resulted in modest increases in patient care costs, the authors concluded that these costs were justified by the benefits that clinical trials bring to all patients.[2]
- The Mayo Clinic has found that the cost of care for patients enrolled in clinical trials is often little more than for patients who received standard therapy.[3]
- Authors of a study conducted at Kaiser Permanente found that the cost of medical care for enrollees in clinical trials without bone marrow transplant were no higher than for patients who were not enrolled in a trial. Kaiser further states, "Kaiser has been participating in cancer clinical trials without substantial increases in the direct costs of medical care."[4]
- The most comprehensive study yet confirms that there are only slightly higher patient-care costs associated with treating patients in cancer clinical trials compared to treating similar patients outside of trials.[5]

Some esteemed hospitals and universities have also conducted cost analysis studies.

- A study at Memorial Sloan-Kettering Cancer Center in New York City showed that the overall average cost of treating clinical trial patients was 17% *less* than treating patients receiving standard care.[6]
- A study conducted at the Karmanos Cancer Center in Detroit showed that the 6-month costs for treating advanced lung cancer were an average $1400 less for patients enrolled in a clinical trial.[7]

The Institute of Medicine has also concluded that the cost impact of providing coverage for routine patient care costs is likely to be "quite small."[8] The IOM's reasoning included the following:

- The reimbursement costs are limited to the cost of "standard care" which would be covered if the patient were not enrolled in the trial;[8]
- Only a small percentage (approximately 20%) of cancer patients are eligible to participate in a clinical trial and very few (approximately 3% of cancer patients and less than 0.5% of Medicare patients) currently enroll. Even if enrollment was increased to the full 20 percent, it is unlikely that these numbers will significantly impact overall costs to health plans;[8]
- Through clinical trials, we will be able to identify ineffective treatments, which could save health plans money and will benefit the nation as a whole.[8]

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National Government Relations Department

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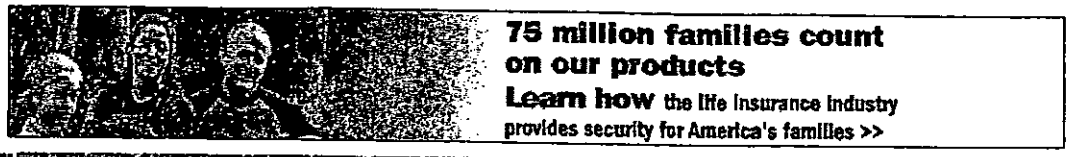

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The Access To Cancer Clinical Trials Act of 2009 (Rep. Sue Myrick)

January 30th, 2009

Clinical trials are so critical for patients and or medical research, yet many patients find that their health insurance won't cover the rest of their routine cancer treatment if they decide to enroll in clinical trials. We're not asking insurance companies to pay for clinical trials. This bill simply state that insurers must continue to pay for routine treatments — that they would be paying for regardless — if patients enroll in a clinical trial.

No patient should ever have to fear exploring all treatment options at the cost of losing coverage. We should be encouraging participation in clinical trials, not discouraging it by removing coverage for routine care. Were it not for patients who have enrolled in past trials, the medial advancements we've experienced toward finding a cure for cancer would not be possible.

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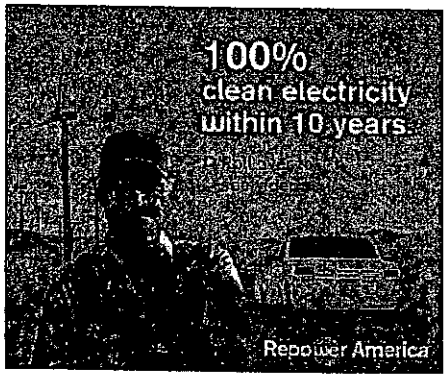
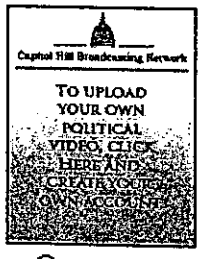
By **N.C. GOP Rep. Sue Myrick**

This entry was posted on Friday, January 30th, 2009 at 5:08 pm and is filed under Healthcare, Lawmaker News .





- QUESTIONS & ANSWERS
- This section is a

Clinical Trials: Questions and Answers

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Key Points

- Clinical trials are research studies that test how well new medical approaches work in people (see Question 1).
- Every clinical trial has a protocol, which describes what will be done in the study, how it will be conducted, and why each part of the study is necessary (see Question 4).
- Informed consent is a process by which people learn the important facts about a clinical trial to help them decide whether to participate (see Question 6).
- Payment of patient care costs in clinical trials varies by health insurance plan and by study (see Question 11).

1. What are clinical trials, and why are they important?

   Clinical trials are research studies that test how well new medical approaches work in people. Each study answers scientific questions and tries to find better ways to prevent, screen for, diagnose, or treat a disease. People who take part in cancer clinical trials have an opportunity to contribute to knowledge of, and progress against, cancer. They also receive up-to-date care from experts.

2. What are the types of clinical trials?

   There are several types of clinical trials:

   - **Prevention trials** test new approaches, such as medications, vitamins, or other supplements, that doctors believe may lower the risk of developing a certain type of cancer. Most prevention trials are conducted with healthy people who have not had cancer. Some trials are conducted with people who have had cancer and want to prevent recurrence (return of cancer), or reduce the chance of developing a new type of cancer.

   - **Screening trials** study ways to detect cancer earlier. They are often conducted to determine whether finding cancer before it causes symptoms decreases the chance of dying from the disease. These trials involve people who do not have any symptoms of cancer.

   - **Diagnostic trials** study tests or procedures that could be used to identify cancer more accurately. Diagnostic trials usually include people who have signs or symptoms of cancer.

   - **Treatment trials** are conducted with people who have cancer. They are designed to answer specific questions about, and evaluate the effectiveness of, a new treatment or a new way of using a standard treatment. These trials test many types of treatments, such as new drugs, vaccines, new approaches to surgery or radiation therapy, or new combinations of treatments.

   - **Quality-of-life (also called supportive care) trials** explore ways to improve the comfort and quality of life of cancer patients and cancer survivors. These trials may study ways to help people who are experiencing nausea, vomiting, sleep disorders, depression, or other effects from cancer or its treatment.

   - **Genetics studies** are sometimes part of another cancer clinical trial. The genetics component of the trial may focus on how genetic makeup can affect detection, diagnosis, or response to cancer treatment.

     Population- and family-based genetic research studies differ from traditional cancer clinical trials. In these studies, researchers look at tissue or blood samples, generally from families or large groups of people, to find genetic changes that are associated with cancer. People who participate in genetics studies may or may not have cancer, depending on the study. The goal

of these studies is to help understand the role of genes in the development of cancer.

3. Who sponsors clinical trials?

Government agencies, such as the National Cancer Institute (NCI) and other parts of the National Institutes of Health (NIH), the Department of Defense, and the Department of Veterans Affairs, sponsor and conduct clinical trials. In addition, organizations or individuals, such as physicians, medical institutions, foundations, volunteer groups, and pharmaceutical companies, also sponsor clinical trials.

NCI sponsors a large number of clinical trials and has a number of programs designed to make clinical trials widely available in the United States. These programs include the following:

- The **Cancer Centers Program** provides support to research-oriented institutions, including those that have been designated as NCI Comprehensive or Clinical Cancer Centers for their scientific excellence. More information is available in the NCI fact sheet *The National Cancer Institute Cancer Centers Program*, which is available at http://www.cancer.gov/cancertopics/factsheet/NCI/cancer-centers on the Internet.

- The **Specialized Programs of Research Excellence (SPOREs)** bring together scientists and researchers to design and implement research programs that can improve prevention, detection, diagnosis, and treatment of specific types of cancer. More information about SPOREs is available at http://spores.nci.nih.gov/index.html on the Internet.

- The **Clinical Trials Cooperative Group Program** brings researchers, cancer centers, and doctors together into cooperative groups. These groups work with the NCI to identify important questions in cancer research, and design and conduct multisite clinical trials to answer these questions. Cooperative groups are located throughout the United States and in Canada and Europe. For more information, refer to the fact sheet *NCI's Clinical Trials Cooperative Group Program* at http://www.cancer.gov/cancertopics/factsheet/NCI/clinical-trials-cooperative-group on the Internet.

- The **Cancer Trials Support Unit (CTSU)** makes NCI-sponsored phase III treatment trials available to doctors and patients in the United States and Canada . Doctors who are not affiliated with an NCI-sponsored Clinical Trials Cooperative Group (see above) must complete an application process, which includes credential verification and site preparedness assessment, to become members of the CTSU's National Network of Investigators. CTSU members can enroll patients in clinical trials through the program's Web site, which is located at http://www.ctsu.org on the Internet. General information about the CTSU is also available on the program's Web site, or by calling 1–888–823–5923.

- The **Community Clinical Oncology Program (CCOP)** makes clinical trials available in a large number of communities across the United States. Local hospitals throughout the country affiliate with a cancer center or a cooperative group. This affiliation allows doctors to offer people participation in clinical trials more easily, so they do not have to travel long distances or leave their usual caregivers. The **Minority-Based Community Clinical Oncology Program** focuses on encouraging minority populations to participate in clinical trials. More information about the CCOP can be found in the NCI fact sheet *Community Clinical Oncology Program: Questions and Answers*, which is available at http://www.cancer.gov/cancertopics/factsheet/NCI/CCOP on the Internet.

- The **National Institutes of Health Clinical Center**, a research hospital located in Bethesda, Maryland, is part of the NIH. Trials at the Clinical Center are conducted by the components of the NIH, including the NCI. The NCI fact sheet *Cancer Clinical Trials at the National Institutes of Health Clinical Center: Questions and Answers* has more information about the Clinical Center. This fact sheet is available at http://www.cancer.gov/cancertopics/factsheet/NCI/clinical-center on the Internet.

4. How are participants protected?

Research with people is conducted according to strict scientific and ethical principles. Every clinical trial has a protocol, or action plan, which acts like a "recipe" for conducting the trial. The plan describes what will be done in the study, how it will be conducted, and why each part of the study is necessary. The same protocol is used by every doctor or research center taking part in the trial.

All clinical trials that are federally funded or that evaluate a new drug or medical device subject to Food and Drug Administration regulation must be reviewed and approved by an Institutional Review Board (IRB). Many institutions require that all clinical trials, regardless of funding, be reviewed and approved by a local IRB. The Board, which includes doctors, researchers, community leaders, and other members of the community, reviews the protocol to make sure the study is conducted fairly and participants are not likely to be harmed. The IRB also decides how often to review the trial once it has begun. Based on this information, the IRB decides whether the clinical trial should continue as initially planned and, if not, what changes should be made. An IRB can stop a clinical trial if the

researcher is not following the protocol or if the trial appears to be causing unexpected harm to the participants. An IRB can also stop a clinical trial if there is clear evidence that the new intervention is effective, in order to make it widely available.

NIH-supported clinical trials require data and safety monitoring. Some clinical trials, especially phase III clinical trials, use a Data and Safety Monitoring Board (DSMB). A DSMB is an independent committee made up of statisticians, physicians, and patient advocates. The DSMB ensures that the risks of participation are as small as possible, makes sure the data are complete, and stops a trial if safety concerns arise or when the trial's objectives have been met.

5. What are eligibility criteria, and why are they important?

Each study's protocol has guidelines for who can or cannot participate in the study. These guidelines, called eligibility criteria, describe characteristics that must be shared by all participants. The criteria differ from study to study. They may include age, gender, medical history, and current health status. Eligibility criteria for treatment studies often require that patients have a particular type and stage of cancer.

Enrolling participants with similar characteristics helps to ensure that the results of the trial will be due to what is under study and not other factors. In this way, eligibility criteria help researchers achieve accurate and meaningful results. These criteria also minimize the risk of a person's condition becoming worse by participating in the study.

6. What is informed consent?

Informed consent is a process by which people learn the important facts about a clinical trial to help them decide whether to participate. This information includes details about what is involved, such as the purpose of the study, the tests and other procedures used in the study, and the possible risks and benefits. In addition to talking with the doctor or nurse, people receive a written consent form explaining the study. People who agree to take part in the study are asked to sign the informed consent form. However, signing the form does not mean people must stay in the study. People can leave the study at any time—either before the study starts or at any time during the study or the follow-up period.

The informed consent process continues throughout the study. If new benefits, risks, or side effects are discovered during the study, the researchers must inform the participants. They may be asked to sign new consent forms if they want to stay in the study.

7. Where do clinical trials take place?

Clinical trials take place in doctors' offices, cancer centers, other medical centers, community hospitals and clinics, and veterans' and military hospitals in cities and towns across the United States and in other countries. Clinical trials may include participants at one or two highly specialized centers, or they may involve hundreds of locations at the same time.

8. How are clinical trials conducted?

Clinical trials are usually conducted in a series of steps, called phases. Treatment clinical trials listed in PDQ®, the NCI's comprehensive cancer information database, are always assigned a phase. However, screening, prevention, diagnostic, and quality-of-life studies do not always have a phase. Genetics clinical trials generally do not have a phase.

- **Phase I** trials are the first step in testing a new approach in people. In these studies, researchers evaluate what dose is safe, how a new agent should be given (by mouth, injected into a vein, or injected into the muscle), and how often. Researchers watch closely for any harmful side effects. Phase I trials usually enroll a small number of patients and take place at only a few locations. The dose of the new therapy or technique is increased a little at a time. The highest dose with an acceptable level of side effects is determined to be appropriate for further testing.

- **Phase II** trials study the safety and effectiveness of an agent or intervention, and evaluate how it affects the human body. Phase II studies usually focus on a particular type of cancer, and include fewer than 100 patients.

- **Phase III** trials compare a new agent or intervention (or new use of a standard one) with the current standard therapy. Participants are randomly assigned to the standard group or the new group, usually by computer. This method, called randomization, helps to avoid bias and ensures that human choices or other factors do not affect the study's results. In most cases, studies move into phase III testing only after they have shown promise in phases I and II. Phase III trials often include large numbers of people across the country.

- **Phase IV** trials are conducted to further evaluate the long-term safety and effectiveness of a

treatment. They usually take place after the treatment has been approved for standard use. Several hundred to several thousand people may take part in a phase IV study. These studies are less common than phase I, II, or III trials.

People who participate in a clinical trial work with a research team. Team members may include doctors, nurses, social workers, dietitians, and other health professionals. The health care team provides care, monitors participants' health, and offers specific instructions about the study. So that the trial results are as reliable as possible, it is important for participants to follow the research team's instructions. The instructions may include keeping logs or answering questionnaires. The research team may continue to contact participants after the trial ends.

9. What are some of the benefits of taking part in a clinical trial?

The benefits of participating in a clinical trial include the following:

- Participants have access to promising new approaches that are often not available outside the clinical trial setting.
- The approach being studied may be more effective than the standard approach.
- Participants receive regular and careful medical attention from a research team that includes doctors and other health professionals.
- Participants may be the first to benefit from the new method under study.
- Results from the study may help others in the future.

10. What are some of the possible risks associated with taking part in a clinical trial?

The possible risks of participating in a clinical trial include the following:

- New drugs or procedures under study are not always better than the standard care to which they are being compared.
- New treatments may have side effects or risks that doctors do not expect or that are worse than those resulting from standard care.
- Participants in randomized trials will not be able to choose the approach they receive.
- Health insurance and managed care providers may not cover all patient care costs in a study.
- Participants may be required to make more visits to the doctor than they would if they were not in the clinical trial.

11. Who pays for the patient care costs associated with a clinical trial?

Health insurance and managed care providers often do not cover the patient care costs associated with a clinical trial. What they cover varies by health plan and by study. Some health plans do not cover clinical trials if they consider the approach being studied "experimental" or "investigational." However, if enough data show that the approach is safe and effective, a health plan may consider the approach "established" and cover some or all of the costs. Participants may have difficulty obtaining coverage for costs associated with prevention and screening clinical trials; health plans are currently less likely to have review processes in place for these studies. It may, therefore, be more difficult to get coverage for the costs associated with them. In many cases, it helps to have someone from the research team talk about coverage with representatives of the health plan.

Health plans may specify other criteria a trial must meet to be covered. The trial might have to be sponsored by a specified organization, be judged "medically necessary" by the health plan, not be significantly more expensive than treatments the health plan considers standard, or focus on types of cancer for which no standard treatments are available. In addition, the facility and medical staff might have to meet the plan's qualifications for conducting certain procedures, such as bone marrow transplants. More information about insurance coverage can be found on the NCI's *Clinical Trials and Insurance Coverage: A Resource Guide* Web page at http://www.cancer.gov/clinicaltrials/learning/insurance-coverage on the Internet.

Many states have passed legislation or developed policies requiring health plans to cover the costs of certain clinical trials. For more information, visit the NCI's Web site at http://www.cancer.gov/clinicaltrials/developments/laws-about-clinical-trial-costs on the Internet.

Federal programs that help pay the costs of care in a clinical trial include those listed below:

- Medicare reimburses patient care costs for its beneficiaries who participate in clinical trials designed to diagnose or treat cancer. Information about Medicare coverage of clinical trials is available at http://www.medicare.gov on the Internet, or by calling Medicare's toll-free number for beneficiaries at 1-800-633-4227 (1-800-MEDICARE). The toll-free number for the hearing impaired is 1-877-486-2048. Also, the NCI fact sheet *More Choices in Cancer Care: Information for Beneficiaries on Medicare Coverage of Cancer Clinical Trials* is available at http://www.cancer.gov/cancertopics/factsheet/support/medicare on the Internet.

- Beneficiaries of TRICARE, the Department of Defense's health program, can be reimbursed for the medical costs of participation in NCI-sponsored phase II and phase III cancer prevention

(including screening and early detection) and treatment trials. Additional information is available in the NCI fact sheet *TRICARE Beneficiaries Can Enter Clinical Trials for Cancer Prevention and Treatment Through a Department of Defense and National Cancer Institute Agreement*. This fact sheet can be found at http://www.cancer.gov/cancertopics/factsheet/NCI/TRICARE on the Internet.

- The Department of Veterans Affairs (VA) allows eligible veterans to participate in NCI-sponsored prevention, diagnosis, and treatment studies nationwide. All phases and types of NCI-sponsored trials are included. The NCI fact sheet *The NCI/VA Agreement on Clinical Trials: Questions and Answers* has more information. It is available at http://www.cancer.gov/cancertopics/factsheet/NCI/VA-clinical-trials on the Internet.

12. What are some questions people might ask their health care provider before entering a clinical trial?

It is important for people to ask questions before deciding to enter a clinical trial. Questions people might want to ask their doctor or nurse include the following:

The Study

- What is the purpose of the study?
- Why do the researchers think the approach being tested may be effective? Has it been tested before?
- Who is sponsoring the study?
- Who has reviewed and approved the study?
- What are the medical credentials and experience of the researchers and other study personnel?
- How are the study results and safety of participants being monitored?
- How long will the study last?
- How will the results be shared?

Possible Risks and Benefits

- What are the possible short-term benefits?
- What are the possible long-term benefits?
- What are the short-term risks, such as side effects?
- What are the possible long-term risks?
- What other treatment options are available?
- How do the possible risks and benefits of the trial compare with those of other options?

Participation and Care

- What kinds of treatment, medical tests, or procedures will the participants have during the study? How often will they receive the treatments, tests, or procedures?
- Will treatments, tests, or procedures be painful? If so, how can the pain be controlled?
- How do the tests in the study compare with what people might receive outside the study?
- Will participants be able to take their regular medications while in the clinical trial?
- Where will the participants receive their medical care? Will they be in a hospital? If so, for how long?
- Who will be in charge of the participants' care? Will they be able to see their own doctors?
- How long will participants need to stay in the study? Will there be follow-up visits after the study?

Personal Issues

- How could being in the study affect the participants' daily lives?
- What support is available for participants and their families?
- Can potential participants talk with people already enrolled in the study?

Cost Issues

- Will participants have to pay for any treatment, tests, or other charges? If so, what will the approximate charges be?
- What is health insurance likely to cover?
- Who can help answer questions from the insurance company or health plan?

13. What happens when a clinical trial is over?

After a clinical trial is completed, the researchers look carefully at the data collected during the trial before making decisions about the meaning of the findings and further testing. After a phase I or II trial, the researchers decide whether to move on to the next phase, or stop testing the agent or intervention because it was not safe or effective. When a phase III trial is completed, the researchers look at the data and decide whether the results have medical importance.

The results of clinical trials are often published in peer-reviewed, scientific journals. Peer review is a process by which experts review the report before it is published to make sure the analysis and conclusions are sound. If the results are particularly important, they may be featured by the media and discussed at scientific meetings and by patient advocacy groups before they are published. Once a new approach has been proven safe and effective in a clinical trial, it may become standard practice. (Standard practice is a currently accepted and widely used approach.)

The National Library of Medicine's Web site offers links to resources for finding the results of clinical trials. It includes information about published and unpublished results. This resource can be found at http://www.nlm.nih.gov/services/ctresults.html on the Internet.

14. Where can people find more information about clinical trials?

In addition to the resources described in Question 3, people interested in taking part in a clinical trial should talk with their health care provider. Information about cancer clinical trials is also available from the NCI's Cancer Information Service (CIS). Information specialists at the CIS use PDQ to identify and provide detailed information about specific ongoing clinical trials. PDQ includes all NCI-funded clinical trials and some studies conducted by independent investigators at hospitals and medical centers in the United States and Europe.

People also have the option of searching for clinical trials on their own. The clinical trials page of the NCI's Web site, located at http://www.cancer.gov/clinicaltrials/ on the Internet, provides information about clinical trials and links to PDQ. Another resource is the NIH's ClinicalTrials.gov Web site. ClinicalTrials.gov lists clinical trials sponsored by the NIH, other Federal agencies, and the pharmaceutical industry for a wide range of diseases, including cancer and other conditions. This site can be found at http://clinicaltrials.gov on the Internet.

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Related Resources

Publications (available at http://www.cancer.gov/publications)

- National Cancer Institute Fact Sheet 1.2, *The National Cancer Institute Cancer Centers Program*
- National Cancer Institute Fact Sheet 1.3, *Community Clinical Oncology Program: Questions and Answers*
- National Cancer Institute Fact Sheet 1.4, *NCI's Clinical Trials Cooperative Group Program*
- National Cancer Institute Fact Sheet 1.13, *TRICARE Beneficiaries Can Enter Clinical Trials for Cancer Prevention and Treatment Through a Department of Defense and National Cancer Institute Agreement*
- National Cancer Institute Fact Sheet 1.17, *The NCI/VA Agreement on Clinical Trials: Questions and Answers*
- National Cancer Institute Fact Sheet 1.22, *Cancer Clinical Trials at the National Institutes of Health Clinical Center: Questions and Answers*
- National Cancer Institute Fact Sheet 8.14, *More Choices in Cancer Care: Information for Beneficiaries on Medicare Coverage of Cancer Clinical Trials*
- *Taking Part in Clinical Trials: What Cancer Patients Need To Know*
- *Taking Part in Clinical Trials: Cancer Prevention Studies*

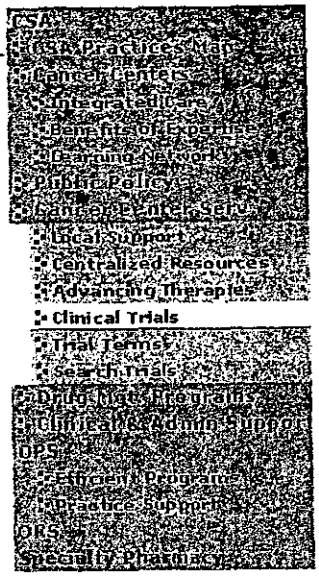
National Cancer Institute (NCI) Resources

Cancer Information Service (toll-free)
Telephone: 1–800–4–CANCER (1–800–422–6237)
TTY: 1–800–332–8615

Online
NCI's Web site: http://www.cancer.gov
LiveHelp, NCI's live online assistance:
https://cissecure.ncl.nih.gov/livehelp/welcome.asp

^ Back to Top

Clinical Trial Information



The greater the number of people who participate in clinical trials, the faster emerging anticancer therapies can be brought to market. US Oncology accrued more than 32,000 cancer patients to clinical trials, and is bringing the search for new therapies directly into local communities across America.

Our research team members conduct more than 50 clinical trials each year. While we have complete Phase I-IV capabilities, the majority of our research is in Phase II and III development stages.

Our extensive clinical trial program, plus our provision of care for approximately 200,000 new cancer patients each year, provides us with a unique research platform. In sharing what we learn with one another, we can more readily advance the latest developments as they relate to investigational drugs, the reduction of side effects, and new methods of care.

If you are interested in contacting a US Oncology-affiliated physician to learn more about our clinical trial program, please click here.

Frequently Asked Questions About Clinical Trials

If you are a cancer patient or someone you know is a cancer patient, you may be interested in learning more about clinical trials. The information below offers a brief overview of the clinical trial process, with a look at key questions and terms.

What are Clinical Trials?
Clinical trials, or research studies, utilize patient volunteers to help investigate different ways to treat diseases - such as cancer. Clinical trials involve the use of investigational drugs (also known as study drugs) and drug delivery methods. Each study tries to answer specific scientific questions about different ways to prevent, diagnose, and treat whatever disease it is addressing.

Why are Clinical Trials Important?
Clinical trials contribute to the overall knowledge and progress made in developing therapies for diseases, such as cancer. These research studies are conducted to determine if a study drug or delivery method is safe and effective. Patients who agree to participate may possibly benefit from the research study, while receiving the best current standard treatment as well.

How are Clinical Trials Structured?
Clinical trials are structured into four phases:

In *Phase I clinical trials*, researchers test a study drug in a small group of people (20 to 80) for the first time to evaluate its safety, determine a safe dosage range, and identify side effects.

In *Phase II clinical trials*, the study drug is tested in a larger group of people (100 to 300) to measure its effectiveness and further evaluate its safety.

In *Phase III clinical trials*, the study drug is tested in large groups of people (1,000 to 3,000) to confirm its effectiveness, monitor side effects, compare it to approved standard treatments, and collect information that will allow the study drug to be used safely.

In *Phase IV clinical trials*, the drug is tested after it has been marketed to collect information about its effect in various populations and about any side effects associated with long-term use.

What Happens During a Clinical Trial?
In many trials, if the patient is eligible and agrees to participate through Informed Consent, the patient is randomized (by chance, like a coin toss) to either receive the current standard treatment, or the current standard treatment and the study drug regimen. If no standard treatment is available, a trial may compare the study drug to a placebo, which is similar to the study drug, but contains no active ingredient. During a trial, patients are treated and monitored by a team of health care professionals. This team will give the patient specific instructions about the trial, about more tests, and additional doctor's visits that might be required.

Throughout the clinical trial, you come first. If there is no improvement or you experience intolerable side effects, you and your physician can decide to discontinue trial participation and resume other

treatment options. Should you do so, your decision will be respected without any effect on future treatment plans.

Why Do Some Cancer Patients Choose to Participate in Clinical Trials?
Some cancer patients may participate because they are hoping for a possible cure and longer life or a way to feel better. Others find that the current standard therapies are not optimal for their cancer and wish to be among the first to participate in a research study and receive an investigational drug. Whatever the reason, participation could make a difference in a patient's future, as well as in the lives of future cancer patients.

How Do I Know If I Should Participate in a Clinical Trial?
The decision to participate in a clinical trial is one that only you can make, with the help of your physician and the people close to you. If you are interested in participating in a clinical trial, you will be informed of the clinical trial's potential benefits and drawbacks before making your decision. If the investigational drug is proven to be effective, you may be among the first to benefit. In addition, through your participation in a research study, you will also be helping future cancer patients.

Are There Risks Involved in Participating?
Because clinical trials are research studies, study drugs may not be better than current standard drugs or treatments. In addition, you may experience side effects that are worse than those of current standard drugs and treatments. Also, your health insurance company or managed care provider may not cover all of the patient care associated with a clinical trial. All of these factors should be discussed thoroughly with your physician and those close to you before deciding whether or not to participate in a clinical trial.

Where are the Trials Held?
Many clinical trials may be available right in your own community. Ask your physician for specific information or search the US Oncology clinical trial list to find a current US Oncology trial in your region.

How Do I Learn More About a Specific Clinical Trial?
Through a process called "Informed Consent," you will learn the key facts about a particular clinical trial before making a decision about participating. Your doctor will explain the purpose and requirements of the study, including any potential drawbacks and benefits. If you agree to take part in the trial, you will be asked to review and sign a form that outlines the study's details prior to participating.

How Do I Get More Information?
Consult your physician to find out whether or not there is a clinical trial that would be appropriate for your care. If you are a US Oncology patient, your physician has information on clinical trials that are being held throughout the company's national research network. Or you can search a list of all current US Oncology clinical trials for more specific information.
For more details on clinical trial research conducted by the US Oncology network, please click USON Research.
For definitions of the clinical trial terms used on this site, please click Trial Terms.

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US Oncology does not own medical practices nor does it employ physicians or nurses or participate in decisions regarding patient care.

State Laws Addressing Third-Party Reimbursement for Clinical Trials for the Treatment of Cancer
(as of September 30, 2007)

State	Statute	Coverage Requirements			Types of Insurers Covered				Clinical Trial Phases Covered			
		Mandatory Coverage	Mandatory Offer	Prohibits Exclusion of Coverage	Private Insurers	Specified Managed Care	Medicaid/Other Medical Assistance	Public Employee Health Plans	Phase I	Phase II	Phase III	Phase IV
Arizona	ARIZ. REV. STAT. ANN. §§ 20-1342.03, 20-826.01, 20-1057.07, 20-1402.01, 20-1404.01, and 20-2328	X[1]			X	X			X	X	X	X
California	CAL. HEALTH & SAFETY CODE § 1370.6; CAL. INS. CODE § 10145.4; and CAL. WELF. & INST. CODE § 14132.98	X[2]			X	X	X		X	X	X	X
Connecticut	CONN. GEN. STAT. ANN §§ 38a-504a to 38a-504g and 38a-542a to 38a-542g	X[3]			X						X	
Delaware*	DEL. CODE ANN. tit. 18, § 3567	X[4]			X							
Georgia	GA. CODE ANN. § 33-24-59.1	X[5]			X	X		X		X[6]	X[6]	
Louisiana	LA. REV. STAT. ANN. § 22:230.4	X			X	X		X		X	X	X
Maine*	ME. REV. STAT. ANN. tit. 24-A, §§ 4301-A and 4310	X			X	X						
Maryland	MD. CODE ANN., INS. § 15-827	X			X	X			X	X	X	X
Massachusetts	MASS. GEN. LAWS ANN. ch. 175, § 110L	X[4]			X	X			X	X	X	X
Missouri	MO. REV. STAT. § 376.429	X			X	X				X	X	X
Nevada	NEV. REV. STAT. §§ 689A.04033, 689B.0306, 695B.1903, 695C.1693, and 695G.173	X			X	X			X	X	X	X
New Hampshire	N.H. REV. STAT. ANN. § 415:18-l	X[7]			X	X			X	X	X	X
New Mexico	N.M. STAT. ANN. § 59A-22-43	X[4]			X	X	X			X	X	X
North Carolina*	N.C. GEN. STAT. ANN. § 58-3-255	X			X	X				X	X	X
Rhode Island	R.I. GEN. LAWS §§ 27-18-36, 27-18-36.2, 27-19-32 to 27-19-32.3, 27-20-27 to 27-20-27.3, and 27-41-41 to 27-41-41.3	X			X	X				X	X	X
Tennessee	TENN. CODE ANN. § 56-7-2365	X[4]			X	X			X	X	X	X
Vermont	VT. STAT. ANN. tit. 8, § 4088b [8]	X			X	X	X					
Virginia	VA. CODE ANN. §§ 2.2-2818 and 38.2-3418.8	X			X	X		X	X[9]	X	X	X

Source: National Cancer Institute, State Cancer Legislative Database Program, Bethesda, MD: SCLD

State Laws Addressing Third-Party Reimbursement for Clinical Trials for the Treatment of Cancer (as of September 30, 2007)

State	Statute	Coverage Requirements			Types of Insurers Covered				Clinical Trial Phases Covered			
		Mandatory Coverage	Mandatory Offer	Prohibits Exclusion of Coverage	Private Insurers	Specified Managed Care	Medicaid/Other Medical Assistance	Public Employee Health Plans	Phase I	Phase II	Phase III	Phase IV
West Virginia	W. VA. CODE §§ 5-16-7d, 5-16-7e, 5-16B-6a, 5-16B-6b, 9-2-12, 9-2-12a, 33-25F-1, and 33-25F-2	X[4]			X	X	X	X		X	X	X
Wisconsin	WIS. STAT. ANN. §§ 632.87 and 40.51			X[4]	X			X	X	X	X	X

Note: Because arrangements for the reimbursement of clinical trials for several states fall outside the scope of the State Cancer Legislative Database protocols, those states are not included herein. Michigan and New Jersey, for example, instituted special non-legislative agreements whereby insurers voluntarily cover routine medical care that is part of a clinical trial. According to the state employee benefits handbook, Ohio provides coverage for cancer treatment clinical trials to state employees who are enrolled in the state employee health benefit plan. In Georgia, a non-legislative agreement among a number of private health plans and state-based plans provides coverage for adults and children.

* Laws in Delaware, Maine, and North Carolina provide coverage of clinical trials for life threatening medical conditions and not specifically for the treatment of cancer.

[1] Indicated insurers are only obligated to provide coverage for covered patient costs that are directly associated with the clinical trial.

[2] Coverage requirement applies only to routine patient care costs related to cancer clinical trials having a therapeutic purpose, upon recommendation by a treating physician.

[3] In order to be eligible for coverage, clinical trials for the *prevention of cancer* must be a Phase III trial that involves a therapeutic intervention and is conducted at multiple institutions under the auspices of an independent peer-reviewed protocol approved by a specified Federal authority.

[4] Coverage requirement applies only to clinical trials that have a therapeutic intent.

[5] Coverage requirement applies only to routine patient care costs incurred in connection with clinical trials for the treatment of children's cancer.

[6] Applies only to Phase II or III prescription drug clinical trial programs.

[7] Coverage for Phase I and Phase II clinical trials is decided on a case-by-case basis.

[8] Requires the state Department of Banking, Insurance, Securities, and Health Care Administration to issue regulations that specify the requirements for coverage of routine costs for patients who participate in approved cancer clinical trials conducted by specified providers. Coverage requirements are included in Regulation H-2001-04.

[9] Treatment in a Phase I clinical trial may be covered on a case-by-case basis.

The Access To Cancer Clinical Trials Act of 2009 (Rep. Sue Myrick)

January 30th, 2009

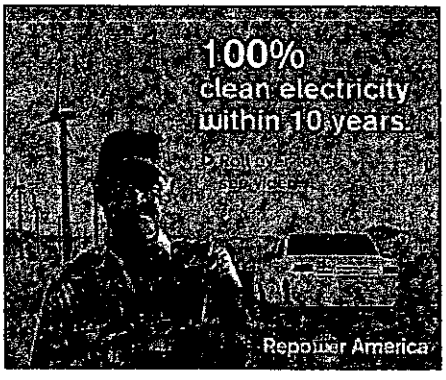
Clinical trials are so critical for patients and or medical research, yet many patients find that their health insurance won't cover the rest of their routine cancer treatment if they decide to enroll in clinical trials. We're not asking insurance companies to pay for clinical trials. This bill simply state that insurers must continue to pay for routine treatments — that they would be paying for regardless — if patients enroll in a clinical trial.

No patient should ever have to fear exploring all treatment options at the cost of losing coverage. We should be encouraging participation in clinical trials, not discouraging it by removing coverage for routine care. Were it not for patients who have enrolled in past trials, the medial advancements we've experienced toward finding a cure for cancer would not be possible.

Permalink | Comment on this post (1)

By **N.C. GOP Rep. Sue Myrick**

This entry was posted on Friday, January 30th, 2009 at 5:08 pm and is filed under Healthcare, Lawmaker News .



- QUESTIONS & ANSWERS
- This section is a

ASCO

American Society of Clinical Oncology

February 17, 2009

The Honorable Bettye Davis
Alaska State Senator
District K
Capitol Building Room 30
Juneau, AK 99801-1182

Dear Senator Davis:

The Denali Oncology Group and American Society of Clinical Oncology are pleased to offer support for your legislation to require insurance coverage for people who participate in clinical trials. Our organizations represent physicians specializing in cancer treatment and clinical research, and clinical research is a vital mission of our membership.

Clinical trials are critically important because they offer the promise of new cancer treatments. As you know from personal experience, they also provide an essential, state-of-the-art treatment option for current cancer patients. Therefore, insurance coverage of the routine patient care costs associated with clinical trials is vital for cancer patients.

For many people with cancer, participation in a clinical trial is often their best treatment option. Yet, as you know, many third-party payers take the position that routine patient care costs should be denied to anyone who enrolls in such trials. We believe such policy deprives beneficiaries of the value of their health insurance, wrongly restricts their treatment options, and inhibits medical progress against serious and life-threatening diseases. DOG and ASCO believe that insurers should cover all routine care costs for patients who are enrolled in cancer clinical trials. Your legislation is the key to making this happen.

DOG and ASCO applaud your leadership in pursuing legislation that provides this essential element of quality cancer care. We are eager to work with you to ensure passage. Please do not hesitate to contact Suanna Bruinooge, ASCO's Director of Research Policy, at 571-483-1613 or suanna.bruinooge@asco.org, or Dr. Mary Stewart at mstewartonc@yahoo.com or 907-279-3155.

Sincerely,

Joseph S. Bailes

Mary Stewart, MD
President, Denali Oncology Group

Joseph S. Bailes, MD
Chair, ASCO Government Relations Council

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2988

American Society of Clinical Oncology
Statement In Support of Insurance Coverage for Clinical Trials

With more than 26,000 members worldwide, ASCO is the leading medical society for physicians involved in cancer treatment and research. Engagement in clinical research is a vital mission of ASCO members. Unfortunately, many cancer patients have limited curative treatment options and enrollment in a clinical trial may offer hope for a response to a new drug or other intervention. Oncologists want their patients to consider enrolling in clinical trials, not only because of potential treatment benefits for the individual patient but also because it is through these trials that general progress against cancer is achieved. Patients are usually eager to participate if given the opportunity. ASCO considers the opportunity to participate in cancer clinical trials as an essential element of quality cancer care.

Unfortunately, participation in clinical trials is significantly deterred by the prospect that insurance coverage may be withheld on the ground that treatment provided in trials is "experimental" or "investigational." This position has been effectively discarded by the federal Medicare program, as well as by the Department of Defense health care system, and by many states. ASCO strongly supports state and federal efforts to ensure that patients enrolled in clinical trials receive coverage for the routine health care costs that would be covered if they did not participate on a trial. It is a basic issue of fairness, and it will help ensure that we continue to improve treatment options for cancer patients and learn about this devastating group of diseases.

What is a Clinical Trial?

Clinical trials are research studies involving people. Clinical trials are designed to evaluate whether a new treatment is safe, effective, and better than the current standard of care. These interventions can include new drugs, new combinations of existing therapies, new approaches to radiation therapy or surgery, new methods of treatment, complementary or alternative therapies, and new prevention methods. Cancer clinical trials are designed to compare an investigational therapy with the standard treatment regimen being used at the time. Placebo-controlled clinical trials in cancer research are rare, but are used when there is no effective, standard treatment available.

Cancer clinical trials have led to scientific advances that have increased doctors' understanding of how and why tumors develop and grow. The knowledge gained has helped scientists and doctors develop new ideas on how

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to slow, halt, and even prevent the development of the disease. Clinical trials are the most reliable route to definitive answers and are the only accepted scientific method to determine if a new treatment works better than the current standard of care.

Clinical trials undergo rigorous review prior to opening and involve regular oversight during and after a trial to protect the safety and rights of the participants involved. Each clinical trial follows a set of rules called a protocol. A protocol describes inclusion and exclusion criteria; the schedule of tests, procedures, medications, and doses; and the length of the study. While in a clinical trial, participants are seen regularly by the research staff to monitor their health and determine the safety and effectiveness of the treatment.

Precedents for Clinical Trials Coverage

For more than two decades, the cancer community has expressed its concerns about the negative impact of restrictions on coverage of clinical trials by third-party payers, both public and private. Such restrictions are harmful not only to individual patients but also to overall progress against cancer. In 1999, public authorities began to respond favorably to these arguments and to reform their coverage policies with respect to clinical trials.

Pursuant to a negotiated agreement between the National Cancer Institute (NCI) and the Department of Defense (DoD), the DoD's TRICARE health care plan commenced coverage of NCI-sponsored clinical trials in 1999. The original agreement, began as a pilot project, was made a permanent benefit in March 2008, accompanied by a DoD press release describing it as "a long successful project between the NCI and DoD."

In 2000, the Medicare program took a more expansive approach to clinical trial coverage. In an Executive Memorandum, President Clinton instructed Medicare officials to adopt a clinical trials policy covering not just cancer trials but all diseases and all phases. To implement the policy, the Centers for Medicare & Medicaid Services (then the Health Care Financing Administration) published a National Coverage Determination in September 2000.

State governments have also been active in ensuring coverage of clinical trials by private insurance plans under their control. Almost half of the states throughout the U.S. enjoy coverage of clinical trials, either through legislation

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or through voluntary consensus agreements with insurers, and more are considering such requirements.

Impact of Policy Changes on Clinical Trial Participation

One of the nation's leading cooperative research groups, the Southwest Oncology Group (SWOG), has conducted studies that underscore the impact of the Medicare coverage policy on clinical trial participation among the elderly. In 1999, SWOG published a study finding significant under-representation of the elderly in cancer clinical trials.[1] The study found that, whereas 63% of cancer patients were Medicare eligible, seniors were only 25% of those patients participating in SWOG clinical trials during the period 1993-1996. Following the Medicare coverage policy in 2000, a second SWOG study found there was a significant increase in participation among Medicare beneficiaries, with seniors representing 38% of SWOG trial participants in the period 2001-2003.[2]

Cost of Clinical Trials Coverage

While there have been no definitive studies of the cost consequences of clinical trial coverage, there have been a series of articles finding that participation in clinical trials "did not result in substantial increases in the direct costs of medical care,"[3] that "[c]linical protocols may add relatively little to that cost,"[4] and that "additional costs of an open reimbursement policy for government-sponsored cancer clinical trials appear minimal."[5] And with almost eight years of experience with the 2000 Medicare coverage policy, there is no evidence of increased cost to the program.

Conclusion

In light of the experience described above, we heartily support efforts to ensure that health plans and all insurers provide coverage for the routine costs

[1] Hutchins et al., "Underrepresentation of Patients 65 Years of Age or Older in Cancer-Treatment Trials," N Engl J Med 341: 2061-2067 (1999).
[2] Unger et al., "Impact of the Year 2000 Medicare Policy Change on Older Patient Enrollment to Cancer Clinical Trials," J Clin Oncol 24:141-144 (2006).
[3] Fireman et al., "Cost of Care for Patients in Cancer Clinical Trials," J Natl Cancer Inst 92:136-142 (2000).
[4] Wager et al., "Incremental Costs of Enrolling Cancer Patients in Clinical Trials: a Population-Based Study," J. Natl. Cancer Inst 91:847-853 (1999).
[5] Goldman et al., "Incremental Treatment Costs in National Cancer Institute-Sponsored Clinical Trials," 289:2970-2977 (2003).

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associated with clinical trials participation. ASCO members strive to ensure access to the best treatment options for their cancer patients, and this requires that health insurers offer clinical trials coverage. We think it is clear that best cancer care and best health care coverage require access to high quality cancer clinical trials.

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February 17, 2009

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 10 (Davis)--Support

Dear Chair Davis,

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 10, authored by you.

SB 10 would require insurance programs, including Medicaid, to provide coverage for cancer victims undergoing clinical trials just as they would if the individual was not in the trial.

Most of our significant advances in cancer treatment that have become standard procedures began as clinical trials.

It makes no sense not to offer health insurance coverage for procedures that may be still considered experimental but offer some hope for the cancer victim. We purchase insurance (or the State provides it through Medicaid) so that we can have help with the costs that accompany a threatening disease. SB 10 is one of those bills that AARP believes makes sense, especially to a cancer victim and his/her family.

AARP recommends an "AYE" vote on SB 10.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Joe Thomas
Senator Fred Dyson
Senator Johnny Ellis

SB 280 Testimony 4/3/08

Jeanne E. Anderson, MD
Katmai Oncology Group, LLC
3851 Piper Street, Suite U340
Anchorage, AK 99508-4627

I am Jeanne Anderson, a Medical Oncologist in practice in Anchorage. On behalf of Alaska cancer physicians and patients, I thank the members of the Labor and Commerce Committee members for considering this bill. It is predicted that 2,650 Alaskans will be diagnosed with cancer in 2008. In the 1970's, only 50% of cancer patients lived 5 years after diagnosis. In 2008, 66% are predicted to survive 5 years. We all know that many Alaskans die of cancer every day and that improvements are desperately needed. The cancer physicians in Alaska are committed to providing the best care possible to our patients, to relieve suffering and reduce death from cancer. In caring for our patients, we often turn to clinical trial as providing the best treatment for our patients. A clinical trial is a formal, scientific way to test whether a new treatment is safe, effective, and superior to existing treatments. The physicians and hospitals in Alaska support clinical trials and there are over 50 trials open in this state for our cancer patients. However, only a small number of our patients enroll on these clinical trials, approximately 40 per year. There are many reasons why enrollment is low. These reasons include lack of knowledge or interest on the part of the patient or physician, lack of availability of an appropriate trial for the patient, and (relevant to this bill) lack of insurance coverage or fear by the patient they will lose coverage if enrolled on a study. Passage of this bill will clearly remove an important barrier to access of a clinical trial. It will result in Alaska physicians providing improved care for our patients, reducing the burden of cancer in our population, and facilitating patients to stay in Alaska for state-of-the-art care.

April 2, 2008

Testimony to Support SB280

To

Senate Labor & Commerce Committee,

I am a medical oncologist-hematologist practicing in Anchorage.
Hence I am involved in caring for many, many patients with cancer, which are oftentimes deadly.
As yet, many cancers do not have curative treatments. One of the options I offer to all my patients is to consider treatment under clinical trials- scientifically conducted studies by approved medical organizations to try & improve cancer care.

Unfortunately, due to Insurers denying coverage for routine medical care when patients enter clinical trials, patients very obviously & naturally, decline to participate in clinical trials.
In my opinion, this state of affairs is a major handicap for patients/ individuals in Alaska to receive State of Art Care for Cancer & related problems in Alaska.

Just to give you an example, Herceptin is now used in early breast cancer treatment as the women with breast cancer who participated proved its efficacy in a clinical trial. This trial included at least 2 women in Alaska.

I wholeheartedly support SB280 & sincerely hope your committee members will too for all of our sakes.

Sincerely,

Latha Subramanian MD, FACP

NSABP®
National Surgical Adjuvant Breast and Bowel Project
PARTNERS IN CANCER RESEARCH

Norman Wolmark, MD
Chairman

Operations Center

Medical Affairs
412/330-4600 412/330-4660 Fax
412/330-4661 Fax

Administrative and Fiscal Affairs
412/330-4600 412/330-4662 Fax

Clinical Coordinating Division
1-800/477-7227

TESTIMONY OF D. LAWRENCE WICKERHAM, MD, ASSOCIATE CHAIRMAN OF THE NSABP, CONCERNING SB280

I am Dr. Lawrence Wickerham, the Associate Chairman of the National Surgical Adjuvant Breast and Bowel Project (NSABP), which is one of the National Cancer Institute's Cooperative Trials Groups.

The NSABP conducts large phase III studies that compare standard treatments with newer innovative therapies in patients with early stage breast or colorectal cancer. The group's mission is to improve the survival and quality of life of these patients. 2008 is the 50th anniversary of the NSABP and over those years we have entered over 130,000 individuals into our trials. Today we have 200 participating centers and 300 satellite centers located throughout the U.S., Canada, Puerto Rico, and Ireland, and we do have centers in Alaska.

Results of previous NSABP studies have had a major impact in improving the care of both breast and bowel cancer The results of our breast cancer studies have eliminated the use of true radical mastectomies, demonstrated that lumpectomy is an effective alternative, and we have shown that adjuvant treatment (treatment after surgery) can improve survival. Adjuvant therapy for breast cancer includes chemotherapy, hormonal therapy, and newer targeted treatments.

Figures from the American Cancer Society demonstrate that the mortality rate from breast cancer in the U.S. has declined for over a decade. This improvement is thought to be the result of screening mammograms to detect the disease and improvements in treatment. These improvements in care come primarily from clinical

trials like those conducted by the NSABP. The more patients that enter these studies, the more quickly we get results and the faster we can improve care. Unfortunately, for a variety of reasons, less than 5% of cancer patients choose to enter clinical trials. Cost is a major barrier.

Requiring health care insurers to cover the standard of care costs for individuals participating in cancer clinical trials would remove one significant barrier to increasing participation. Any research trial includes two general categories of costs: 1) research costs – expenses that the patient would not routinely incur if he or she was not a part of the trial (extra lab tests, x-rays, etc.), and 2) standard of care costs – expenses that would occur whether or not the patient entered the trial.

NSABP studies routinely identify the non-standard of care components. We provide the drug(s) being studied and typically provide additional non-federal funding to help defray the costs of trial participation, including the cost of non-standard of care items. The goal is to minimize any additional costs to the patient, improve trial participation and improve cancer care in general.

I and the NSABP strongly urge you to enact this bill so that cancer patients in Alaska can have improved access to state-of-the-art research studies like those available to patients in other states.

Thank you for listening to my testimony and I would be pleased to try to answer your questions.

American Association for Cancer Research

Association of American Cancer Institutes

American Society of Clinical Oncology

December 1, 2008

Kevin J. Cullen, MD
Director, University of Maryland
Marlene and Stewart Greenebaum Cancer Center
22 South Greene Street
Baltimore, MD 21201

Dear Dr. Cullen:

This letter is written in follow-up to our recent discussions about Medicare coverage of routine patient care costs for beneficiaries participating in phase I cancer clinical trials. As the world's leading professional and scientific organizations representing oncology cancer care professionals, we write to affirm our position that phase 1 cancer clinical trials are the essential gateway for advancement of new cancer treatments—and a vital component of our cancer treatment armamentarium.

It is the view of the undersigned organizations that the current Medicare National Coverage Determination (NCD) (310.1) for Routine Costs in Clinical Trials explicitly includes coverage of phase I cancer clinical trials and that these trials should be covered.

Requirements for Medicare Coverage
The NCD lays out three basic requirements for Medicare coverage:

- The subject or purpose of the trial must be the evaluation of an item or service that falls within a Medicare benefit category (e.g., physicians' service, durable medical equipment, diagnostic test) and is not statutorily excluded from coverage (e.g., cosmetic surgery, hearing aids).
- The trial must not be designed exclusively to test toxicity or disease pathophysiology. It must have therapeutic intent.
- Trials of therapeutic interventions must enroll patients with diagnosed disease rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients in order to have a proper control group.

The NCD also requires that clinical trials covered under the policy have seven "desirable characteristics."

1. The principal purpose of the trial is to test whether the intervention potentially improves the participants' health outcomes;
2. The trial is well-supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

3. The trial does not unjustifiably duplicate existing studies;
4. The trial design is appropriate to answer the research question being asked in the trial;
5. The trial is sponsored by a credible organization or individual capable of executing the proposed trial successfully;
6. The trial is in compliance with Federal regulations relating to the protection of human subjects; and
7. All aspects of the trial are conducted according to the appropriate standards of scientific integrity.

The policy also states that certain trials "are presumed to meet these characteristics and are automatically qualified to receive Medicare coverage." Trials that are automatically deemed include:

1. Trials funded by NIH, CDC, AHRQ, CMS, DOD, and VA;
2. Trials supported by centers or cooperative groups that are funded by the NIH, CDC, AHRQ, CMS, DOD and VA;
3. Trials conducted under an investigational new drug application (IND) reviewed by the FDA; and
4. Drug trials that are exempt from having an IND under 21 CFR 312.2(b)(1) will be deemed automatically qualified until the qualifying criteria are developed and the certification process is in place. At that time the principal investigators of these trials must certify that the trials meet the qualifying criteria in order to maintain Medicare coverage of routine costs. This certification process will only affect the future status of the trial and will not be used to retroactively change the earlier deemed status."

Phase 1 Cancer Clinical Trials Have Therapeutic Intent

The National Cancer Institute's (NCI) Investigator Handbook is instructive as to the therapeutic intent of a Phase I trial. That handbook includes the following information about phase 1 cancer clinical trials (emphasis added):

> Phase 1 trials determine a safe dose for Phase 2 trials and define acute effects on normal tissues. In addition, these trials examine the agent's pharmacology and may reveal evidence of antitumor activity. **Therapeutic intent is always present in Phase 1 trials**; indeed, anticancer agents are not tested in patients unless preclinical activity studies have already demonstrated evidence of significant activity in laboratory models.[1]

The Food and Drug Administration (FDA) has also adopted a definition of phase 1 trials that is consistent with the NCI's definition. FDA states that phase 1 studies "are designed to determine the metabolic and pharmacologic actions of the drug in humans, the side effects associated with increasing doses, and, if possible, to **gain early evidence of effectiveness**." This early evidence of effectiveness is the grounding for therapeutic intent – both in the choice of oncologists and patients to enroll in the trial, and as one of the aims of the trial.

Although the scientific goals of a phase 1 trial are to determine the toxic effects, pharmacologic behavior, and recommended doses for future study of a new agent, there is always a strong preclinical

[1] Available on the NCI website at http://ctep.cancer.gov/handbook/index.html

rationale for bringing the drug into the clinic with the expectation of positive clinical outcomes for some patients.[2] In fact, Institutional Review Boards would not permit the administration of potentially toxic treatments to patients unless there was some reasonable prospect of antitumor effect.[3] It is also important to note that phase 1 oncology treatment trials are **never** done in healthy volunteers because of the potential toxicities associated with the treatments under investigation.

Additionally, many of the NCI phase 1 trials involve agents that are already approved for the treatment of one type of cancer and are being studied in a different type of cancer, or in combination with other treatments. As a result, we have some evidence of therapeutic effectiveness that provides solid grounding on which to base therapeutic intent. Indeed, an analysis of 12,000 individuals who participated in 460 NCI-funded phase 1 trials done in 2005 found that 10.6% of patients experienced an objective response. This number increased to 17.8% of patients when one drug included in the trial regimen was already FDA-approved.[4]

Furthermore, our growing knowledge of the molecular basis of cancer is allowing us to increasingly develop treatments that are targeted to particular molecular pathways and personalized to specific patient populations. These types of agents will provide a "high pretreatment probability of achieving both an objective response and more subjective clinical benefit" for the trial participants.[5]

To bring about these exciting new developments in cancer treatment, clinical trials participation is required. It is particularly important in the Medicare-aged population not only because of the increased incidence of cancer in the elderly and but also to develop our understanding of how treatments work in this population. Both the NCI and FDA definitions demonstrate that phase 1 oncology trials meet the requirements for Medicare coverage, including therapeutic intent, and should be covered.

Sincerely,

Raymond N. DuBois, MD, PhD
President
American Association for
Cancer Research

Edward J. Benz, Jr., MD
President
Association of American
Cancer Institutes

Richard L. Schilsky, MD
President
American Society of
Clinical Oncology

[2] ASCO: Critical role of phase 1 clinical trials in cancer treatment. J Clin Oncol 15:853-859, 1997.
[3] Kodish E, Stocking C, Ratain MJ, et al: Ethical issues in phase I oncology research: A comparison of investigators and IRB chairpersons. J Clin Oncol 10:1810-1816, 1992.
[4] Horstmann E, McCabe MS, Grochow L, et al: Risks and benefits of phase 1 oncology trials, 1991 through 2002. New Engl J Med 352:895-905, 2005.
[5] Markman M: Further evidence of clinical benefits associated with participation in phase 1 oncology trials. B J Cancer 98:1021-1022, 2008.

NFIB
The Voice of Small Business®

Alaska

January 20, 2009

The Honorable Bettye Davis
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

RE: Senate Bill 10

Dear Senator Davis,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 10. The National Federation of Independent Business is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues.

For many small employers in Alaska insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates

Unfortunately, SB10 mandates specified coverage of medical care coverage during specified clinical trials that may not fit employee's needs but for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced

National Federation of Independent Business — ALASKA
P.O. Box 34761 • Juneau, AK 99803 • 907-723-6667 • denny.dewitt@nfib.org

by increased prices to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

SB 10 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by the state and other governmental entities or large employers who typically offer ERISA programs. Thus it creates a less fair business environment for small employers.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

SB

11

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Labor and Commerce
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/18/09

Health and Social Services Committee considered SENATE BILL NO. 11

SB 11 DEPENDENT HEALTH INSURANCE; AGE LIMIT

"An Act relating to health care insurance coverage of a dependent child who is less than 26 years of age and making a conforming age amendment in the statute describing health insurance policies that may be delivered or issued in this state."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
UA	3/6	✓			1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
Dave Patkun	Patkun	X			
Fred Dyson	Dyson			X	
CHAIR: Betty Davis	DAVIS	X			

3003

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 11, 26-LS0074\A

"An Act relating to health care insurance coverage of a dependent child who is less than 26 years of age and making a conforming age amendment in the statute describing health insurance policies that may be delivered or issued in this state."

Sponsor Statement

SB 11 requires an insurer to enroll, and prohibits taking off the rolls or eliminating health care insurance coverage without the consent of the insured, for a person less than 26 years old who is related to the insured, unmarried, financially dependent on the insured, does not have dependents, enrolled in an institution of higher education, and not insured under another policy. SB 11 changes the age that a person is considered a child from 23 years of age to 26 for purposes of determining who may be insured under the same policy of health insurance.

Young adults, ages 19-29, are one of the largest growing segments of the U.S. population without health insurance. In 2004 almost 14 million young adults lacked coverage, an increase of 2.5 million since 2000. This rapid change is due in part to their losing coverage under their parents' policies at 19, or Medicaid, or State Children's Health Insurance Program, or graduation from high school or college. Almost half of college graduates and high graduates will be uninsured for a substantial time after graduation.

Age 19 is a crucial year in health insurance coverage. Both public and private insurance plans treat this age as a turning point for insurance coverage. Even if youth go on to college, parents' insurance plans often stop before graduation. Almost all private universities and about one fourth of public universities require health insurance as a condition of enrollment. Forty percent of part-time students and non-students, and 20% of full-time students ages 19-23 are uninsured.

Insurance coverage is important for this generally healthy group of young adults who should be encouraged to start taking responsibility for their own health care. It has been found that 14% of adults 18-29 are obese, an increase of 70% in the 1990s, - the fastest rate of increase among all adults. There are 3.5 million pregnancies each year among the 21 million women ages 19-29. One-third of all diagnoses of HIV are made among young adults. Emergency room visits are far more common among young adults than children or older adults. Most young adults have no regular doctor, no link to the health care system, and more than one-third of those who do require medical attention are often saddled with debt and collection agencies.

States are taking action to mandate coverage for young adults, often allowing for targeted policy options. For example, in 2006 New Jersey required most group health plans to cover single adult dependents up to age 30. Massachusetts as part of its expanded health insurance law in 2006 considered dependents for insurance purposes up to age 25 or for two years after they are no longer claimed on their parents' tax returns. Since 1994 Utah has required coverage through age 26, and New Mexico provides coverage for unmarried dependents up to age 25, regardless of school enrollment. Texas in 2003 allowed full-time students up to be covered by their parents' insurance plans to age 25. It is not uncommon, or unreasonable, therefore, that Senate Bill 179 requires offering family health insurance coverage to dependent children up to age 26.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 2, 2009

SUBJECT: Health insurance for a person who is 26 years of age (SB 11)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Dennis C. Bailey
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. Requires an insurer to enroll, and prohibits disenrolling or eliminating health care insurance coverage without the consent of the insured, for a person less than 26 years old who is related to the insured, unmarried, financially dependent on the insured, does not have dependents, enrolled in an institution of higher education, and not insured under another policy.

Section 2. Changes the age that a person is considered a child from 23 years of age to 26 years of age for purposes of determining who may be insured under the same policy of health insurance.

DCB:plm
09-061.plm

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB011
() Publish Date:

Identifier (file name): SB011-UA-03-06-09
Dept. Affected: University of Alaska
Title: Health Care Insurance Coverage of dependent children
RDU: Various
Component:
Sponsor: Senator Davis
Requester: Health and Social Services
Component Number:

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	1,200.0	1,200.0					
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**1,200.0**	**1,200.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	1,200.0	1,200.0					
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	**1,200.0**	**1,200.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time	0.0						
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The University of Alaska currently has 200 non-active dependents between the ages of 24 and 26 who would become re-eligible for health care insurance coverage if this bill were to pass. The expected annual increased cost to UA would be approximately $1.2 million

Prepared by: Alesia Kruckenberg
Phone 907-450-8426
Division: University of Alaska
Date/Time 03/06/2009 12:00pm
Approved by: Michelle Rizk
Date 3/6/2009
University of Alaska

(Revised 9/10/2008 OMB)

NFIB
The Voice of Small Business®

Alaska

January 20, 2009

The Honorable Bettye Davis
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

RE: Senate Bill 11

Dear Senator Davis,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 11. The National Federation of Independent Business is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues.

For many small employers in Alaska insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates

Unfortunately, SB11 mandates coverage for dependents to age 26 that may not fit employee's needs but for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices to eliminate health

National Federation of Independent Business — ALASKA
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insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

SB 11 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by the state and other governmental entities or large employers who typically offer ERISA programs. Thus it creates a less fair business environment for small employers.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

National Conference of State Legislatures

LEGISBRIEF

BRIEFING PAPERS ON THE IMPORTANT ISSUES OF THE DAY

JUNE/JULY 2008 VOL. 16, NO. 29

Health Insurance Coverage for Young Adults

By Laura Tobler

Young adults are at risk of being uninsured.

Young adults between the ages of 19 and 29 are at risk of being uninsured more often than any other age group. Eleven percent of the nation's children through age 18 are uninsured, while 30 percent of those between the ages of 19 and 29 lack coverage.

Percent Uninsured Children and Young Adults by Federal Poverty Level*, 2005

Income Level	Children Age 18 and Younger	Young Adults Ages 19 to 29
Total	11%	30%
Makes less than 100% FPL	20	51
Makes between 100% - 199% FPL	16	42
Makes more than 200% FPL	7	16

*Federal poverty level (FPL) guidelines are used to determine financial eligibility for many government programs.

Source: Analysis of the March 2006 Current Population Survey by S. Giled and B. Mahato for the Commonwealth Fund.

Graduation from high school or college may mean loss of health insurance.

Young adults typically lose health insurance coverage under a parent's or guardian's policy at age 19 or upon college graduation. Most parents who cover their children or dependents do so through their employer's health insurance benefits. Sixty percent of employer health plans do not cover young adults after they reach age 19 if they are not enrolled full time in college. In the first year after graduation, about 40 percent of college graduates and 50 percent of high school graduates who do not enroll in college will be uninsured.

Eligibility for coverage as a child under Medicaid and the State Children's Health Insurance Program ends when the child reaches age 19. To remain covered by either of these public programs, children must meet the more restricted eligibility standards for an adult that, in most states, is limited to very low-income parents and adults with disabilities. As a result, most young adults are dropped from public coverage when they reach age 19.

Employment and lifestyle affect young adults' ability to obtain coverage.

The employment opportunities for and lifestyles of young adults also affect their ability to get health insurance. Young adults often move in and out of school and jobs throughout their 20s—working part-time while attending school, changing jobs for personal or professional reasons, or taking time off from school to work and then returning to school. This affects their ability to remain on their parent's or guardian's policy or to become eligible for employer-sponsored insurance. When they enter the workforce, young adults are more often faced with low-wage, temporary or hourly positions that typically do not include benefits. If they are hired by an employer who offers benefits, young adults may have a three- to six-month waiting period before coverage begins.

National Conference of State Legislatures

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William T. Pound

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3010

Purchasing private health insurance coverage as an individual is unaffordable for many uninsured young adults who disproportionately reside in low-income households. About 50 percent of uninsured young adults between the ages of 19 and 29 reside in households with incomes below the federal poverty level ($21,200 per year for a family of four).

Many young adults cannot afford private health insurance coverage.

2008 Department of Health and Human Services Poverty Guidelines			
People in Family or Household	48 Contiguous States and District of Columbia	Alaska	Hawaii
1	$10,400	$13,000	$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

Source: *Federal Register* 73, no. 15 (Jan. 23, 2008): 3971-3972.

State Action Several states have enacted legislation to extend dependent benefits to older children and to young adults who are not enrolled in college. In 1994, Utah became the first state to enact legislation allowing coverage to continue for unmarried dependents up to age 26, regardless of whether the dependent is enrolled in school. A 2006 New Jersey law requires most group health plans to offer health insurance coverage (at the option of the insured) to unmarried dependents up to age 30. At least 21 states—including Colorado, Connecticut, Florida, Idaho, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, Utah and Washington—have passed this type of legislation.

Expanded coverage for young adults may be structured as an insurance policy rider with a supplemental premium. In New Jersey, for example, the insurance provider may charge a higher rate, which cannot exceed 3 percent of the premium. More commonly, coverage is extended to all policies, and the young adult is simply covered by the family premium. Some experts predict that the latter strategy may increase employer premiums for family coverage by about 5 percent to 9 percent.

Federal Action Under current Internal Revenue Service (IRS) regulations, children must meet specific requirements to be considered a dependent for tax purposes, including relying on the parent or guardian for more than half of their financial support. If the dependent who is eligible for coverage based on a state law does not meet the requirements for the IRS definition of dependent, the value of the benefit is taxable income for the employee. This could create an administrative burden for some employers.

IRS regulations define dependent for tax purposes.

Health insurance coverage under the Federal Employees Health Benefits Program for government employees and members of Congress currently is available for unmarried dependent children up to age 22.

Contacts for More Information

Laura Tobler
NCSL—Denver
(303) 364-7700, ext. 1545
laura.tobler@ncsl.org

NCSL's Dependent Coverage website
www.ncsl.org/programs/health/dependentstatus.htm

2008 POVERTY LEVEL GUIDELINES

ALASKA

Income Guidelines as Published in the Federal Register on January 23, 2008

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	120%	133%	135%	150%	175%	185%	200%	250%
1	13,000.00	15,600.00	17,290.00	17,550.00	19,500.00	22,750.00	24,050.00	26,000.00	32,500.00
2	17,500.00	21,000.00	23,275.00	23,625.00	26,250.00	30,625.00	32,375.00	35,000.00	43,750.00
3	22,000.00	26,400.00	29,260.00	29,700.00	33,000.00	38,500.00	40,700.00	44,000.00	55,000.00
4	26,500.00	31,800.00	35,245.00	35,775.00	39,750.00	46,375.00	49,025.00	53,000.00	66,250.00
5	31,000.00	37,200.00	41,230.00	41,850.00	46,500.00	54,250.00	57,350.00	62,000.00	77,500.00
6	35,500.00	42,600.00	47,215.00	47,925.00	53,250.00	62,125.00	65,675.00	71,000.00	88,750.00
7	40,000.00	48,000.00	53,200.00	54,000.00	60,000.00	70,000.00	74,000.00	80,000.00	100,000.00
8	44,500.00	53,400.00	59,185.00	60,075.00	66,750.00	77,875.00	82,325.00	89,000.00	111,250.00

For family units of more than 8 members, add $4,500 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	120%	133%	135%	150%	175%	185%	200%	250%
1	1,083.33	1,300.00	1,440.83	1,462.50	1,625.00	1,895.83	2,004.17	2,166.67	2,708.33
2	1,458.33	1,750.00	1,939.58	1,968.75	2,187.50	2,552.08	2,697.92	2,916.67	3,645.83
3	1,833.33	2,200.00	2,438.33	2,475.00	2,750.00	3,208.33	3,391.67	3,666.67	4,583.33
4	2,208.33	2,650.00	2,937.08	2,981.25	3,312.50	3,864.58	4,085.42	4,416.67	5,520.83
5	2,583.33	3,100.00	3,435.83	3,487.50	3,875.00	4,520.83	4,779.17	5,166.67	6,458.33
6	2,958.33	3,550.00	3,934.58	3,993.75	4,437.50	5,177.08	5,472.92	5,916.67	7,395.83
7	3,333.33	4,000.00	4,433.33	4,500.00	5,000.00	5,833.33	6,166.67	6,666.67	8,333.33
8	3,708.33	4,450.00	4,932.08	5,006.25	5,562.50	6,489.58	6,860.42	7,416.67	9,270.83

May 2006

Issue Brief

Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help

Sara R. Collins, Cathy Schoen, Jennifer L. Kriss, Michelle M. Doty, and Bisundev Mahato*

ABSTRACT: Young adults (ages 19 to 29) are one of the largest and fastest-growing segments of the U.S. population without health insurance: 13.7 million lacked coverage in 2004, an increase of 2.5 million since 2000. Young adults often lose coverage under their parents' policies, Medicaid, or the State Children's Health Insurance Program at age 19, or when they graduate from high school or college. Nearly two of five college graduates and one-half of high school graduates who do not go on to college will be uninsured for a period during the first year after graduation. Three policy changes could extend coverage to uninsured young adults and prevent others from losing it: extending eligibility for Medicaid and the State Children's Health Insurance Program beyond age 18; extending eligibility for dependents under private coverage beyond age 18 or 19 regardless of student status; and ensuring that colleges and universities require full- and part-time students to have insurance, and that they offer coverage to both.

* * * * *

OVERVIEW

Young adults between the ages of 19 and 29 represent one of the largest and fastest-growing segments of the population without health insurance in the United States. Often dropped from their parents' policies or public insurance programs at age 19 or on graduation day, they are left to find insurance on their own as they make the transition from high school to work or college.

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This is a revision of the issue brief *Rite of Passage*, first released in May 2003. It updates analyses with new data from the March 2005 Current Population Survey, the 2003 Medical Expenditure Panel Survey, and the Commonwealth Fund Biennial Health Insurance Survey (2005). It also provides new information on state legislation and other proposals recently introduced to increase health insurance coverage among young adults.

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Yet, jobs available to young adults are usually low-wage or temporary—the type that generally do not come with health benefits. Young adults who are able to go to college full-time may have some protection through their parents' policies, but upon graduation usually lose access to family coverage.

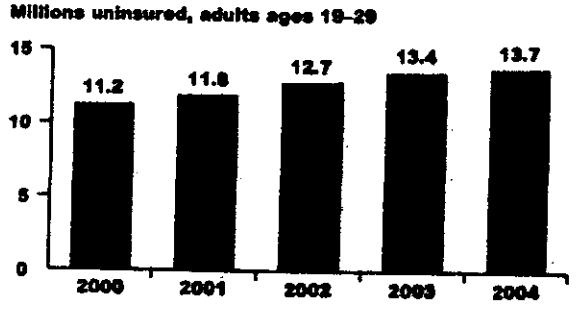
Moving on and off coverage places the health of young adults at risk and subjects them and their families to financial stress just as they are starting out in the workforce. This issue brief assesses the scope of the health insurance problem facing young adults, its causes and implications, and what can be done to ensure stable and continuous coverage. It also offers some targeted policy steps that could help young adults stay insured as they make the transition to independent living.

A LARGE AND GROWING PROBLEM

The number of uninsured young adults ages 19 to 29 climbed to 13.7 million in 2004, an increase of 2.5 million since 2000 (Figure 1). Young adults were the fastest-growing age group among the uninsured over this period, accounting for 40 percent of the increase in the uninsured under age 65. Even though they comprise just 17 percent of the under-65 population, young adults account for 30 percent of the nonelderly uninsured.[1]

By far, the young adults most at risk of lacking coverage are those from low-income households.

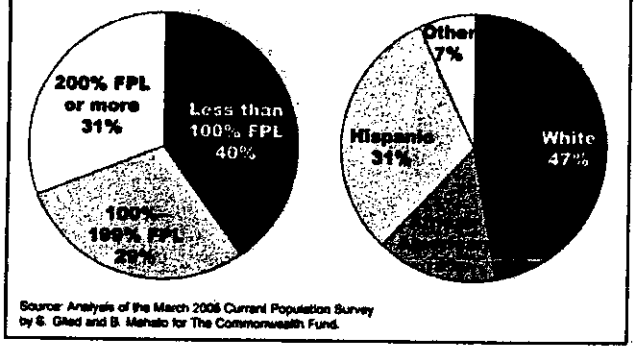
Figure 1. Uninsured Young Adults Up by 2.5 Million in Last Four Years



Source: Analyses of the March 2001–2005 Current Population Surveys by S. Glied and B. Mahato for The Commonwealth Fund.

These individuals, like children and older adults in low-income families, are disproportionately represented among the uninsured. About 23 percent of adults ages 19 to 29 live in households with incomes below 100 percent of the poverty level, but two-fifths (40%) of the 13.7 million young adults who are uninsured live in households with incomes below poverty (Figure 2).[2]

Figure 2. Distribution of Uninsured Young Adults Ages 19–29 by Poverty Status and Race/Ethnicity, 2004



Source: Analysis of the March 2005 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

Nearly half of uninsured young adults are white. But Hispanics are disproportionately represented among the young and uninsured. While Hispanics comprise 19 percent of adults ages 19 to 29, they comprise 31 percent of uninsured young adults (Figure 2). Hispanics and African Americans are both at greater risk of being uninsured than white young adults: about 36 percent of African Americans and 52 percent of Hispanics ages 19 to 29 are uninsured, compared with 24 percent of whites in that age range (data not shown).

WHAT A DIFFERENCE A YEAR CAN MAKE

Nineteenth birthdays are crucial milestones in Americans' health insurance coverage. Both public and private insurance plans treat this age as a turning point for coverage decisions. Employer health

plans often do not cover young adults as dependents after age 18 or 19 if they do not go on to college. Public programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), also typically have one set of income and eligibility standards for children and another for adults, with the 19th birthday as the critical divide.

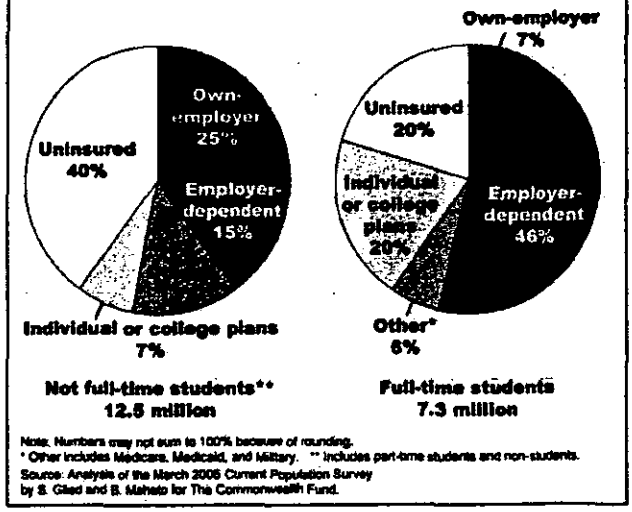
Losing Coverage Under a Parent's Policy

Employer-sponsored health insurance is the mainstay of most family and dependent coverage. Typically, such policies cover children as dependents as long as they meet eligibility rules. Age 18 or 19 tends to be a crucial turning point, after which coverage most often continues only for those young adults who attend college full-time. A 2004 Commonwealth Fund study found that, among employers who offer coverage, nearly 60 percent do not insure dependent children over age 18 or 19 if they do not attend college.[3]

Young adults who enroll in college full-time when they graduate from high school are the most likely in their age group to have insurance coverage, primarily because they are able to maintain eligibility under their parents' employer's policies. A small share of full-time students also gains coverage through plans offered by universities. Roughly 25 percent of public universities and about 90 percent of private universities and colleges require that students have health insurance as a condition of enrollment.[4] Idaho, Massachusetts, and New Jersey have passed either legislative or administrative rulings requiring that students have health insurance in order to enroll.[5] About half (46%) of full-time students ages 19 to 23 receive health insurance through their parents' employer-sponsored plans, while another 20 percent have individual coverage, including college and university plans (Figure 3).

Young adults who are not in school full-time post-high school graduation are much more likely to be uninsured, primarily because it is much harder for them to gain access to employer coverage.

Figure 3. Insurance Sources for College-Age Adults Ages 19–23, 2004



Note: Numbers may not sum to 100% because of rounding.
* Other includes Medicare, Medicaid, and Military. ** Includes part-time students and non-students.
Source: Analysis of the March 2005 Current Population Survey by S. Glied and S. Maheta for The Commonwealth Fund.

Forty percent of part-time and non-students ages 19 to 23 are uninsured, compared with 20 percent of full-time students. Young adults who opt to enter the labor market rather than go to college are unlikely to be eligible for coverage under their parents' policies, and may have difficulty finding a job with health benefits. New entrants to the labor market without college educations are often candidates for positions that are the least likely to come with health benefits—those that pay low wages, are in small companies, or are part-time or temporary in nature.[6] The Commonwealth Fund Biennial Health Insurance Survey (2005) found that 43 percent of all workers ages 19 to 29 who earn less than $10 per hour are uninsured.[7] Almost one-third (31%) of workers between ages 19 and 29 have jobs that pay less than $10 per hour.[8]

Losing Medicaid/SCHIP Coverage at Age 19

Medicaid and SCHIP reclassify all teenagers as adults the day they turn 19. As a result, young adults who had been insured under Medicaid or SCHIP as children typically do not have an option to stay on public coverage unless they are able to qualify for Medicaid as adults. Regardless of

school, work, or dependent status, they lose their eligibility as dependents or children. Most low-income young adults become ineligible for public programs, since eligibility for adults generally is restricted to very low-income parents or disabled adults. Even teenagers with disabilities who qualified for Medicaid before their 19th birthdays have to go through a new set of screening tests to determine whether they will still be eligible for benefits as disabled adults.[9]

Net Impact of the 19th Birthday

As a result of the combined impact of such public and private insurance rules, uninsured rates jump sharply at age 19. Turning 19 increases the risk of being uninsured by more than twofold: the uninsured rate rises from 12 percent among children age 18 and under to 31 percent among those ages 19 to 29 (Figure 4).

Figure 4. Percent Uninsured, Children and Young Adults, by Poverty Level, 2004

Percent Uninsured	Children Age 18 and Under	Young Adults Ages 19–29
Total	12%	31%
<100% FPL	20	54
100%–199% FPL	17	42
≥200% FPL	7	18

Source: Analysis of the March 2005 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

Low-income young adults are particularly vulnerable. Among those living in families below the poverty level, more than half (54%) are uninsured, compared with about one of five (20%) children in low-income families. Those with slightly higher incomes (100% to 199% of poverty) fare only marginally better—roughly two of five (42%) are uninsured.

THE (UNINSURED) GRADUATE

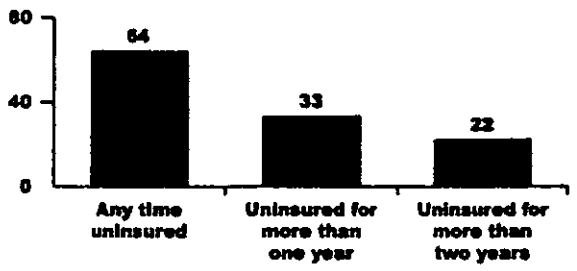
The transitional nature of young adults' lives following their 19th birthday makes it difficult to secure a stable and consistent source of health insurance coverage. Young adults move in and out of school and jobs throughout their 20s. Full-time students might take a leave of absence from school, attend college part-time, or graduate—effectively closing off access to their parents' insurance policies or university-sponsored plans. In addition, job tenure is shorter among younger workers, thus increasing the risk that they will be without health insurance coverage for periods of weeks, months, or even years.

Surveys that track people over time provide an opportunity to examine what happens to the insurance coverage of young adults as they graduate from high school or college or move through their early adult years. The federal multiyear longitudinal survey known as SIPP (Survey of Income and Program Participation) interviewed a sample of people about their health insurance and other characteristics in 1996 and tracked their history through 2000.

The four-year insurance history of all young adults who were ages 19 to 23 at the beginning of 1996 reveals the extent to which life transitions disrupt insurance coverage. Over the 1996–2000 period, two-thirds (64%) of this cohort of young adults went without coverage for at least part of the time (Figure 5).[10] One-third were uninsured for more than a year, while one-fifth were uninsured for more than two years.

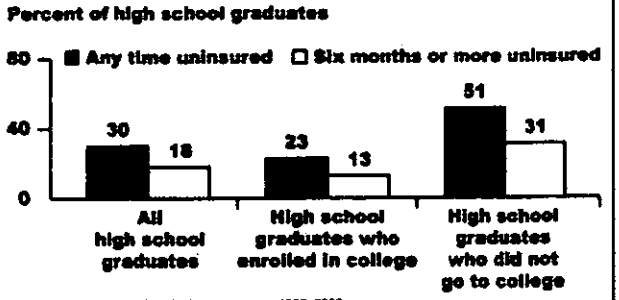
Young adults from households with low incomes were most exposed: they were both more likely to go without insurance for at least some period and more likely to endure long periods without insurance. Nearly 80 percent of young adults living under 200 percent of the poverty level were uninsured for at least part of the four-year period; more than half (52%) were uninsured for 13 months or more (Table 1). Reflecting their generally lower incomes, Hispanic and African American young adults were at similarly high risk of losing insurance and experiencing long spells

Figure 5. Percent of Young Adults Who Had a Time Uninsured During Four Years, 1996–2000*



* People who were 19–23 in 1996 were followed over 1996–2000. Data show what percent had time uninsured during that period.
Source: Analysis of the 1996 Panel of the Survey of Income and Program Participation by P. F. Short and D. Graefe for The Commonwealth Fund.

Figure 6. Percent of High School Graduates with Gaps in Insurance Coverage in the Year Following Graduation, by Student Status, 1996–2000*



* People who graduated from high school during 1996–2000.
Source: Analysis of the 1996 Panel of the Survey of Income and Program Participation by P. F. Short and D. Graefe for The Commonwealth Fund.

without coverage. Fifteen percent of Hispanic young adults ages 19 to 23 at the beginning of the four years were uninsured for the entire period.

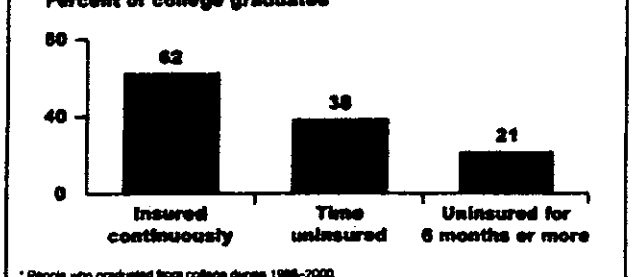
Graduation: High School and College

Tracking people over time also reveals how the major life events of early adulthood noted in this brief disrupt insurance coverage.

Graduation from high school marks a key juncture in the health insurance coverage of young adults. Tracking a sample of young adults in the year following graduation reveals the extent to which college enrollment is correlated with more secure insurance coverage. Among all young adults graduating from high school, three of 10 were uninsured for some time in the year following high school (Figure 6). Half of young adults who graduated from high school but did not go to college were uninsured for some time during the year following their graduation—twice the rate for young adults who attended college that year.

Among those young adults who go to college, the year following their college graduation also can be a time during which connections to the health system are fragile and break down. The protections afforded them by virtue of being a full-time student—coverage through a parent's employer policy or a student health plan—are lost upon graduation. As new, albeit college-educated, entrants to the labor force, they confront similar hazards that high school graduates face: waiting periods, temporary positions, lower-wage jobs, employment in small firms, and job turnover. Of those college students who graduated during 1996 to 2000, 38 percent were uninsured for at least part of the time in the year following graduation, with 21 percent uninsured for six months or more (Figure 7). Based on the experiences of recent graduates, nearly two of five college graduates can expect to spend at least some time uninsured in the year just after graduation.

Figure 7. Nearly Two of Five College Graduates Had Time Uninsured in Year Following Graduation, 1996–2000*



* People who graduated from college during 1996–2000.
Source: Analysis of the 1996 Panel of the Survey of Income and Program Participation by P. F. Short and D. Graefe for The Commonwealth Fund.

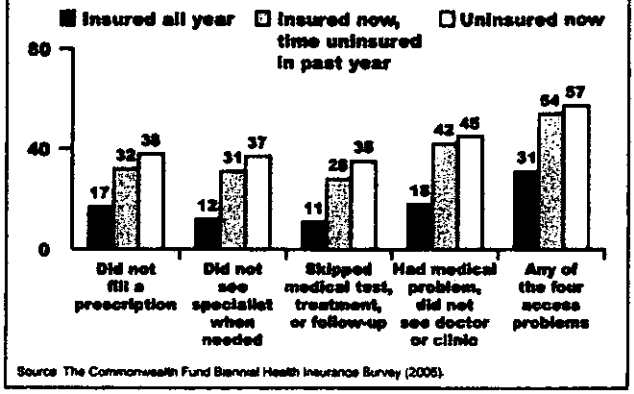
WHY COVERAGE IS IMPORTANT FOR YOUNG ADULTS

Although young adults in general constitute a healthy group, going without insurance disrupts their access to the health care system, introduces barriers to care when it is needed, and leaves young adults and their families at risk for high out-of-pocket costs in the event of a severe illness or injury. Young adults, particularly women, are in need of regular preventive care. If young adults lose their coverage at age 19 or upon graduation from college, their ties with primary care physicians may be severed at precisely the time they should be forming stronger links to the health care system and taking responsibility for their own care. The following are just a few reasons coverage is so important for young adults:

- Fourteen percent of adults ages 18 to 29 are obese. In the 1990s, obesity increased by 70 percent in this age group—the fastest rate of increase among all adults.[11]
- There are 3.5 million pregnancies each year among the 21 million women ages 19 to 29.[12]
- One-third of all HIV diagnoses are made among young adults.[13]
- Injury-related visits to emergency rooms are far more common among young adults than they are among either children or older adults.[14]
- More than 20,000 people with congenital heart disease reach their 19th birthday each year.[15]

The Commonwealth Fund Biennial Health Insurance Survey (2005) shows that being uninsured or having unstable health insurance hampers access to the health care system. More than half (54%–57%) of young adults ages 19 to 29 who either were uninsured for the entire year or had a time without coverage said that they had gone without needed health care because of cost (Figure 8). Forgone care included failing to fill a prescription, not seeing a doctor or specialist when sick, or skipping a recommended medical test, treatment, or follow-up visit.

Figure 8. Lacking Health Insurance for Any Period Threatens Young Adults' Access to Care, 2005



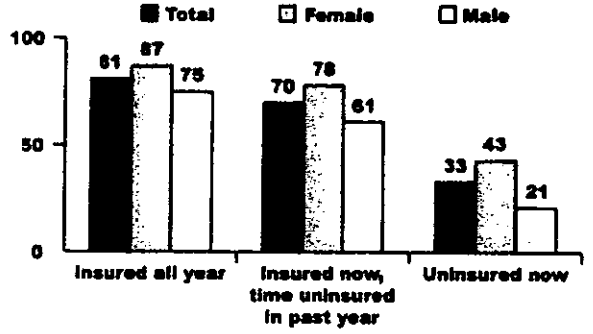
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

In addition, uninsured young adults are far less likely than those with coverage to have a regular doctor. Only one-third of uninsured young adults ages 19 to 29 had a regular doctor, compared with 81 percent of those who were insured all year (Figure 9). Uninsured female young adults had regular doctors at about half the rate of young women who were insured all year. Male young adults who were uninsured had the most fragile link to the health care system: just 21 percent had a regular doctor compared with 75 percent of male young adults who were insured all year.

Many young adults have problems paying medical bills or are paying off medical debt over time. More than one-third (35%) of all young adults, both insured and uninsured, said that they had experienced problems with medical bills: having trouble making payments, being contacted by a collection agency because of inability to pay

Figure 9. Young Adults Without Insurance Are Less Likely to Have a Regular Doctor, 2005

Percent of adults ages 19-29 who have a regular doctor



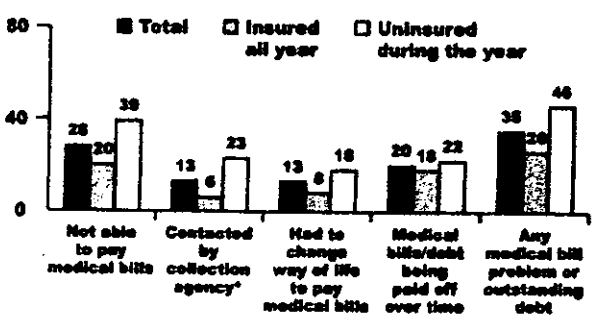
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005)

bills, significantly changing their way of life in order to pay medical bills, or paying off medical debt over time (Figure 10). About one of five (20%) young adults were paying off medical debt over time. Uninsured young adults were the most burdened with medical bills and debt; 46 percent reported at least one of the aforementioned problems.

Contrary to conventional wisdom, young adults appear to value the protection that health insurance coverage provides. The Commonwealth Fund Biennial Health Insurance Survey (2005) found that nearly three-quarters (73%) of employed young adults accept health insurance coverage when it is offered to them, only slightly less than the take-up rate (82%) of workers age 30 or older (Table 2).

Figure 10. Young Adults with Any Time Uninsured Have High Rates of Medical Bill Problems, 2005

Percent of adults ages 19-29 who had the following problems in past year:



* Includes only those whose bill was sent to a collection agency when they were unable to pay the bill.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005)

POLICY OPTIONS TO HELP YOUNG ADULTS STAY INSURED

Health insurance coverage of young adults would be improved by system-wide changes to expand access to and stabilize coverage among the general population. Some recent proposals to achieve near-universal coverage would build on the existing health insurance system, and several have included specific provisions to increase coverage among young adults in current private and public insurance arrangements.[16] For example, The Commonwealth Fund's Karen Davis and Cathy Schoen have proposed a framework for achieving near-universal coverage that includes a requirement for companies to extend coverage to dependent young adults under age 23 through their parents' insurance plan.[17] Other proposals would expand coverage for children as well as young adults, or exclusively target young adults. Senator Jay Rockefeller (D-W.Va.) and Representative Pete Stark (D-Calif.) have introduced legislation creating a Medicare-like program for children that will eventually cover young adults up to age 23.[18] Representative Vic Snyder (D-Ark.) and Senator Blanche Lincoln (D-Ark.) have introduced legislation that would permit states to cover low-income young adults under Medicaid and SCHIP up to age 23.[19] Senate Republicans have proposed financial incentives for colleges and universities that provide or require health insurance for full-time students.[20]

Recent State Action

In the absence of federal action to expand coverage, several states have recently passed or are considering legislation to substantially increase the age

of dependency for young adults for private insurance coverage eligibility status.[21] In general, these laws apply to plans covered under state insurance regulations and thus would not apply to self-insured employers.

In a law taking effect in May 2006, New Jersey will require most group health plans to cover single adult dependents up to age 30 (Table 3).[22] A Colorado law that became effective in January 2006 requires group and privately purchased individual health plans to cover unmarried dependents up to age 25.[23] Dependents must be unmarried or financially dependent, or live at the same address as the parent(s), but eligibility is not dependent on full-time enrollment in school. The New Jersey and Colorado laws both allow insurers to charge a separate premium for extended dependent coverage.

As part of Massachusetts' April 2006 health insurance expansion law, young adults are considered dependents for insurance purposes up to age 25 or for two years after they are no longer claimed on their parents' tax returns, whichever comes first.[24]

Utah has required insurance policies that include dependent coverage to cover unmarried dependents through age 26 since 1994,[25] and New Mexico requires that all insurance policies provide coverage for unmarried dependents up to age 25, regardless of school enrollment.[26]

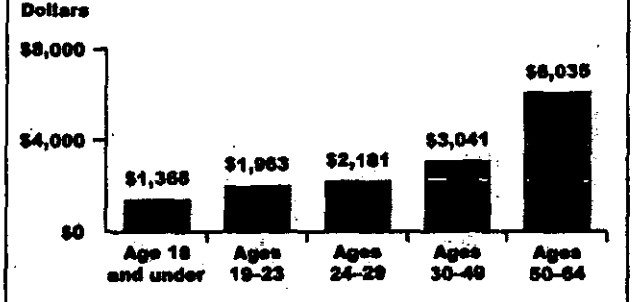
A Texas law effective in September 2003 allows full-time students up to age 25 to be covered by their parents' insurance plans.[27] South Dakota prohibits any insurance provider that offers dependent benefits from terminating coverage before age 19, or 24 if the dependent is a student.[28]

Several state legislatures are considering similar laws. Rhode Island is currently considering a bill that would phase in, through 2009, coverage of unmarried and financially dependent young adults up to age 25.[29] And a California bill that was passed by the state legislature but vetoed by the governor would have prohibited health plans that cover dependent children from establishing a limiting age for coverage of less than 26 years.[30] The bill is expected to be submitted to the governor for consideration again this year.

Targeted Policy Options

Whether as part of a broader expansion plan or implemented on their own, targeted policy options like those recently pursued by states could improve access to coverage for young adults and help them stay insured during the transition to independence. This is a relatively low-cost group to insure: young adults generally are healthier than older adults and therefore have far lower per capita health care expenditures (Figure 11).[31] Indeed, keeping young adults in insurance pools may have the effect of lowering the average costs for group insurance.

Figure 11. Annual Per Capita Total Health Expenditures by Age Group, 2006*



* Inflated to 2006 dollars using actual and estimated annual growth rates in national health expenditures.
Source: Analysis of the 2003 Medical Expenditure Panel Survey by S. Glied and S. Mahato for The Commonwealth Fund.

Three different public or private policy changes could extend coverage to a substantial portion of uninsured young adults and prevent others from losing coverage in the future.

1. *Extend eligibility for Medicaid/SCHIP public coverage beyond age 18.* Congress could allow or require states to extend coverage to those young adults in Medicaid and SCHIP who lose their eligibility because of age, with federal matching funds provided. Young

adults in households with incomes under 100 percent of poverty are by far the group most at risk of lacking health insurance coverage. Such an expansion would have the biggest impact in terms of lowering the number of uninsured young adults. Young adults with incomes of 100 percent to 199 percent of poverty also lack insurance at a high rate. As proposed in the Snyder and Lincoln legislation, states would have the option of extending coverage up to a target age such as 23, and could phase in coverage one year at a time. Alternatively, Congress could require states to extend coverage to those currently enrolled in the programs and who "age off," just as states are now required to extend Medicaid coverage to those who become ineligible because of higher earnings.[32] Such a policy change could help the 2.9 million uninsured young adults ages 19 to 23 with incomes under 100 percent of poverty.

2. *Extend eligibility for dependents under private coverage beyond age 18 or 19.* Private insurers and both public and private employers could be required to define dependent coverage as all unmarried dependents beyond age 18 or 19. As noted above, many states have recently redefined the age at which a young adult is no longer a dependent—from age 25 in Colorado and New Mexico up to age 30 in New Jersey. Some private and public employers already provide such coverage voluntarily. Under the Federal Employees Health Benefits Program, federal employees and members of Congress currently enjoy coverage for unmarried dependent children under age 22.[33] Such an expanded benefit could either be structured as a rider with a supplemental premium or simply be extended to all policies and covered by the family premium. Even increasing the age to 23 could cover an estimated 1 million unmarried, dependent young adults.[34] If the benefit requirement were extended to family policies, the average premium for those plans would rise by about 3 to 5 percent.[35]

3. *States could ensure that all colleges and universities require full-time and part-time students to have health insurance, and that they offer health insurance coverage to both.* Many colleges and universities already require health insurance coverage as a condition of enrollment, and a handful of states (Idaho, Massachusetts, New Jersey) have legislative or administrative rulings requiring all students at local institutions to be covered. Students at these institutions generally can choose to enroll in a school health plan or provide proof of coverage from another source, usually a parent's employer-based plan. The cost of the school plans, which ranges from about $500 to $2,400 per year, is usually added to tuition along with other required fees.[36] Increasing the number of schools that require students to have health insurance coverage and that offer such coverage through state mandates could help cover the 1.9 million part-time and full-time uninsured students ages 19 to 23. Federal or state subsidies for premiums would help offset the costs of insurance coverage for students.

Notes

[1] All analyses of the March Annual Social and Economic Supplement to the Current Population Survey (CPS), 1987–2005, are from S. Glied and B. Mahato, Columbia University, for The Commonwealth Fund. See Methodology for a description of the CPS.

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[2] In 2004, the under-65 poverty thresholds were $9,827 for one person, $12,649 for two adults, $13,020 for two adults and one child under 18, and $19,157 for two adults and two children under 18. See C. DeNavas-Walt, B. D. Proctor and R. J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2004,* Current Population Reports, Consumer Income (Washington, D.C.: U.S. Census Bureau, Aug. 2005).

[3] S. R. Collins, C. Schoen, M. M. Doty, and A. L. Holmgren, *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace* (New York: The Commonwealth Fund, Mar. 2004).

[4] Communication with S. Beckley, Stephen L. Beckley & Associates, Inc., Fort Collins, Colo.

[5] Ibid.

[6] S. R. Collins, K. Davis, and A. Ho, "A Shared Responsibility: U.S. Employers and the Provision of Health Insurance to Employees," *Inquiry,* Spring 2005 42(1):6–15; S. R. Collins, K. Davis, M. M. Doty, and A. Ho, *Wages, Health Benefits, and Workers' Health* (New York: The Commonwealth Fund, Oct. 2004); S. R. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage, Findings from the 2001 Health Insurance Survey* (New York: The Commonwealth Fund, Mar. 2003); B. Garret, L. M. Nichols, and E. K. Greenman, *Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?* (Washington, D.C.: The Urban Institute, Sept. 2001); S. H. Long and M. S. Marquis, "Low-Wage Workers and Health Insurance Coverage: Can Policymakers Target Them Through Their Employers?" *Inquiry,* Fall 2001 38(3):331–37.

[7] Authors' analysis of the Commonwealth Fund Biennial Health Insurance Survey (2005).

[8] Ibid.

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[11] A. H. Mokdad, E. S. Ford, B. A. Bowman et al., "Prevalence of Obesity, Diabetes, and Obesity-Related Health Risk Factors, 2001," *Journal of the American Medical Association,* Jan. 1, 2003 289(1):76–79; T. A. Hillier and K. L. Pedula, "Complications in Young Adults with Early Onset Type 2 Diabetes: Losing the Relative Protection of Youth," *Diabetes Care,* Nov. 2003 26(11):2999–3005; A. H. Mokdad et al., "The Spread of the Obesity Epidemic in the United States, 1991–1998," *Journal of the American Medical Association,* Oct. 27, 1999 282(16): 1519–22.

[12] K. Quinn, C. Schoen, and L. Buatti, *On Their Own: Young Adults Living Without Health Insurance* (New York: The Commonwealth Fund, May 2000).

[13] Ibid.

[14] National Center for Health Statistics, *Health, United States, 2005* (Hyattsville, Md.: NCHS, Nov. 2005), Table 89.

[15] G. Rosenthal, "Prevalence of Congenital Heart Disease," in *The Science and Practice of Pediatric Cardiology,* Second Edition, A. Garson, J. T. Bricker, D. J. Fisher, and S. R. Neish (eds.) (Baltimore: Williams and Wilkins, 1998), pp. 1095–96.

[16] J. M. Lambrew, J. D. Podesta, and T. L. Shaw, "Change in Challenging Times: A Plan for Extending and Improving Health Coverage," *Health Affairs* Web Exclusive (Mar. 23, 2005):W5-119–W5-132; S. R. Collins, K. Davis, and J. M. Lambrew, *Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals* (New York: The Commonwealth Fund, updated Oct. 2004).

[17] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive (Apr. 23, 2003):W3-199–W3-211.

[18] S. 1303, MediKids Health Insurance Act of 2005; H.R. 3055 MediKids Health Insurance Act of 2005.

[19] H.R. 3040 Health Care for Young Adults Act of 2005; S. 1298 Health Care for Young Adults Act of 2005.

[20] U.S. Senate Republican Task Force on Health Care Costs and the Uninsured, *Building on a Record of Creative Solutions* (May 2004).

[21] See National Conference of State Legislatures, http://www.ncsl.org/programs/health/dependentstatus.htm.

[22] New Jersey Public Act 2005 c.375, http://www.njleg.state.nj.us/2004/Bills/PL05/375_.pdf.

[23] Colorado H.B. 05-1101 Section 10-16-104.3, C.R.S., http://www.leg.state.co.us/Clics2005a/csl.nsf/fsbillcont3/C496911BCAEEE00987256F5100652C3E?Open&file=1101_enr.pdf.

[24] Massachusetts H.B. 4850, http://www.mass.gov/legis/bills/house/ht04/ht04850.htm.

[25] Utah Code, Title 31A-22-610.5, http://www.le.state.ut.us/~code/TITLE31A/htm/31A17101.htm.

[26] New Mexico H.B. 335, http://legis.state.nm.us/Sessions/05%20Regular/final/HB0335.pdf.

[27] Texas H.B. 1446, http://www.capitol.state.tx.us/cgi-bin/tlo/textframe.cmd?LEG=78&SESS=R&CHAMBER=H&BILLTYPE=B&BILLSUFFIX=01446&VERSION=5&TYPE=B.

[28] South Dakota H.B. 1045, Chapter No. 265, http://legis.state.sd.us/sessions/2005/bills/HB1045enr.pdf.

[29] Rhode Island S.B. 2211, http://www.rilin.state.ri.us/Billtext/BillText06/SenateText06/S2211.pdf.

[30] California A.B. 1698, http://www.leginfo.ca.gov/pub/bill/asm/ab_1651-1700/ab_1698_bill_20050913_enrolled.pdf.

[31] Analysis of the Medical Expenditure Panel Survey (MEPS), 2003, by S. Glied and B. Mahato, Columbia University, for The Commonwealth Fund. See Methodology for a description of the MEPS.

[32] J. M. Lambrew and A. Garson, Jr., *Small But Significant Steps to Help the Uninsured* (New York: The Commonwealth Fund, Jan. 2003).

[33] Federal Employees Health Benefits Program Handbook, see http://www.opm.gov/insure/handbook/fehb28.asp.

[34] Analysis of the March 2005 Annual Social and Economic Supplement to the CPS, S. Glied and B. Mahato.

[35] This estimate is based on the costs of adding the estimated number of adults 19 to 23 who currently do not have employer-sponsored health insurance to different types of family policies. The range reflects the average premium increases resulting from spreading those costs across family policies with dependent children (5%) or all non-single policies (3%).

[36] The range reflects the costs of those school health plans that are consistent with standards recommended by the American College Health Association. Communication with S. Beckley, Stephen L. Beckley & Associates, Inc., Fort Collins, Colo.; L. Rosellini, "Healthcare Headaches," *U.S. News & World Report,* Apr. 15, 2002, p. 52.

Table 1. Months Uninsured Among Young Adults, 1996–2000

	Population in millions	Any part of 4-year period	13 months or more	25 months or more	48 months
Total 19–23*	17	64%	33%	22%	6%
Poverty					
≤ 200% FPL	5	79	52	37	12
> 200% FPL	12	57	25	15	3
Race					
White	12	61	29	18	3
Black	2	65	38	25	11
Hispanic	2	76	52	39	15

* People who were 19–23 at beginning of survey in 1996.

Source: Analysis of the 1996 Panel of the Survey of Income and Program Participation by P. F. Short and D. Graefe for The Commonwealth Fund.

Table 2. Availability of and Workers' Eligibility for Employer Insurance (base: workers ages 19–64)

	Total	Ages 19–29	Ages 30–64
Total (millions)	125.8	26.0	99.8
Eligibility			
Employer offers a plan	77%	71%	78%
Eligible for employer plan	71	62	73
Coverage			
Covered through own employer	57	45	60
Covered through someone else's employer	17	15	17
Covered through public program	4	6	3
Individual	5	5	6
Other	3	6	2
Uninsured	15	23	13
Take-up rate of own-employer insurance	80	73	82

Note: Workers include full-time and part-time workers.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Table 3. State Laws That Increase the Age Up to Which Young Adults Are Considered Dependents for Insurance Purposes

State	Year law passed or implemented	Limiting age of dependency status	Applies to non-students?
Colorado	2006	25	Yes
Massachusetts	2006	25[1]	Yes
New Jersey	2006	30	Yes
New Mexico	2005	25	Yes
South Dakota	2005	24[2]	No
Texas	2003	25	No
Utah	1994	26	Yes

[1] Or for two years after they are no longer claimed on their parents' tax returns, whichever comes first.

[2] Age 19 for non-students.

Notes: Four states have passed laws to extend the dependency eligibility age for young adults in the military or who are disabled. Pennsylvania requires that full-time students whose studies are interrupted by military service are considered dependents until they finish school, regardless of age; Illinois requires that full-time students whose studies are interrupted by military service are considered dependents for the amount of time they spent serving, up to age 25. Oregon includes disabled adult children in the definition of dependent; Maine requires that children with a mental or physical disability that prevents them from enrolling in school are considered dependents up to age 24.

Source: National Conference of State Legislatures, *Changing Definition of 'Dependent': Who Is Insured and For How Long?* (Washington, D.C.: NCSL). Available at http://www.ncsl.org/programs/health/dependentstatus.htm.

Methodology

Most data in this issue brief are from four surveys: the March Annual Social and Economic Supplement to the Current Population Survey (CPS), 2000–2005; the Medical Expenditure Panel Survey (MEPS), 2003; the 1996 Panel of the Survey of Income and Program Participation (SIPP); and the Commonwealth Fund Biennial Health Insurance Survey (2005). Sherry Glied and Bisundev Mahato of Columbia University, Mailman School of Public Health, provided analysis of the CPS and MEPS. Pamela Farley Short and Deborah Graefe of Pennsylvania State University, Center for Health Care and Policy Research, provided analysis of the SIPP. The authors analyzed the Commonwealth Fund Biennial Health Insurance Survey.

The CPS, MEPS, and SIPP are federal surveys sponsored by the Census Bureau (CPS and SIPP) and the Agency for Healthcare Research and Quality (MEPS). The CPS, the primary source of information on U.S. labor force characteristics, is conducted monthly on a sample of about 57,000 households representing approximately 140,000 people. The Annual Social and Economic Supplement to the CPS is conducted in March of each year with a sample of about 99,000 households. The MEPS uses an overlapping panel design in which data are collected in a series of five interviews over a 30-month period, with a new panel started each year. The sample size in 2003 was about 13,000 families, representing 33,000 people. The SIPP is a multiyear panel survey that interviews a sample of households every four months for several years. The 1996 panel was fielded for four years and consisted of about 37,000 households.

The Commonwealth Fund Biennial Health Insurance Survey (2005) was conducted by Princeton Survey Research Associates International from August 18, 2005, through January 5, 2006. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 4,350 adults age 19 and older living in the continental United States. The analysis in this report is based on 603 adults ages 19 to 29 in the sample. Statistical results are weighted to correct for the disproportionate sample design and to make the final total sample results representative of all adults age 19 and older living in the continental U.S. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, and telephone service interruption, using the U.S. Census Bureau's 2005 Annual Social and Economic Supplement. The resulting weighted sample is representative of the approximately 212 million adults age 19 and older, including 35.5 million young adults ages 19 to 29.

The Commonwealth Fund is a private foundation that undertakes independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff, or of The Commonwealth Fund Commission on a High Performance Health System or its members.

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2009 POVERTY GUIDELINES

ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	10,830.00	12,996.00	14,403.90	14,620.50	16,245.00	18,952.50	20,035.50	21,660.00	27,075.00
2	14,570.00	17,484.00	19,378.10	19,669.50	21,855.00	25,497.50	26,954.50	29,140.00	36,425.00
3	18,310.00	21,972.00	24,352.30	24,718.50	27,465.00	32,042.50	33,873.50	36,620.00	45,775.00
4	22,050.00	26,460.00	29,326.50	29,767.50	33,075.00	38,587.50	40,792.50	44,100.00	55,125.00
5	25,790.00	30,948.00	34,300.70	34,816.50	38,685.00	45,132.50	47,711.50	51,580.00	64,475.00
6	29,530.00	35,436.00	39,274.90	39,865.50	44,295.00	51,677.50	54,630.50	59,060.00	73,825.00
7	33,270.00	39,924.00	44,249.10	44,914.50	49,905.00	58,222.50	61,549.50	66,540.00	83,175.00
8	37,010.00	44,412.00	49,223.30	49,963.50	55,515.00	64,767.50	68,468.50	74,020.00	92,525.00

For family units of more than 8 members, add $3,740 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	902.50	1,083.00	1,200.33	1,218.38	1,353.75	1,579.38	1,669.63	1,805.00	2,256.25
2	1,214.17	1,457.00	1,614.84	1,639.13	1,821.25	2,124.79	2,246.21	2,428.33	3,035.42
3	1,525.83	1,831.00	2,029.36	2,059.88	2,288.75	2,670.21	2,822.79	3,051.67	3,814.58
4	1,837.50	2,205.00	2,443.88	2,480.63	2,756.25	3,215.63	3,399.38	3,675.00	4,593.75
5	2,149.17	2,579.00	2,858.39	2,901.38	3,223.75	3,761.04	3,975.96	4,298.33	5,372.92
6	2,460.83	2,953.00	3,272.91	3,322.13	3,691.25	4,306.46	4,552.54	4,921.67	6,152.08
7	2,772.50	3,327.00	3,687.43	3,742.88	4,158.75	4,851.88	5,129.13	5,545.00	6,931.25
8	3,084.17	3,701.00	4,101.94	4,163.63	4,626.25	5,397.29	5,705.71	6,168.33	7,710.42

Produced by: CMSO/DEHPG/DEEO

Derived from poverty guidelines as published in the Federal Register on January 23, 2009

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2009 POVERTY GUIDELINES

ALASKA ONLY

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	13,530.00	16,236.00	17,994.90	18,265.50	20,295.00	23,677.50	25,030.50	27,060.00	33,825.00
2	18,210.00	21,852.00	24,219.30	24,583.50	27,315.00	31,867.50	33,688.50	36,420.00	45,525.00
3	22,890.00	27,468.00	30,443.70	30,901.50	34,335.00	40,057.50	42,346.50	45,780.00	57,225.00
4	27,570.00	33,084.00	36,668.10	37,219.50	41,355.00	48,247.50	51,004.50	55,140.00	68,925.00
5	32,250.00	38,700.00	42,892.50	43,537.50	48,375.00	56,437.50	59,662.50	64,500.00	80,625.00
6	36,930.00	44,316.00	49,116.90	49,855.50	55,395.00	64,627.50	68,320.50	73,860.00	92,325.00
7	41,610.00	49,932.00	55,341.30	56,173.50	62,415.00	72,817.50	76,978.50	83,220.00	104,025.00
8	46,290.00	55,548.00	61,565.70	62,491.50	69,435.00	81,007.50	85,636.50	92,580.00	115,725.00

For family units of more than 8 members, add $4,680 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	1,127.50	1,353.00	1,499.58	1,522.13	1,691.25	1,973.13	2,085.88	2,255.00	2,818.75
2	1,517.50	1,821.00	2,018.28	2,048.63	2,276.25	2,655.63	2,807.38	3,035.00	3,793.75
3	1,907.50	2,289.00	2,536.98	2,575.13	2,861.25	3,338.13	3,528.88	3,815.00	4,768.75
4	2,297.50	2,757.00	3,055.68	3,101.63	3,446.25	4,020.63	4,250.38	4,595.00	5,743.75
5	2,687.50	3,225.00	3,574.38	3,628.13	4,031.25	4,703.13	4,971.88	5,375.00	6,718.75
6	3,077.50	3,693.00	4,093.08	4,154.63	4,616.25	5,385.63	5,693.38	6,155.00	7,693.75
7	3,467.50	4,161.00	4,611.78	4,681.13	5,201.25	6,068.13	6,414.88	6,935.00	8,668.75
8	3,857.50	4,629.00	5,130.48	5,207.63	5,786.25	6,750.63	7,136.38	7,715.00	9,643.75

Produced by: CMSO/DEHPG/DEEO
Derived from poverty guidelines as published in the Federal Register on January 23, 2009

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2009 POVERTY GUIDELINES

HAWAII ONLY

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	12,460.00	14,952.00	16,571.80	16,821.00	18,690.00	21,805.00	23,051.00	24,920.00	31,150.00
2	16,760.00	20,112.00	22,290.80	22,626.00	25,140.00	29,330.00	31,006.00	33,520.00	41,900.00
3	21,060.00	25,272.00	28,009.80	28,431.00	31,590.00	36,855.00	38,961.00	42,120.00	52,650.00
4	25,360.00	30,432.00	33,728.80	34,236.00	38,040.00	44,380.00	46,916.00	50,720.00	63,400.00
5	29,660.00	35,592.00	39,447.80	40,041.00	44,490.00	51,905.00	54,871.00	59,320.00	74,150.00
6	33,960.00	40,752.00	45,166.80	45,846.00	50,940.00	59,430.00	62,826.00	67,920.00	84,900.00
7	38,260.00	45,912.00	50,885.80	51,651.00	57,390.00	66,955.00	70,781.00	76,520.00	95,650.00
8	42,560.00	51,072.00	56,604.80	57,456.00	63,840.00	74,480.00	78,736.00	85,120.00	106,400.00

For family units of more than 8 members, add $4,300 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	1,038.33	1,246.00	1,380.98	1,401.75	1,557.50	1,817.08	1,920.92	2,076.67	2,595.83
2	1,396.67	1,676.00	1,857.57	1,885.50	2,095.00	2,444.17	2,583.83	2,793.33	3,491.67
3	1,755.00	2,106.00	2,334.15	2,369.25	2,632.50	3,071.25	3,246.75	3,510.00	4,387.50
4	2,113.33	2,536.00	2,810.73	2,853.00	3,170.00	3,698.33	3,909.67	4,226.67	5,283.33
5	2,471.67	2,966.00	3,287.32	3,336.75	3,707.50	4,325.42	4,572.58	4,943.33	6,179.17
6	2,830.00	3,396.00	3,763.90	3,820.50	4,245.00	4,952.50	5,235.50	5,660.00	7,075.00
7	3,188.33	3,826.00	4,240.48	4,304.25	4,782.50	5,579.58	5,898.42	6,376.67	7,970.83
8	3,546.67	4,256.00	4,717.07	4,788.00	5,320.00	6,206.67	6,561.33	7,093.33	8,866.67

Produced by: CMSO/DEHPG/DEEO
Derived from poverty guidelines as published in the Federal Register on January 23, 2009

SB

12

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Labor and Commerce
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/25/09

Health and Social Services Committee considered SENATE BILL NO. 12

SB 12 LIMIT OVERTIME FOR REGISTERED NURSES

"An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS/N	3/6/09			✓	1
OHS/PH	3/6/09			✓	2
COR/oc	2/20/09			✓	3
LWF/WH	3/5/09	✓			4
DHS/API	3/9/09			✓	5

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Thomas				✓
	Dyson				✓
	PASKVAN				X
CHAIR: Betty Davis	DAVIS	✓			

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Alaska State Legislature

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Session: (Jan. - May)
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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 12 26-LS0075\R

"An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

Sponsor Statement

SB 12 prevents registered nurses and licensed practical nurses from being forced to work mandatory overtime, *i.e.,* work beyond an agreed to, predetermined, regularly scheduled shift, and it protects patients from the dangers caused by overworked nurses. Senate Bill 12 is applicable to all hospitals and health care facilities licensed in Alaska. Under SB 12 a nurse may not be required or coerced directly or indirectly to work more than 14 consecutive hours without 10 hours of rest; beyond 80 hours in a 14-day period; or to accept an assignment of overtime if, in the judgment of the nurse, the overtime would jeopardize patient or employee safety. Nurses, however, can volunteer to work additional shifts beyond this limit, so long as the nurse does not work more than 14 consecutive hours without 10 hours of rest.

In recognizing the complexity in delivering quality nursing care on a 24-hour basis, a number of concessions have been made to Alaska hospitals in this bill. The 14-hour maximum workday with 10 hours rest, which exceeds that allowed in many other states, permits a two-hour transition for nursing supervisors to call in additional help after 12-hour shifts. This provision was intended to help remedy the problem of nurses being called back to work without adequate rest after working a 12-hour shift. Also, exceptions have been provided for flight nurses on medical transport, school nurses on school sponsored field trips, and official state emergencies. This bill limits hospital reporting of hours to twice a year; it eliminates triple-time penalties for egregious violations; it limits maximum fines; and it requires enforcement for only "knowing" violations.

There are few official overtime complaints by nurses due to constant attention to patients, busy and varied schedules, and to some extent, fear of direct or indirect retaliation by employers. Many nurses testified to overwork, fatigue, disruption of family life, unexpected shift changes, mandatory overtime, and mandatory on-call over the course of several hearings on a similar bill, SB 28, in the 25th Legislature. Low numbers of complaints and benign exit interviews may belie growing dissatisfaction with the difficult work life of nurses, many of whom report "burn-out" and are leaving the profession.

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It has been estimated that 500,000 licensed registered nurses have left or are not working in the profession. There are bills in Congress to stem the nursing shortage, including financial aid for education, and more rigorous regulation of overtime hours, *e.g.,* H.R. 2122, and S.1842 in the 110th Congress, and before that, H.R. 791, "The Safe Nursing and Patient Care Act." The *Journal of the American Medical Association*, October 23-30, 2002, reported that nurses who suffer from fatigue, increased patient work-loads, and shifts in excess of 12 hours greatly increase nursing errors and mortality among patients who have common surgeries. Both nurses and employers alike state that patient safety is paramount, but nurses are allowed to work far beyond their endurance levels, depending on age and condition, unlike other safety-sensitive jobs, including commercial airline pilots, FAA controllers, railroad engineers, and long-haul truckers.

The nursing profession must attract more young people to replace the aging nurses' workforce which nationwide averages 46 years of age and is 95% women. In 2000 only 9% of RNs were under age 25, compared to 25% in 1980. Women are finding alternative career choices, so it is important for the nursing profession to create more jobs for nurses with higher wages, greater responsibilities, and better quality of work life. Although the University of Alaska has made great progress in increasing the numbers of nursing graduates in Alaska and in improving nursing programs at all levels, these efforts can only be successful through employment and retention if the nursing profession can provide a quality of life comparable to that in other competitive fields. SB 12 will help remedy this problem by encouraging employers to employ more nurses rather using mandatory overtime and mandatory on-call with short staffs to fill both routine and critical care positions on a regular basis. The greatest beneficiaries will be the patients who will receive the care and safety they deserve.

Alaska State Legislature

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Senator_Bettye_Davis@legis.state.ak.us
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Senator Bettye Davis

Senate Bill 12

"An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

Sectional Analysis

Note: As a preliminary matter, this sectional analysis should not be considered an authoritative interpretation of the bill; the bill itself is the best statement of its contents.

Section 1. Adds a temporary law section on legislative findings and intent concerning administration of overtime provisions in the nursing profession.

Section 2. Adds an "Article 4" to AS 18.20 that includes the following sections concerning working hours for nurses:

Sec. 18.20.0400. Subsection (a) prohibits the use of direct or indirect coercion to cause a nurse in a health care facility to:

(1) "work beyond a predetermined and regularly scheduled shift that is agreed to by the nurse and the health care facility;
(2) work beyond 80 hours in a 14-day period; or to
(3) accept an assignment of overtime if, in the judgment of the nurse, the overtime would jeopardize patient or employee safety."

Subsection (b) requires that the nurse shall not have less than 10 consecutive hours of off-duty time immediately following the end of work on a predetermined and regularly scheduled shift agreed to by the nurse and the health care facility.
Subsection (c) lists exceptions to subsection (a).

Sec. 18.20.410 Provides an anonymous process by which a patient or nurse may make a complaint about staffing levels and patient safety that relates to overtime work by nurses;

Sec. 18.20.420 Provides enforcement; lists offenses and penalties for violations;

Sec. 18.20.430 Prohibits retaliation for reporting alleged violations.

Sec. 18.20.440 Provides enforcement against prohibition of retaliation. Requires the Commissioner of Labor and Workforce Development to investigate all complaints and provide to the complainant a written determination within 90 days.

Sec. 18.20.445 Provides semiannual reporting requirements

Sec. 18.30.449 Defines key words, including "health care facility," "nurse," "on-call," and "overtime."

Section 3. Requires that if the bill becomes law the filing of the first semi-annual reports under AS 18.20.445 must be filed before February 1, 2010 for the period July 1, 2009 through December 31, 2009.

Section 4. requires that the reporting requirements of AS 18.20.445 take effect July 1, 2009.

Section 5. provides that except as provided in sec. 4 of this Act, this Act takes effect January 1, 2010.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB012
() Publish Date:

Identifier (file name): SB012-DHSS-N-03-06-09
Dept. Affected: Health & Social Services
Title: Limit Overtime for Registered Nurses
RDU: Public Health
Component: Nursing
Sponsor: Davis
Requester: Senate HSS
Component Number:

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill sets limitations for nurses working overtime hours beyond the scope of their regular duties. While the language in the bill makes it applicable to public health nurses, it would have a very limited effect on the Division of Public Health Section of Public Health Nursing. Most Public Health Nurses, as salaried employees, are not overtime eligible.

The mandated semi-annual report to the Department of Labor and Workforce Development would typically require no effort because public health nurses rarely work "in excess of a predetermined and regularly scheduled shift that is agreed upon by the nurse and a health care facility." Normal itinerant schedules, even though they often involve more than a 7.5-hour day, are always predetermined and agreed upon. In addition, the bill exempts reporting requirements for unforeseen emergencies requiring extra work. There is no projected fiscal impact on the Section of Public Health Nursing.

Prepared by: Jay Butler, Chief Medical Officer
Phone 269-8126
Division: Public Health
Date/Time 3/6/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/6/2009
DHSS Finance & Management Services

(Revised 9/10/2008 OMB)

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FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB012
() Publish Date:

Identifier (file name): SB012-DHSS-API-03-09-09
Dept. Affected: Health & Social Services
Title: Limit Overtime for Registered Nurses
RDU: Behavioral Health
Component: Alaska Psychiatric Institute
Sponsor: Davis
Requester: Senate HSS
Component Number: 311

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time		2.0	2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB12 establishes limitations on overtime for Registered Nurses (RNs) in health care facilities, provides penalties for violations, and requires reporting of any overtime, with the overtime designated as voluntary or mandatory by the RN. The intent of SB12 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event. Under the bill, use of mandatory overtime in excess of the bill's limitations will result in a report to the Department of Labor.

The division has determined that passage of this bill will have a zero fiscal impact. The option that API will pursue to replace its current policy requiring mandatory overtime is to add two registered psych nurses and develop, in conjunction with the Department of Administration, Division of Personnel and Labor Relations, a

Prepared by: Melissa Stone, Director
Phone 269-3410
Division: Behavioral Health
Date/Time 3/9/09 11:30 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/9/2009
DHSS Finance & Management Services

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB012

ANALYSIS CONTINUATION

voluntary standby system of employment that would replicate a private sector "on call" system. Any additional costs associated with the positions and "on-call" system will be offset by the cost savings from reduced overtime payment.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB012
() Publish Date:

Identifier (file name): SB012-DHSS-API-03-06-09
Dept. Affected: Health & Social Services
Title: Limit Overtime for Registered Nurses
RDU: Behavioral Health
Component: Alaska Psychiatric Institute
Sponsor: Davis
Requester: Senate HSS
Component Number:

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB12 establishes limitations on overtime for Registered Nurses (RNs) in health care facilities, provides penalties for violations, and requires reporting of any overtime, with the overtime designated as voluntary or mandatory by the RN. The intent of SB12 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event. Under the bill, use of mandatory overtime in excess of the bill's limitations will result in a report to the Department of Labor.

The division has determined that passage of this bill will have a zero fiscal impact. Situations requiring overtime are adequately addressed by requesting voluntary overtime. Changes in the pay to nurses and new management strategies have resulted in the limited use of mandatory overtime, and does not pose a significant burden to API. The semi-annual reporting requirement costs will be absorbed by the division.

See update

Prepared by: Melissa Stone, Director
Phone 465-2817
Division: Behavioral Health
Date/Time 3/6/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/6/2009
DHSS Finance & Management Services

(Revised 9/10/2008 OMB)

3039

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB012
() Publish Date:

Identifier (file name): SB012-DHSS-PH-03-06-09
Dept. Affected: Health & Social Services
Title: Limit Overtime for Registered Nurses
RDU: Alaskan Pioneer Homes
Component: Pioneers Homes
Sponsor: Davis
Requester: Senate HSS
Component Number:

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 12 establishes limitations on overtime for Registered Nurses (RNs) in health care facilities, provides penalties for violations, and requires reporting of any overtime, with the overtime designated as voluntary or mandatory by the RN. The intent of SB12 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event. Under the bill, use of mandatory overtime in excess of the bill's limitations will result in a report to the Department of Labor.

The division has determined that passage of this bill will have a zero fiscal impact. Situations requiring overtime are adequately addressed by utilizing on-call RNs and requesting voluntary overtime.

Prepared by: Dave Cote, Director — Phone 465-5737
Division: Alaska Pioneer Homes — Date/Time 3/6/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner — Date 3/6/2009
DHSS Finance & Management Services

(Revised 9/10/2008 OMB)

3040

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB 12**
() Publish Date:

Identifier (file name): SB012-DOLWD-WH-03-05-09
Title: Limit Overtime for Registered Nurses
Sponsor: Senator Davis
Requester: Senate Health and Social Services

Dept. Affected: Labor and Workforce Development
RDU: Labor Standard & Safety
Component: Wage and Hour
Component Number: 345

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	73.6		73.6	73.6	73.6	73.6	73.6
Travel	3.0		3.0	3.0	3.0	3.0	3.0
Contractual	18.9		18.9	18.9	18.9	18.9	18.9
Supplies	3.8		0.5	0.5	1.8	0.5	0.5
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**99.3**	**0.0**	**96.0**	**96.0**	**97.3**	**96.0**	**96.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	99.3		96.0	96.0	97.3	96.0	96.0
1005 GF/Program Receipts							
1037 GF/Mental Health							
1157 Worker Safety Account							
TOTAL	**99.3**	**0.0**	**96.0**	**96.0**	**97.3**	**96.0**	**96.0**

Estimate of any current year (FY2009) cost: None

POSITIONS

Full-time	**1.0**		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The bill requires the Department of Labor and Workforce Development to investigate and take enforcement action to resolve complaints of unlawful mandatory overtime use and alleged retaliation. Due to the significant number of registered nurses and licensed practical nurses currently licensed in Alaska (approximately 10,000 RN's and 1,000 LPN's), the department anticipates the workload will require at least one full-time Wage and Hour Investigator I position funded with General Funds. Costs include $73.6 for salary and benefits, $3.0 for investigation travel, $18.9 for contractual which includes normal per position costs such as office space, phone, data processing and administrative support and $5.0 for Department of Law advice and representation, $0.5 for office supplies and an additional $3.3 for office furniture and equipment in the first year and an additional $1.3 for computer equipment replacement in the fourth year.

Prepared by: Grey Mitchell, Director — Phone 465-4855
Division: Labor Standard & Safety — Date/Time 3/5/09 2:51 PM
Approved by: Click Bishop, Commissioner — Date 3/5/09
Agency: Department of Labor and Workforce Development

(Revised 9/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB12-DOC-OC-02-20-09
() Publish Date:

Identifier (file name): SB12-DOC-OC-02-20-09
Dept. Affected: DOC
Title "Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; ...."
RDU Adminstration & Support
Component Office of the Commissioner
Sponsor Senator Davis
Requester Governor
Component Number 694

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB12 would place limitations on mandatory overtime for registered nurses and licensed practical nurses within health care facilities.

Passage of this legislation should have no impact to the Department of Corrections.

Prepared by: Leslie Houston, Director
Phone (907) 465-3339
Division Administration and Support
Date/Time 2/20/2009 17:54:00 PM
Approved by: Dwayne Peeples, Deputy Commissioner
Date 2/20/2009
Department of Corrections

(Revised 9/10/2008 OMB)

3042

26-LS0075\R.1
Wayne
2/5/09

AMENDMENT

OFFERED IN THE SENATE BY SENATOR DAVIS

TO: SB 12

Page 3, following line 16:

Insert a new paragraph to read:

"(7) a nurse at a residential psychiatric treatment center who agrees to work under a contract that requires the employer to provide full-time pay and benefits equivalent to the pay and benefits for a 40-hour workweek if the nurse works a weekend schedule of four eight-hour shifts with not more than 16 consecutive hours on duty without a break of at least eight hours; in this paragraph, "residential psychiatric treatment center" has the meaning given in AS 18.07.111 and "weekend" means the period that begins Friday at 5:00 p.m. and ends Monday at 8:00 a.m.;"

Renumber the following paragraph accordingly.

Lynda Zaugg

From: Thomas Obermeyer
Sent: Monday, February 09, 2009 8:27 AM
To: Sen. Bettye Davis; Lynda Zaugg; Don Burrell
Subject: FW: Final Answer from Hospitals

From: mshickey@gci.net [mailto:mshickey@gci.net]
Sent: Sunday, February 08, 2009 1:07 PM
To: Thomas Obermeyer
Subject: Final Answer from Hospitals

Tom,

Rod Betit called me on Friday afternoon and said it's a **no go** on working something out. Believe Rod made a good faith effort, but think it was just a stall tactic by the hospitals. Please let Senator Davis know. We are proceeding to put in the hard push. I'll keep you posted.

Am curious if there's any feedback from the recent visit by Providence?

Mark

Re Navos - bill

Lynda Zaugg

From: Patrick Higgins [Patrick.Higgins@uhsinc.com]
Sent: Tuesday, March 24, 2009 1:50 PM
To: Thomas Obermeyer
Cc: Sen. Bettye Davis; raygillespie@ak.net
Subject: nurses overtime bill SB 12

Tom, our nurses love our Baylor plan and we use it at both our hospital and residential treatment centers. This plan is used for both full and part-time employees. An employee who regularly works only one weekend Baylor shift (16 hours) receives 20 hours pay and part-time benefits. If they work two Baylor shifts (32 hours) they receive 40 hours pay and full time benefits. I provided language earlier and at one time last year Senator Davis' bill exempted our Baylor plan.

I would propose the following language.

"A nurse at a psychiatric treatment hospital or residential treatment center who agrees to work two consecutive eight hour shifts on weekends, provided the employer provides pay and benefits equivalent to twenty hours for each two consecutive shifts. A nurse that works four eight hours shifts cannot work more than 16 consecutive hours on duty without a break of at least eight hours. In this paragraph, a weekend means Friday at 5:00 p.m. and ends Monday at 8:00 a.m."

Thanks. Feel free to call me on my cell, 952-5871, if you have any questions.

Pat

Patrick Higgins
HR Director
Northstar Behavioral Health
2530 DeBarr Rd.
Anchorage, Alaska 99508

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Nurse 01

Bill Text 26th Legislature

HOUSE BILL NO. 50

"An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

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

* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE FINDINGS AND INTENT. The legislature finds that

(1) it is essential that registered nurses and licensed practical nurses providing direct patient care be available to meet the needs of patients;

(2) quality patient care is jeopardized by registered nurses and licensed practical nurses who work unnecessarily long hours in health care facilities;

(3) registered nurses and licensed practical nurses are leaving their profession because of workplace stresses, long work hours, and depreciation of their essential role in the delivery of quality and direct patient care;

(4) it is necessary to safeguard the efficiency, health, and general well-being of registered nurses and licensed practical nurses, and the health and general well-being of the persons receiving care from registered nurses and licensed practical nurses in health care facilities;

(5) it is necessary that registered nurses and licensed practical nurses be made aware of their rights, duties, and remedies concerning hours worked and patient safety; and

(6) health care facilities should provide adequate and safe nurse staffing without the need for or use of mandatory overtime.

* **Sec. 2.** AS 18.20 is amended by adding new sections to read:

Article 4. Overtime Limitations for Nurses.

Sec. 18.20.400. Limitations on nursing overtime. (a) Except as provided in (c) of this section, a nurse in a health care facility may not be required or coerced, directly or indirectly,

(1) to work beyond a predetermined and regularly scheduled shift that is agreed to by the nurse and the health care facility;

(2) to work beyond 80 hours in a 14-day period; or

(3) to accept an assignment of overtime if, in the judgment of the nurse, the overtime would jeopardize patient or employee safety.

(b) Except as provided by (c) of this section, after working a predetermined and regularly scheduled shift that is agreed to by the nurse and the health care facility as authorized by (a)(1) of this section, a nurse in a health care facility shall be allowed not less than 10 consecutive hours of off-duty time immediately following the end of that work.

(c) Subsection (a) of this section does not apply to

(1) a nurse who is employed by a health care facility providing services for a school, school district, or other educational institution, when the nurse is on duty for more than 14 consecutive hours during an occasional special event, such as a field trip, that is sponsored by the employer;

(2) a nurse voluntarily working overtime on an aircraft in use for medical transport, so long as the shift worked is allowable under regulations adopted by the Board of Nursing based on accreditation standards adopted by the Commission on Accreditation of Medical Transport Systems;

(3) a nurse on duty in overtime status because of an unforeseen emergency situation that could jeopardize patient safety; in this paragraph, "unforeseen emergency situation" means an unusual, unpredictable, or unforeseen situation caused by an act of terrorism, disease outbreak, natural disaster, major disaster as defined in 42 U.S.C. 5122, or disaster emergency under AS 26.23.020 or 26.23.140, but does not include a situation in which a health care facility has reasonable knowledge of increased patient volume or inadequate staffing because of some other cause, if that cause is foreseeable;

(4) a nurse fulfilling on-call time that is agreed on by the nurse and a health care facility before it is scheduled;

(5) a nurse voluntarily working overtime so long as the work is consistent with professional standards and safe patient care and does not exceed 14 consecutive hours;

(6) a nurse voluntarily working beyond 80 hours in a 14-day period so long as the nurse does not work more than 14 consecutive hours without a 10-hour break and the work is consistent with professional standards and safe patient care;

(7) the first hour on overtime status when the health care facility is obtaining another nurse to work in place of the nurse in overtime status.

Sec. 18.20.410. Health care facility complaint process for overtime work by nurses. A health care facility shall provide for an anonymous process by which a patient or a nurse may make a complaint about staffing levels and patient safety that relate to overtime work by nurses and to limitations on overtime work by nurses under AS 18.20.400.

Sec. 18.20.420. Enforcement, offenses, and penalties. (a) The commissioner shall administer AS 18.20.400 - 18.20.449 and adopt regulations for implementing and enforcing AS 18.20.400 - 18.20.449.

(b) A complaint alleging a violation of AS 18.20.400 - 18.20.449 must be filed with the commissioner within 30 days after the date of the alleged violation. The

commissioner shall provide a copy of the complaint to the health care facility named in the filing within three business days after receiving the complaint.

(c) If the commissioner finds that a health care facility has knowingly violated an overtime provision of AS 18.20.400 - 18.20.449, the following civil penalties shall apply:

(1) for a first violation of AS 18.20.400 - 18.20.449, the commissioner shall reprimand the health care facility;

(2) for a second violation of AS 18.20.400 - 18.20.449 within 12 months, the commissioner shall reprimand the health care facility and assess a penalty of $500;

(3) for a third violation of AS 18.20.400 - 18.20.449 within 12 months, the commissioner shall reprimand the health care facility and assess a penalty of not less than $2,500 but not more than $5,000;

(4) for each violation of AS 18.20.400 - 18.20.449 after a third violation of AS 18.20.400 - 18.20.449 within 12 months, the commissioner shall reprimand the health care facility and assess a penalty of not less than $5,000 but not more than $25,000.

(d) As an employer, a health care facility violates an overtime provision of AS 18.20.400 - 18.20.449 "knowingly" when the facility is either aware that its conduct is of a nature prohibited by the overtime provision or aware that the circumstances described in the overtime prohibition exist; however, when knowledge of the existence of a particular fact is required to establish that the violation was knowing, that knowledge exists when the facility is aware of a substantial probability of its existence, unless the facility reasonably believes it does not exist.

Sec. 18.20.430. Prohibition of retaliation. A health care facility may not discharge, discipline, threaten, discriminate against, penalize, or file a report with the Board of Nursing against a nurse for exercising rights under AS 18.20.400 - 18.20.449 or for the good faith reporting of an alleged violation of AS 18.20.400 - 18.20.449.

Sec. 18.20.440. Enforcement of prohibition against retaliation. The commissioner shall investigate every complaint alleging a violation of AS 18.20.430, and, within 90 days after the date of filing of the complaint, provide to the complainant, the Department of Law, and the health care facility named in the complaint a written determination as to whether the health care facility violated AS 18.20.430. If the commissioner finds a violation of AS 18.20.430, the commissioner shall request that the Department of Law represent the department and the complainant and obtain from the health care facility all appropriate relief, including rehiring or reinstatement of the complainant to the complainant's former position with back pay.

Sec. 18.20.445. Report requirements. A health care facility shall file with the division of labor standards and safety, Department of Labor and Workforce Development, a semiannual report. The report for the six-month period ending June 30 must be filed before the following August 1, and the report for the six-month period ending December 31 must be filed before the following February 1. The report must include, for each nurse employed by the health care facility or under contract with the health care facility, the number of overtime hours worked, the number of overtime hours that were mandatory, the number of overtime hours that were voluntary, the number of on-call hours, the number of on-call hours that were mandatory, and the number of on-call hours that were voluntary.

Sec. 18.20.449. Definitions. In AS 18.20.400 - 18.20.449,

(1) "commissioner" means the commissioner of labor and workforce development;

(2) "health care facility" means a private, municipal, state, or federal hospital; psychiatric hospital; independent diagnostic testing facility; residential psychiatric treatment center, as defined in AS 18.07.111; skilled nursing facility; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility; ambulatory surgical facility; Alaska Pioneers' Home or Alaska Veterans' Home administered by the Department of Health and Social Services under AS 47.55; correctional facility owned or administered by the state; juvenile detention facility, juvenile detention home, juvenile work camp, or treatment facility, as defined in AS 47.12.990; private, municipal, state, or federal facility employing one or more public health nurses; long-term care facility; or primary care outpatient facility;

(3) "nurse" means an individual licensed to practice registered nursing or practical nursing under AS 08.68 who provides nursing services through direct patient care or clinical services and includes a nurse manager when delivering in-hospital patient care;

(4) "on-call" means a status in which a nurse must be ready to report to the health care facility and may be called to work by the health care facility;

(5) "overtime" means the hours worked in excess of a predetermined and regularly scheduled shift that is agreed to by a nurse and a health care facility.

* **Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. The first report required to be filed under AS 18.20.445, enacted in sec. 2 of this Act, shall be filed before February 1, 2010, for the period July 1, 2009, through December 31, 2009.

* **Sec. 4.** AS 18.20.445, enacted in sec. 2 of this Act, and sec. 3 of this Act take effect July 1, 2009.

* **Sec. 5.** Except as provided in sec. 4 of this Act, this Act takes effect January 1, 2010.

Alaska State Legislature
State Capitol
Juneau, AK 99801
907 465-3822 office
907 465-3756 fax
From the Office of Senator Bettye Davis

To: Legal Services **Fax:** 465-2029; phone: 465-2450

From: Thomas S. Obermeyer **Date:** 2/4/2009

Re: Cancel request 2/3/09 for CS for SB 12, 26-LS0075\R Nurses' Mandatory Overtime- **Instead:**

REQUEST FOR ONLY ONE AMENDMENT

Pages: ___ page(s) including cover

CC:

Urgent [X] **For Review** ☐ **Please Comment** **Please Reply** ☐ **Please Recycle**

February 4, 2009

To Whom It May Concern:

PLEASE CANCEL previous request 2/3/09 for CS for SB 12, 26-LS0075\R Nurses' overtime. **Instead**, please draft an amendment identical to exception #7 (attached) found in last version of SB 28: HS CS for CS for SB 28(HES), 25-LS0212\R, Section 2(c)(7), page 3, lines 15-20 which reads:

SB 28, 26-LS0075\R Amendment 1:

"(7) a nurse at a residential psychiatric treatment center who agrees to work under a contract that requires the employer to provide full-time pay and benefits equivalent to the pay and benefits for a 40-hour workweek if the nurse works a weekend schedule of four eight-hour shifts with not more than 16 consecutive hours on duty without a break of at least eight hours; in this paragraph, a "weekend" means the period that begins Friday at 5:00 p.m. and ends Monday at 8:00 a.m.;"

Please call if you have questions.
Tom Obermeyer, phone: 465-3762

ALASKA NATIVE MEDICAL CENTER

Pat Jackson

FOR IMMEDIATE RELEASE

Brandy M. Dixon, 907.729.1967

Alaska's only Magnet Status Hospital Retains Distinction

Alaska Native Medical Center wins highest honor in nursing excellence – *Again!*

Anchorage, AK – Jan. 19, 2009 – For the second time, the Alaska Native Medical Center (ANMC) has earned the highest honor offered by the American Nurses Credentialing Center (ANCC). ANCC is the world's largest and most prestigious nurse credentialing organization.

ANMC first earned this distinction in 2003, and remains the first and only hospital in Alaska, and the first and only tribal hospital in the nation to receive Magnet Status. According to ANCC, fewer than 5 percent of hospitals nationwide achieve Magnet Status, and even fewer achieve re-designation.

"This award validates the outstanding care our employees provide to our patients every single day. We've set the standard in Alaska – now we're going to set the standard in the country," said Alaska Native Tribal Health Consortium Chief Executive Officer Don Kashevaroff.

"It's an honor to work with such a dedicated team of professionals whose expertise and pursuit of excellence is evident in everything they do," said ANMC Chief Nurse Executive Kathy Hillburn. "For all patients who come here and those already in our care, our Magnet designation assures them that ANMC's healthcare is of the highest quality in the nation."

The call announcing the designation came via a speaker phone surrounded by anxious staff members who work at ANMC. They burst into cheers upon hearing the good news from Gail Wolf, chairwoman of the Commission on Magnet Recognition.

In her phone call, Wolf said "in recognizing quality patient care, nursing excellence, and innovations in professional nursing practice, the Magnet Recognition Program gives consumers the ultimate benchmark to measure the quality of care that they can expect to receive."

When U.S. News & World Report publishes its annual showcase of America's Best Hospitals" status as a Nurse Magnet™ facility contributes to the total score for quality of inpatient care. Of the hospitals listed on the exclusive 2007 Honor Roll (July 23, 2007), seven of the top ten were Magnet hospitals. (For more information on Magnet status, visit ancc.org.)

# # #

The Alaska Native Tribal Health Consortium and Southcentral Foundation jointly own and manage ANMC under the terms of Public Law 105-83. These parent organizations have established a Joint Operating Board to ensure unified operation of health services provided by the Medical Center.

Alaska State Legislature
State Capitol
Juneau, AK 99801
907 465-3822 office
907 465-3756 fax
From the Office of Senator Bettye Davis

To:	Legal Services	**Fax:**	**465-2029; phone: 465-2450**
From:	Thomas S. Obermeyer	**Date:**	2/3/2009
Re:	CS for SB 12, 26-LS0075\R Nurses' Mandatory Overtime	**Pages:**	_1_ page(s) including cover
CC:			

Urgent **[X] For Review** **☐ Please Comment** **Please Reply** **☐ Please Recycle**

February 3, 2009
To Whom It May Concern:

Please draft a committee substitute for SB 12, 26-LS0075\R, to add back a formerly included clause which had been removed in the present draft of exceptions to overtime limitations, ref: Sec. 18.20.400(c). This clause presently is mirrored in HB 51, 26-LS0288\R, page 3, lines 16-22 and is quoted below:

"(7) a nurse at a residential psychiatric treatment center who agrees to work under a contract that requires the employer to provide full-time pay and benefits equivalent to the pay and benefits for a 40-hour workweek if the nurse works a weekend schedule of four eight-hour shifts with not more than 16 consecutive hours on duty without a break of at least eight hours; in this paragraph, a "weekend" mean the period that begins Friday at 5:00 p.m. and ends Monday at 8:00 a.m.;"

When complete and delivered, please e-mail me a pdf of the same:
Thomas_Obermeyer@legis.state.ak.us.

Thank you. Please call if you have any questions.

Tom

Tom Obermeyer
465-3762

3050

Alaska Nurses Association

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Mandatory Overtime Legislation: A positive approach to improved patient care for the State of Alaska

January 2008

Executive Summary

Robert Steinbrook, MD, begins his report in the New England Journal of Medicine about nurses this way: "Nursing is an embattled profession." (2002). Since the Institute of Medicine Report (IOM) in 1996 and this article in 2002, many states have taken positive steps to stop the hemorrhaging of seasoned, experienced professional registered nurses from the workforce and to add more, younger energetic people to the mix. The same can be said of other health professionals such as pharmacists, certain physician specialties, and health care professionals in general. How the states are accomplishing this is through positive legislative efforts evidencing a sincere desire for improved working conditions and health care environments.

In the nursing profession, states that have passed legislation in four main target areas are having the most success in retaining and drawing registered nurses to employment. The four legislative areas include but are not limited to: banning mandatory overtime, safe patient handling, staffing ratio systems, and increasing scholarship funds.

In this context, we will discuss the necessity of banning mandatory overtime and/or mandatory call as a first step in advancing the retention of professional registered nurses in the State of Alaska.

Background

The population in Alaska as well as the rest of the United States is aging. Registered nurses (RN's) are aging as well. In 2000, the average age of the RN was 45. Today that age is 46 and remains 95 percent female; in Alaska, the average age is 48 (2007 Alaska Senate Testimony by AaNA). At the same time, the IOM report concluded that "women are finding other choices". Dr. Steinbrook quoted Frank Sloan of Duke University and co-chair of the committee of the IOM that reported on nursing as saying, nursing "is a very stressful job with a very flat career path." Dr. Steinbrook continued by noting RN's are discontented for many reasons including inadequate levels of staffing for both nurses and support staff and excessive workloads. That discontent goes beyond the RN's according to the April 2002 report of the American Hospital Association's Commission on Workforce for Hospitals and Health Systems. That report notes, "Most health care professionals entered their profession to make a difference through personal interaction with people in need. Today many in direct patient care feel tired and burned out from a stressful, often understaffed environment, with little or no time to experience the one-on-one caring that should be the heart of hospital employment."

Linda H. Aiken of the University of Pennsylvania School of Nursing notes that, "There is a sense that nursing is becoming an impossible job, and that nurses have no control over things that are required to provide good patient care. Yet nurses are accountable for the health and welfare of their patients." Combine this feeling with an aging work force and the future looks bleak. In 2000, only 9 percent of RN's were less than 30 years of age, as

compared with 25 percent in 1980. According to Buerhaus et al in their 2000 JAMA article, by 2020 a shortage of more than 400,000 RN's is possible. The Bureau of Labor Statistics estimates that the United States will need an additional 1.1 million registered nurses by 2014.

Ann Converso, Vice-President of the UAN, when addressing the 6th International Conference on Occupational Stress and Health, March 2, 2006 noted: **"In one of the latest Institute of Medicine reports, they found that work shifts longer than twelve hours per day endanger patient safety due to fatigue, causing reduced attention span and capacity to catch errors. However, the same study found that 27 percent of full-time hospital and nursing home nurses reported working more than 13 consecutive hours one or more times per week. The IOM recommends that states prohibit nurses from working more than 12 hours in a 24 hour period or more than 60 hours per week."**

Through it all, the worst case scenario is a tired, over-extended health care professional administering care to a patient.

Statement of the Problem

In October of 2007, the Alaska Statewide Nurses Conference was held in Anchorage. Over 120 nurses attended over a three day period representing RN's from Kotzebue to Ketchikan. Every staff nurse in attendance agreed that mandatory overtime is a curtailment to the working environment. Over 50 nurses (a majority of the staff nurses present) indicated that not only have they been asked to work overtime in the past three months, many indicated they had to take mandatory call. Several nurses indicated that "not only does it mess with your family life; you really worry about patient safety when you're so exhausted." In the instance of mandatory call, the RN may or may not be called to work, but must curtail personal/family time above and beyond the normal work time just in case they're needed for work. In many cases, the callback occurs within a few hours of completing a regular-12 hour shift – resulting in working more than 14 hours within a 24-hour period. Most facilities do provide incentives for on-call pay and on-call return to work status, but it continues to remain a way to staff facilities across the state without hiring more RN's.

Upon further questioning of the staff nurses at the Statewide Conference, 100 percent indicated that mandatory overtime, if used and maintained in their workplace, would cause them to leave the profession early and/or look for employment elsewhere. Several nurses with spouses in other professions noted their spouses have time curtailments in their work areas for safety, especially pilots and truck drivers. "You'd think the same people who set those limits would worry if their grandmother was in the hospital being treated by someone who had been there for over 14 hours." one nurse said. At meetings held between AaNA members, staff, hospital managers and administrators during the fall and winter of 2007, no one could say overtime does not exist and no one could guarantee mandatory overtime or mandatory call didn't occur at times.

In her testimony to the House Ways and Means Committee in Washington, D.C., Mary Foley, President of the American Nurses Association, stated, "By far the riskiest result of understaffing is the abuse of mandatory overtime as a staffing tool" (2002). According to a study published by the American Association of Nurse Executives, 61 percent of respondent RN's said they had observed increases in overtime or double shifts during the past year (2002).

Solutions

Around the country, **California, Washington, Oregon, Missouri, Texas, Connecticut, Illinois, Maine, Minnesota, New Hampshire, New Jersey, and West Virginia have all passed legislation limiting nurses to 12 hour shifts with mandatory rest periods prior to another work time. Rhode Island's legislature just passed the same legislation on an override of a governor's veto.** New York and Pennsylvania are poised to pass the legislation this year. Congress has HR2122 and S1842 pending with the support of the United American Nurses and the American Nurses Association.

"In the long term, the future of the nursing profession is related to its ability to attract more young nurses, to support the careers of current nurses, and to create more jobs for nurses with higher wages, and greater responsibilities. Such efforts can be successful only if the positions students are training to fill are sufficiently attractive, as compared with the alternatives in other fields." (Steinbrook, 2002)

In Alaska we are on the cusp of a legislative effort to begin making a true commitment to the professional registered nurse. **The current version of Senate Bill 28 actually provides for an extended work period up to 14 hours to assist hospitals that routinely schedule nurses for 12-hour shifts. The legislation also provides for an exemption from this limitation to address legitimate, unforeseeable emergencies. The Alaska Nurses Association urges the passing of this legislation as an effort to retain nurses in the state, increase the incentives to new nurses, and most importantly assist with improved patient safety.**

ANA
AMERICAN NURSES ASSOCIATION

Mandatory Overtime

Position

ANA opposes the use of mandatory overtime as a staffing tool.

Background

Nurses report a dramatic increase in the use of mandatory overtime as a staffing tool and fear potential consequences for the safety and quality of care provided to their patients. Today, overtime (mandatory and voluntary) is the most common method facilities use to cover staffing insufficiencies. In fact, some employers have described mandatory overtime as a staffing model and have actually coined the term "mandation" to define the methodology. Many nurses contend employers insist they work an extra shift (or more) or face dismissal for insubordination and being reported to the state board of nursing for patient abandonment.

Federal regulations place limits on the amount of time that can be worked in other industries in which the work directly affects public safety (e.g., aviation and transportation). Those regulations also set requirements for defined periods of time that workers must rest or be off duty before returning to work. Health care is exempt from such overtime regulations.

A few United American Nurse bargaining units have been successful in negotiating limits on mandatory overtime. In fact, concerns about the effects of mandatory overtime were central concerns in recent strikes in Washington, D.C., Minnesota, and New York.

Rationale

The American Nurses Association (ANA) is concerned about the impact of mandatory overtime on the ability of our nation's acute care nurses to provide high-quality health care services. ANA believes that the elimination of mandatory overtime for the nation's nurses is a critical step in efforts to improve the quality of health care and reduce medical errors. Following are a few facts about the dangers of forced overtime:

- Nurses are, in general, an aging workforce. The average working nurse is slightly over 43 years of age.
- Increased reliance on mandatory overtime has occurred at the same time that patient acuity has increased, the use of sophisticated technology has increased, and the length of hospital stay has decreased.
- Research in 1977 by Dawson and Reid at the University of Australia showed that "work performance is more likely to be impaired by moderate fatigue than by alcohol consumption." Their research shows that workers staying awake for long periods pose significant safety risks.
- Sleep loss influences several aspects of performance, slowing thinking and reaction time, delaying responses, causing failure to respond when appropriate or false responses, and diminishing memory, among others.

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What will legislation regulating mandatory overtime really do?

The mandatory overtime legislation being suggested does not prohibit nurses from working overtime. It will discourage an employer from assigning mandatory overtime and will prohibit an employer from threatening or retaliating against a nurse who refuses overtime. It will support the nurse who believes patient care would be compromised if that nurse is forced to work overtime. We must be able to count on the professional nurses who are providing care to make the judgment call about whether or not they are safe to practice.

Basic Facts on Mandatory Overtime

In the United States there has been an overall increase in overtime hours for all American workers over the last two decades. Almost one third of the workforce regularly works more than 40-hours a week and one fifth work more than 50 hours. It has been no different in health care where working overtime is becoming an every day occurrence. "Time after Time: Mandatory Overtime in the US Economy" Briefing Paper. January 2002. 1

"Mandatory overtime hours" are those hours above an agreed upon, predetermined, regularly scheduled shift, that the employer makes compulsory (as opposed to voluntary) with the threat of job loss or reprisals such as discharge, discipline, demotion or assignment to unattractive tasks or work shifts or in some cases licensure removal, retaliatory reporting, and charges of "abandonment". RN schedules are often 12, 10 or 8 hour shifts and some nurses do not get overtime for staying additional time unless they have reached 40 hours in one week. For example, a RN could work their regular 8 hour shift, but then be mandated to work an additional 8 hours for a total of 16, but not qualify for overtime pay.

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1 - 18 page report available at http://www.epinet.org/briefingpapers/120/bp120.pdf

A recent study, published in July 2004, shows a strong link between medical errors and the long work hours of nurses and it has called on congress to take action on the Safe Nursing and Patient Care Act (H.R. 745, S. 373), which would strictly limit the use of mandatory overtime for nurses. 5

Ann E Rogers, Wei-Ting Hwang, Linda D. Scott, Linda H. Aiken, and David F. Dinges did an important study called, "The Working Hours Of Hospital Staff Nurses And Patient Safety", which was published in the July/August issue of Health Affairs6

This study found that the risk of making an error was three times higher when nurses had to work shifts that were longer than 12 hours, when they worked significant overtime or when they worked more than 40 hours in a week. Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled. Fatigue related to working overtime was identified as the cause of approximately 12% of the absences reported by a random sample of Canadian staff nurses.

This reported outcome reinforced the findings of the 2003 Institute of Medicine Report, "Keeping Patients Safe: Transforming the Work Environment of Nurses" (7), which also said that nurses' long working hours pose a serious threat to patient safety.

...And Because We Are Losing Nurses

Mandatory overtime is one of the main reasons nurses leave nursing. Recent studies indicate that one in five nurses are considering leaving nursing. When polled on their reasons for leaving, mandatory overtime is always listed in the top ten reasons. In the face of a severe nursing shortage, we need to keep nurses at the bedside.

Surveys have shown that the exodus of registered nurses, therapists, technologists, technicians and service and maintenance workers is directly attributable to difficult working conditions, including inadequate staffing, mandatory overtime and insufficient compensation. This is not expected to improve over the next decade because as well as leaving the bedside, much fewer numbers of people are looking to nursing as a career.

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5 Safe Nursing and Patient Care Act of 2003 (Introduced in Senate) [S.373.IS]
Safe Nursing and Patient Care Act of 2003 (Introduced in House)[H.R.745.IH]
http://thomas.loc.gov/cgi-bin/thomas

6 . Available for purchase at http://www.healthaffairs.org/ .

7 http://www.iom.edu/project.asp?id=4671

Retaliation by Employers

Nurses do suffer retaliation from employers for refusing to accept overtime hours. There are reports from all over the country. According to a report, The Minnesota Nurses Association has documented complaints from nurses who were threatened by their employer. These nurses were told that if they would not work additional shifts, they would be reported to the State Board of Nursing for "patient abandonment". While the Board does not view the refusal to accept additional shifts because of fatigue as "patient abandonment", the fear of such a complaint often compels nurses to work against their better judgment. Another form of retaliation is more direct and involves simply firing or suspending the nurse who refuses overtime. In this situation, the nurse is forced to choose between their ethical obligation to the patient to provide quality care and their livelihood. This is a choice that nurses should not have to make.

What is this term ABANDONMENT?

According to the New Jersey Board of Nursing, the term "patient abandonment" should be differentiated from the term "employment abandonment," which becomes a matter of the employer-employee relationship and not that of the Board of Nursing. It should be noted that from a regulatory perspective, in order for patient abandonment to occur, the nurse must have first accepted the patient assignment and established a nurse-patient relationship, then severed that nurse-patient relationship without giving reasonable notice to the appropriate person (supervisor, employer) so that arrangements can be made for continuation of nursing care by others. Providing appropriate nursing personnel to care for patients is the responsibility of the employer. Failure of a nurse to work beyond his/her scheduled shift, refusal to accept an assignment, refusal to float to another unit, refusal to report to work, and resigning without notice are examples of employment issues and not considered by the New Jersey Board to constitute patient abandonment.

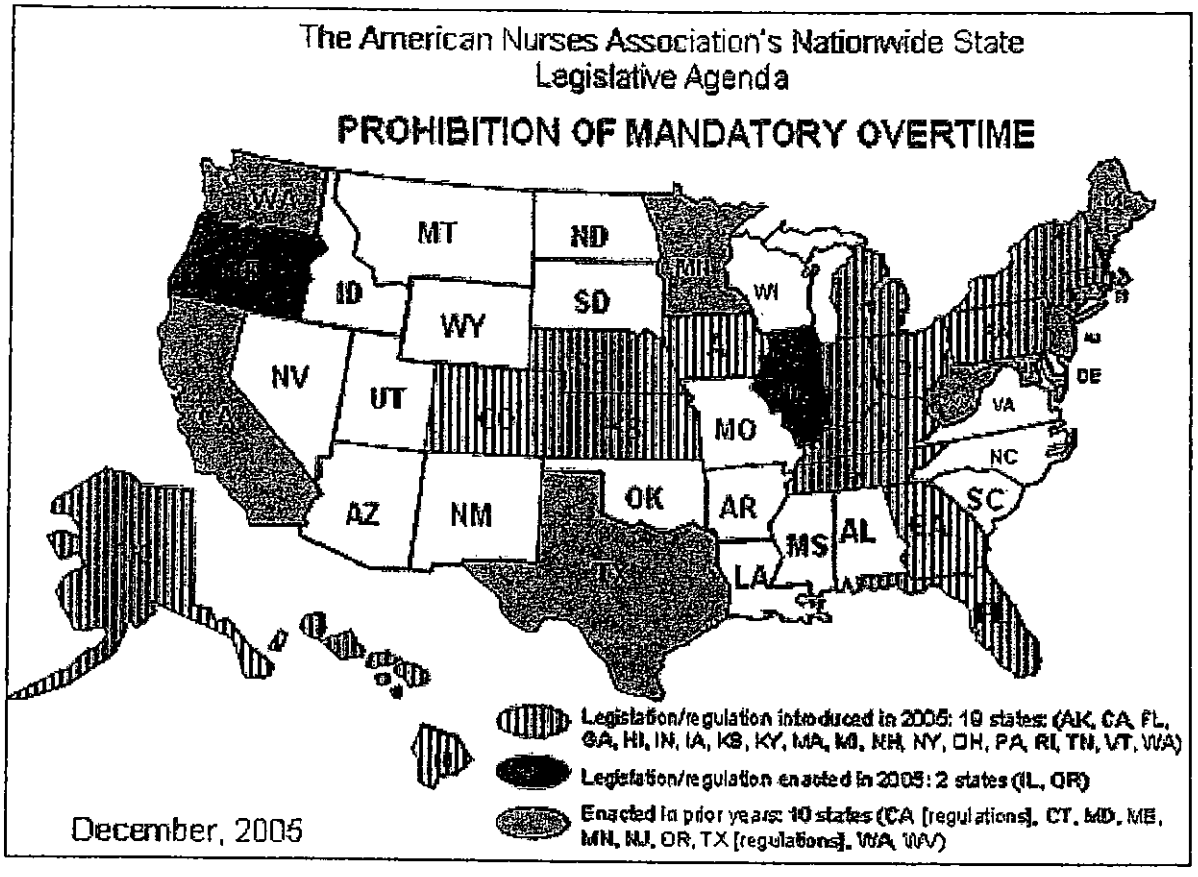
What are other states doing?

In 2003, three states, LA, NV and WV enacted legislation requiring the establishment of study committees to further explore the issue. 22 other states introduced prohibition of mandatory overtime legislation/regulation designed to set maximum hours of work per day/week with protected right of refusal for work time requested in excess of predetermined maximums.

Approximately 28+ states have completed or initiated steps toward legislation to restrict mandatory overtime for RNs, LPNs and, in some cases, all health care workers. In 2004, WV enacted legislation prohibiting a hospital from mandating a nurse to accept an assignment of overtime. CT enacted legislation that prohibits a hospital from requiring a nurse to work in excess of a predetermined scheduled work shift except in certain circumstances (emergency etc). Legislation was also introduced in FL, GA, HI, IA, IL, MA, MI, MO, NY, OH, PA, RI, TN, VT, and WA.

ANA State Government Relations

2005 Legislation: Mandatory Overtime (updated 12/05)



Background: Mandatory Overtime

Mandatory overtime is a difficult problem for RNs and health care facilities. Because of inadequate RN staffing, employers have used mandatory overtime to staff facilities often as a cost savings factor. Nurses are concerned about the health effects of long term overtime and the quality of care being provided. Research indicates that risks of making an error were significantly increased when work shifts were longer than 12 hours, when nurses worked overtime, or when they worked more than 40 hours per week[1].

As part of the American Nurses Association's (ANA) Nationwide State Legislative Agenda on the nurse staffing crisis, State Nurses Associations support the enactment of mandatory overtime legislation in state legislatures and regulatory agencies. ANA is also pursuing the enactment of federal legislation to prohibit mandatory overtime. The Safe Nursing and Patient Care Act of 2005 (HR

not to exceed 40 hours per week. **TX** regulations require hospitals to develop policy and procedures for mandatory overtime. **WA**'s new language states that acceptance of mandatory overtime by a nurse is strictly voluntary and refusal is not grounds for adverse actions against the nurse.

Legislation enacted in 2001 in **ME** would prevent a nurse from being disciplined for refusing to work more than 12 consecutive hours except in certain circumstances and must be given 10 consecutive hours off following overtime. **OR** enacted legislation prevents a nurse from being required to work more than 2 hours beyond a regularly scheduled shift or 16 hours in a 24 hour time period. Regulations adopted in **CA** prior to 2001 prevent an employee scheduled to work a 12 hour shift from working more than 12 hours in a 24 hour period except in a health care emergency.

[1] Rogers A, et al. The working hours of hospital staff nurses and patient safety. *Health Affairs* 2004;23(4):202-12.

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AACN Public Policy

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Mandatory Overtime

A Statement from The American Association of Critical-Care Nurses (AACN)

BACKGROUND

Mandatory overtime is identified as a workplace issue and a patient safety issue. Mandatory overtime is the practice of hospitals and health care institutions to maintain adequate numbers of staff nurses through forced overtime, usually with a total of twelve to sixteen hours worked, with as little as one hour's notice. With mandatory overtime nurses are unable to refuse the required extra hours due to 1) fatigue, or 2) feeling that she/he would be unable to deliver adequate, safe patient care. This does not include overtime mandated in an unforeseen emergency, such as a mass casualty situation, or a sudden snowstorm. "On call" time is not included in this definition, unless the nurse's on call time is immediately before or after a scheduled shift, and it would force him or her to work a double shift.

THE ISSUE

The dramatic changes in the health care environment that have impacted nursing practice in recent years have come as managed care programs grew in dominance and federal Medicare and Medicaid reimbursements declined (Berens, M.J.). With the nursing shortage continuing, the growing trend is for hospitals to use mandatory overtime as a common staffing practice (ANA, June 2000).

Mandatory overtime may cause or lead to increased stress on the job, less patient comfort and mental and physical fatigue that can contribute to errors and "near-misses" with medications and case-related procedures. This is occurring as patient acuity has increased. The practice of mandatory overtime ignores the responsibilities nurses may have at home with children, other family members, or other obligations. Being forced into excessive overtime can cause an exhausted

a lower incidence of needlestick injuries among nurses was also noted. If mandatory overtime is allowed to continue, one could easily project:

1) Increase in medication errors,
2) Decrease in safe, quality patient care,
3) Decrease in patient satisfaction,
4) Increase in hospital length of stay,
5) Increase in mortality and morbidity,
6) Decrease in recruitment of new nurses,
7) Decrease in retention of nurses, and
8) Increase in legal liability issues against nurses.

LEGISLATIVE HISTORY

February 12, 2003 - Senator Edward M Kennedy re-introduced **S. 373, the Safe Nursing and Patient Care Act of 2003**, which amends title XVIII of the Social Security Act to provide for patient protection by limiting the number of mandatory overtime hours a nurse may be required to work in certain providers of services to which payments are made under the Medicare program. A companion bill, H.R. 745 was again re-introduced in the House by Representative Pete Stark. The bills are currently in committee.

November 14, 2001- Senator Edward M Kennedy, introduced **S. 1686 "The Safe Nursing and Patient Care Act of 2001"** which was referred to the Committee on Finance. The bill would amend title XVIII of the Social Security Act to provide for patient protection by limiting the number of mandatory overtime hours a nurse may be required to work in certain providers of services to which payments are made under the Medicare Program. and referred to the House Committee on Education and the Workforce and to the Subcommittee on Workforce Protections.

September 15, 2000- H.R. 5179 "The Registered Nurses and Patients Protection Act" was introduced into the U.S. House of Representatives by Rep.Tom Lantos (D-Calif.). The bill would amend the Fair Labor Standards Act so that no RN would be required to work beyond eight hours in any workday or 80 hours in any 14-day work period. This legislation was not acted on in the 106th Congress and Lantos reintroduced the bill **(H.R. 1289)** in the 107th Congress where it was referred to the House Committee on Education and the Workforce and to the Subcommittee on Workforce Protections.

AACN's POSITION

AACN believes that mandatory overtime is not an acceptable means of staffing a hospital, because it may place nurses and their patients at increased risk of being involved in medical errors. Instead, nurses should be able to decide whether working overtime will affect their ability to care safely and effectively for patients. They should have the option of refusing overtime assignments and not be forced into working beyond their capacity to provide optimal care. AACN supports this legislation and will continue to work to educate the public on the negative impact that mandatory overtime can have on patient safety.

RN to practice unsafe patient care, jeopardizing her nursing licensure status. Impact is felt at the level of the bedside nurse in three major areas identified through current literature: medication errors, quality patient care, and nurses' legal liability.

Medication Errors - The Institute of Medicine's report *To Err is Human: Building a Safer Health System* (IOM, 12/1999) states the deaths from medication errors that take place both in and out of hospitals, more than 7000 annually, exceed those from workplace injuries. In a separate report, investigation by the Chicago-Tribune states that since 1995, at least 1,720 hospital patients have died and 9,548 others have been injured because of mistakes made by RN's across the country (Associated Press, 9/10/2000).

Quality Patient Care - As the nurse-to-patient ratio worsens, and as patient acuity increases, hospital management is free to demand that nurses work mandatory sixteen-hour shifts, with one-hour notice (MNA, 4/3/2000). In a 1989 article published in the Journal of Occupational Health and Safety, the author stated, "Once a shift exceeds twelve consecutive hours, acute fatigue sets in. A worker may still be able to perform routine tasks, but his brain waves exhibit a pattern of stage one alpha sleep. Errors made in this stage are frequently major, since the worker tends to perform the opposite of the correct action."

Legal Liability - Nurses practice under each state's Nurse Practice Act, which govern nursing practice. Most nurse practice acts state that nurses are held accountable for the safety of their patients. Thus, if a nurse accepts a patient assignment and something untoward happens to that patient, the nurse is liable under her license. Once a nurse accepts an assignment, her license can be in jeopardy if she is unable to deliver safe patient care.

Implications of Change - If mandatory overtime is legally banned in all states, hospitals and health care institutions will have to look at real remedies for understaffed facilities such as:
1) Hiring more RN's, and
2) Utilizing strategies to recruit and retain more nurses.

ANA's recent study, *Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting* (3/2000), tracks five adverse outcomes measures that can be mitigated if adequate patient staffing is provided: hospital length of stay, nosocomial pneumonia, postoperative infections, pressure ulcers, and nosocomial urinary tract infections. With sufficient nurse staffing, time is available for more thorough patient assessment and interventions to improve outcomes.

The American Academy of Nursing (AAN) conducted research in the 80's, which has had several follow-up studies since, which reinforce the original findings of researcher Linda Aiken. Her research affirmed that specific organizational variables create a milieu that not only attracts nurses, but also create practice environments that provide better outcomes for patients. "Magnet facilities" have higher nurse-staffing levels, and lower mortality and morbidity rates, shorter length of stay, and lower utilization of ICU days. In the 1999 follow-up research,

WHAT YOU CAN DO

Work with the administrators in your facility to develop systems that support the delivery of quality care and a safe work environment.

Let your legislators know that this bill has strong support of nurses. Discuss with him or her:

Your concern that mandatory overtime is not an acceptable means of staffing a hospital because it can place nurses and their patients at increased risk for making errors.

The fact that studies have shown that when a worker (especially a health care worker) exceeds 12 hours of work, and is fatigued, the likelihood of their making an error increases. The IOM report on medication errors substantiates these findings, where the experts who compiled the report specifically recommended that safe staffing and limits on mandatory overtime are a component to preventing medication errors.

Explain RN accountability for the delivery of safe care and that nurses should not be forced into working beyond his or her capacity to provide optimal care without the right to refuse that assignment.

3/01
Revised 3/03

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JAMA study: High RN workloads impact mortality

Nurse researchers add more evidence to growing body of work on nurse staffing

In a new study looking at nursing care, University of Pennsylvania (Penn) researchers have determined that patients who have common surgeries in hospitals with the worst nurse staffing levels have up to a 31 percent increased chance of dying. Further, more nurses at the bedside could save thousands of patients' lives every year, report researchers in the Oct. 23-30 issue of the Journal of the *American Medical Association (JAMA).*

The researchers found that every additional patient in a hospital nurse's average workload increased the risk of death in surgical patients by seven percent. Patients with life-threatening complications also were less likely to be rescued in hospitals where nurses' patient loads were heavier.

"Nurses reported greater job dissatisfaction and emotional exhaustion when they're responsible for more patients that they can safely care for," said Pennsylvania State Nurses Association member Linda Aiken, PhD, RN, FAAN, director of the Center for Heath Outcomes and Policy Research at Penn's School of Nursing. Aiken, along with colleagues, conducted the study. "Failure to retain nurses contributes to avoidable patient deaths."

ANA President Barbara Blakeney, MS, APRN,BC, ANP, said: "This new study is dramatic because it highlights the fact that people can die when nursing care is inadequate. It is an important contribution, but frankly, this is something that nurses have known for years. Nurses make the critical, cost-effective difference in providing safe, high quality patient care."

Specifically, the Penn nursing researchers found that:

* If all hospitals in the nation staffed at eight patients per nurse rather than four, the risk of hospital deaths would increase by 31 percent, roughly translating to as many as 20,000 avoidable deaths in the United States annually.

* Having too few nurses may actually cost more because of the high costs of replacing burned-out nurses and the higher cost of caring for patients with poor outcomes.

* Adding two patients to a nurse already caring for four increases the risk of death by 14 percent.

The report, "Hospital Nurse Staff and Patient Mortality, Nurse Burnout and Job Dissatisfaction," concluded that, "When taken together, the impacts of staffing on patient and nurse outcomes suggest that by investing in registered nurse staffing, hospitals may avert both preventable mortality and ... problems with low nurse retention in hospital practice."

The study, funded by the National Institute of Nursing Research of the National Institutes of Health, examined data collected from 168 hospitals, 232,342 surgical patients, and 10,184 nurses in Pennsylvania from 1998 to 1999. They examined data on relatively common, general, orthopedic surgeries and vascular surgeries, excluding cardiac operations such as coronary bypass.

JAMA study: High RN workloads impact mortality

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ANA Press Release October 23, 2002

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JAMA Article Links Hospital Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction

ANA's Blakeney calls on hospitals to utilize Principles for Nurse Staffing to address problem

Washington, DC -- A study published today in the Journal of the American Medical Association (JAMA) found that Registered Nurse (RN) staffing levels have a significant effect on preventable hospital deaths among surgical patients. According to researchers, the odds of patient mortality rose 7 percent for every additional patient added to the average nurses's workload. The difference between four to six and four to eight patients-per-nurse was accompanied by a 14 percent and 31 percent increase in mortality respectively. The study from the University of Pennsylvania affirms the critical role RNs play in patient safety when able to make direct assessments and life-saving interventions.

"This new study is dramatic because it highlights the fact that people can die when nursing care is inadequate," said Barbara A. Blakeney, MS, APRN,BC, ANP, president of the American Nurses Association (ANA). "It is an important contribution, but, frankly, this is something that nurses have known for years," she said. "Nurses make the critical, cost-effective difference in providing safe, high-quality patient care," she added. Blakeney pointed to ANA's own report, Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting," which was released in May 2000. The study looked at hospital and Medicare data in nine states in five categories of adverse outcomes: length of hospital stay, hospital-acquired pneumonia, postoperative infection, bed sores and hospital-acquired urinary tract infections. All five measures were markedly lower with higher levels of RN involvement in patient care. Two other studies published this year, one in the New England Journal of Medicine and one by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), also found direct links between nurse staffing levels and better patient outcomes.

Today's JAMA article also reported that patient load had a direct impact on nurse retention rates. Adding one patient-per-nurse to a hospital's staffing level increased nurse burnout by 23 percent and job dissatisfaction by 15 percent. The data indicate that more than 40 percent of nurses who reported high burnout and job dissatisfaction intended to leave their job within the next year.

"Inappropriate staffing is the number one concern of nurses today," Blakeney said. "Nurses already face great stress and challenges on the job. They must care for greater numbers of patients than ever before and patients in hospitals are more acutely ill than in the past. Adequate nurse staffing is critical to the delivery of quality patient care because it allows nurses time for appropriate assessment of patients and their needs and initiation of suitable interventions."

Blakeney emphasized that nurses are dissatisfied because of a lack of control over their work environment which prevents them from delivering high-quality nursing care. In addition to the

right number and mix of direct care staff for hands-on care, other resources are necessary to support RNs' ability to deliver the best possible care. ANA has developed and strongly encourages the use of its Principles for Nurse Staffing, which include: nurse control over the practice environment; effective and efficient support services; readily available and current patient information; sufficient orientation and mentoring for new staff and new nursing graduates; education in the use of new technology; and sufficient time for collaboration, planning, coordination and delivery of care that meets both patient and family needs. Research has shown that hospitals which incorporate much of the philosophy embedded in the Principles for Nurse Staffing into their organizational culture and practice have higher rates of satisfaction and retention among nursing staff, and better outcomes for patients.

ANA is advocating for a comprehensive set of strategies to address the nurse staffing crisis, including state and federal legislation that would limit mandatory overtime, provide whistle-blower protections for nurses, mandate collection of workforce and nursing-sensitive quality data, establish patient staffing systems and provide funding for nursing education.

In addition, hospitals that utilize nursing "best practices" can apply for designation as "Magnet" facilities a recognition made by the American Nurses Credentialing Center, a subsidiary of ANA. Hospitals that have achieved "Magnet"status have higher retention rates for nurses and improved patient outcomes.

Many of the issues touched on in the JAMA study have been addressed in Nursing's Agenda for the Future (www.NursingWorld.org/naf). The plan, which was released in April, is the result of an in-depth strategic planning process that involved leaders from more than 60 national nursing organizations. It reflects the brain trust of nursing and includes strategies to address basic issues, such as recruitment, as well as more complex issues, such as the economic value of nursing.

The authors of the new JAMA study said that improving nurse staffing may not only save patient lives and decrease nurse turnover but also reduce hospital costs, if recently published estimates of the costs of replacing a hospital medical and surgical general unit and a specialty nurse ($42,000 to $64,000) are correct.

"Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," by Linda H. Aiken, et. al, appears in the October 23/30, 2002 issue of JAMA. The study, funded by the National Institute of Nursing Research of the National Institutes of Health, looked at 232,342 patients between the ages of 20 and 85 who underwent general surgical, orthopaedic, or vascular procedures in 168 Pennsylvania hospitals from April 1, 1998, to Nov. 30, 1999.

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ANA is the only full-service professional organization representing the nation's 2.7 million Registered Nurses through its 54 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Number 22 Volume 346:1715-1722

May 30, 2002

Nurse-Staffing Levels and the Quality of Care in Hospitals

Jack Needleman, Ph.D., Peter Buerhaus, Ph.D., R.N., Soeren Mattke, M.D., M.P.H., Maureen Stewart, B.A., and Katya Zelevinsky

ABSTRACT

Background It is uncertain whether lower levels of staffing by nurses at hospitals are associated with an increased risk that patients will have complications or die.

Methods We used administrative data from 1997 for 799 hospitals in 11 states (covering 5,075,969 discharges of medical patients and 1,104,659 discharges of surgical patients) to examine the relation between the amount of care provided by nurses at the hospital and patients' outcomes. We conducted regression analyses in which we controlled for patients' risk of adverse outcomes, differences in the nursing care needed for each hospital's patients, and other variables.

Results The mean number of hours of nursing care per patient-day was 11.4, of which 7.8 hours were provided by registered nurses, 1.2 hours by licensed practical nurses, and 2.4 hours by nurses' aides. Among medical patients, a higher proportion of hours of care per day provided by registered nurses and a greater absolute number of hours of care per day provided by registered nurses were associated with a shorter length of stay ($P=0.01$ and $P<0.001$, respectively) and lower rates of both urinary tract infections ($P<0.001$ and $P=0.003$, respectively) and upper gastrointestinal bleeding ($P=0.03$ and $P=0.007$, respectively). A higher proportion of hours of care provided by registered nurses was also associated with lower rates of pneumonia ($P=0.001$), shock or cardiac arrest ($P=0.007$), and "failure to rescue," which was defined as death from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis ($P=0.05$). Among surgical patients, a higher proportion of care provided by registered nurses was associated with lower rates of urinary tract infections ($P=0.04$), and a greater number of hours of care per day provided by registered nurses was associated with lower rates of "failure to rescue" ($P=0.008$). We found no associations between increased levels of staffing by registered nurses and the rate of in-hospital death or between increased staffing by licensed practical nurses or nurses' aides and the rate of adverse outcomes.

Conclusions A higher proportion of hours of nursing care provided by registered nurses and a greater number of hours of care by registered nurses per day are associated with better care for hospitalized patients.

Source Information

From the Department of Health Policy and Management, Harvard School of Public Health, Boston (J.N., S.M., M.S., K.Z.); the Vanderbilt University School of Nursing, Nashville (P.B.); and Abt Associates, Cambridge, Mass. (S.M.).

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Nurses' Solutions to the Nurse Staffing Shortage
UAN National Sample Survey of Staff RNs

Key Findings and Talking Points for CMAs

The United American Nurses has conducted a national poll exclusively of hospital staff RNs on the front lines of direct patient care to spotlight their experience and expertise about the critical staffing shortage and how to solve it.

Lake Snell Perry and Associates, a leading national political and public policy research firm, designed and administered this survey which was conducted by phone using professional interviewers in November 2002. The survey reached 600 licensed hospital staff nurses who provide direct patient care.

1. **Problems in today's hospitals**

The nursing shortage is the top problem in hospitals today. Eight of ten nurses feel there is a serious shortage in their hospital.

When asked about the two biggest problems facing them, nurses identify the staffing shortage and inadequate wages as top concerns.

Other problems include:
Workload issues
Nurse to patient ratios
Stress and fatigue
Lack of respect and recognition
Long hours
Support from the administration
Quality of patient care
Turnover rate and retaining nurses

Time for patient care has decreased, according two-thirds of those surveyed (67%), and nearly four in ten nurses (38%) say less than half their day is spent on direct patient care. 31% say administrative reports and documentation take more than half their day.

2. **Why nurses leave the profession.**

Work-related stress, patient load, and inadequate pay are the top three reasons nurses leave the profession.
Three out of ten nurses say it's unlikely they will be a hospital staff nurse in five years.
The majority of nurses surveyed feel their hospital is doing only a fair to poor job attracting and retaining nurses.

3. **Solutions to the Nursing Shortage**

The best solutions are:
Increased pay (82%),
Reduced nurse patient ratios (85%)

Collectively, staff nurses have a lot of experience. Over a third (35%) have worked as a staff nurse for more than 20 years and 65% have more than 10 years experience. Only 12% have 5 years or less experience. The other side of that coin is that the lower percentages of less experienced nurses reflects fewer people entering the nursing profession now and foreshadows future shortages.

An overwhelming number (86%) say they would be confident having someone close to them receive care at the hospital in which they work. The fact that one of every ten (13%) said they would not is a strong reminder that patients need to choose hospitals carefully.

When asked about how good a place to work their hospital is, just over half (52%) said it was too good a place to work to leave. However, four out of ten (41%) said their hospital isn't a great place to work, but they probably would not leave and 5% said it was so bad a place to work that they definitely intend to leave.

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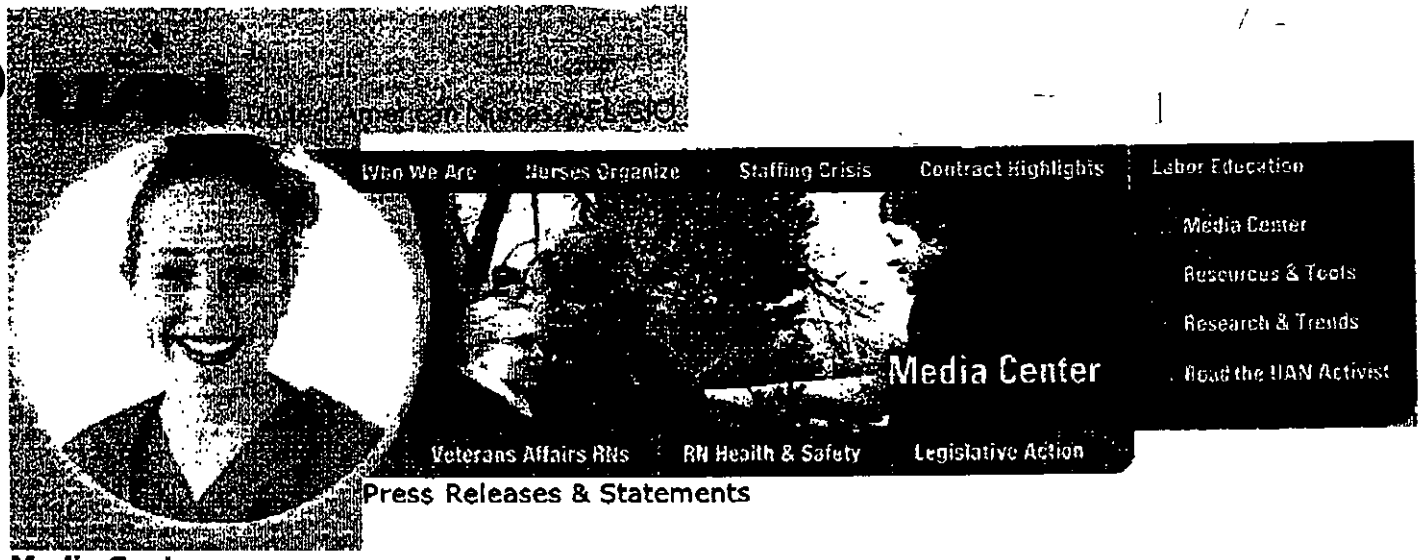

Press Releases & Statements

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Nurses in the News
UAN *Activist* Newsletter

UAN gives a voice to the issues that are important to staff nurses. Here's what UAN staff nurses are saying to the media, Congress and the public:

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FOR IMMEDIATE RELEASE: February 18th 2009

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Historic Pact Creates Largest RN Union Ever in U.S.

Powerful New Association of 150,000 RNs Joins to Organize All RNs, Promote Healthcare Justice

United American Nurses, California Nurses Assn/NNOC, and Massachusetts Nurses Assn Reach Landmark Accord

In a dramatic move to unite the power and influence of America's leading direct care RN organizations, the United American Nurses, California Nurses Association/National Nurses Organizing Committee, and the Massachusetts Nurses Association today announced they are joining together to form a new, 150,000-member association.

The new organization will be called the United American Nurses-National Nurses Organizing Committee, UAN-NNOC (AFL-CIO), the three said in a joint statement issued today.

"Under the principle that RNs should be represented by an RN union," the statement declared, "we resolve to create a new union of staff nurse-led organizations named UAN-NNOC" to:

1. "Build an RN movement in order to defend and advance the interests of direct care nurses across the country;
2. "Organize all non-union direct care RNs (a substantial majority of the budget shall be dedicated to new organizing);
3. "Provide a powerful national voice for RN rights, safe RN practice, including RN-to-patient staffing ratios under the principle that safe staffing saves lives, and health care justice;
4. "Provide a vehicle for solidarity with sister nurse and allied organizations around the world;
5. "Create a national Taft-Hartley pension for union RNs."

Central to the new organization is a guiding principle that all RNs "should be represented by an RN union," the joint statement declared.

Link to other years' news releases and statements:

- **2008**
- **2007**
- **2006**
- **2005**
- **2004**
- **2003**
- **2002**

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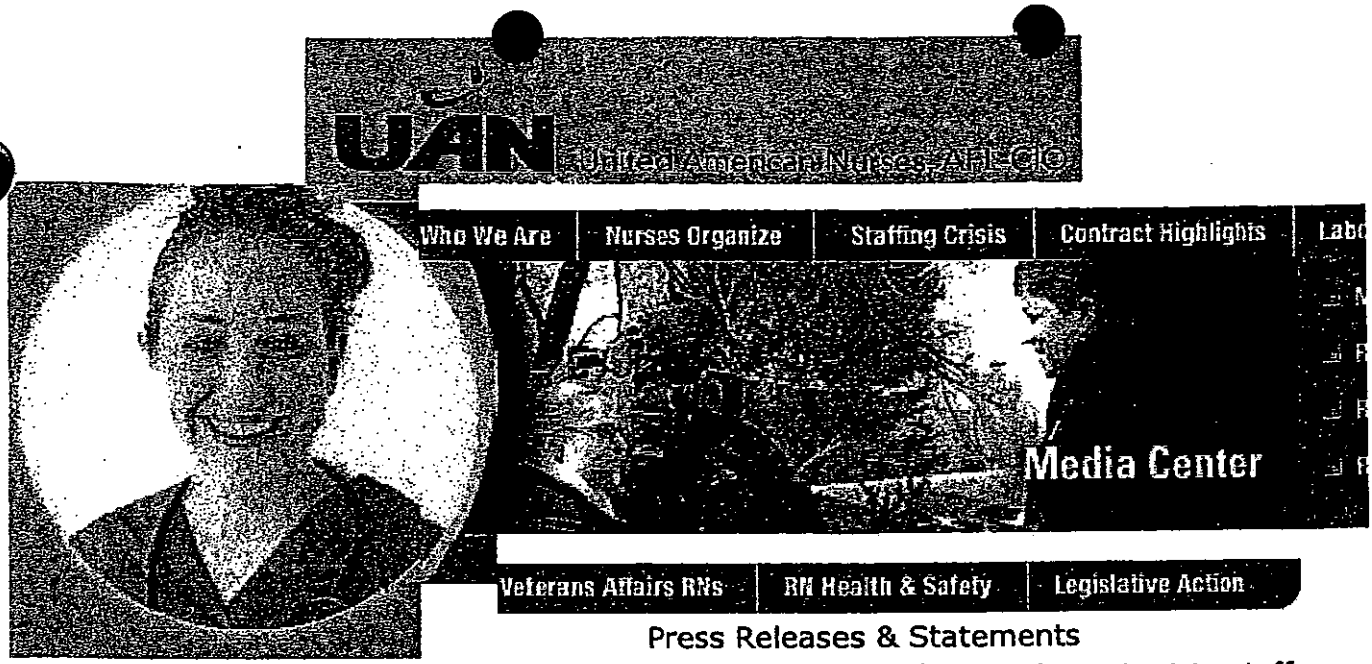

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Press Releases & Statements

UAN gives a voice to the issues that are important to staff nurses. Here's what UAN staff nurses are saying to the media, Congress and the public:

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FOR IMMEDIATE RELEASE: March 2nd 2006

UAN VP Converso's remarks to the Sixth International Conference on Stress and Health

THE OCCUPATIONAL SAFETY AND HEALTH IMPACTS OF INADEQUATE STAFFING AND MANDATORY OVERTIME ON REGISTERED NURSE

Ann Converso, RN, Vice President
United American Nurses, AFL-CIO

The Sixth International Conference on Occupational Stress and Health
March 2, 2006

Long hours of work, mandatory overtime, and inadequate staffing cause extreme stress to nurses, impacting their physical and mental health. They also ultimately affect the quality of patient care. Like many other industrialized nations, the United States is experiencing a severe shortage of nurses that will intensify as the baby boom

generation ages, with shortages currently in at least 30 states according to the Health Resources and Services Administration. The Bureau of Labor Statistics estimates that the United States will need an additional 1.1 million registered nurses by 2014.

At the same time, health care costs continue to rise. Managed care compels hospitals to discharge patients more rapidly, resulting in higher patient acuity levels. Hospitals attempt to control labor costs by reducing the number of registered nurses they employ. But cutting the number of nurses at the bedside is counterproductive as overworked nurses get injured or burned out and leave the professionóexacerbating the shortage of nurses.

A 2003 study by Aiken with Clarke, Sloane, Sochalski, and Silber found that higher emotional exhaustion and greater job dissatisfaction were strongly associated with higher nurse-to-patient ratios. Each additional patient per nurse correlated to a 23 percent increased risk of burnout, as well as a 15 percent increase in the risk of job dissatisfaction. Among the nurses surveyed in this study, 43 percent reporting job burnout and dissatisfaction stated that they intended to leave their current position within the year. When the United American Nurses surveyed hospital nurses in 2002 about staffing and job satisfaction issues, a third said they were likely to leave the profession within five years due to frustration about inadequate staffing and mandatory overtime.

How bad is the situation? Unfortunately, we do not have systematic national data on nurse-to-patient ratios and the hours worked by nurses. We are looking forward to a NIOSH study on the combined influence of shift work and overtime on nursesí health and safety.

In the interim, some studies on patient safety have shed light on nurse-to-patient ratios and hours of work. Patient safety has gotten a lot of attention since the Institute of Medicine announced in 1999 that approximately 98,000 people in the United States die annually due to hospital errors. In 2003, the IOM surveyed the literature on factors in the nursing profession and the impact on patient safety. They concluded that there is ample evidence that leaner nurse staffing and long work shifts are associated with errors and adverse reactions, such as post-operative infections, pneumonia, urinary tract infections, and increased length of hospital stay.

The IOM found that while the average registered nurse-to-patient ratio in medical-surgical units is one-to-six, 23

percent of hospitals reported that day shift registered nurses in medical-surgical units were responsible for seven to twelve patients. Night shift nurse-to-patient ratios are likely to be even poorer. In contrast to those staffing ratios, Aikenís study found that for each additional patient over four in a nurseís workload, the risk of death increased by seven percent for surgical patients.

The Institute of Medicine also found that work shifts longer than twelve hours per day endanger patient safety due to fatigue, causing reduced attention span and capacity to catch errors. However, the same study found that 27 percent of full-time hospital and nursing home nurses reported working more than 13 consecutive hours one or more times per week. The IOM recommends that states prohibit nurses from working more than 12 hours in a 24-hour period or more than 60 hours per week.

However, available data suggest that hospital staff nurses are working longer hours, with fewer breaks, with little time for recovery between shifts. A 2004 study by Rogers with Hwang, Scott, Aiken, and Dinges on the impact of long working hours on patient safety reveals excessively long work shifts among hospital nurses. In this study, 393 Registered nurses were asked to log their actual work times over a four-week period, providing 5,317 work shifts over 28 consecutive days to analyze.

- On average, the nurses in the study worked 55 minutes beyond their scheduled shift, of 8.5 or 12.5 hours. (An extra 30 minutes for the handover period at the end of shifts is already built into the schedule.)

- Nurses reported leaving work at the end of the scheduled shift less than 20 percent of the time during the study.

- Although 31 percent of the shifts were scheduled for 12.5 or more hours, the percentage of shifts that the nurses actually worked 12.5 or more hours was 39 percent.

- Fourteen percent of the respondents reported working 16 or more consecutive hours at least once during the four-week period. The longest shift recorded was 23 hours, 40 minutes.

- Almost two-thirds of the nurses worked overtime ten or more times during the period, and a third reported working overtime each day during the 28-day period.

- Not surprisingly, the risk of making an error increased with longer work hours and was three times higher when nurses worked 12.5 or more hours. Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled.

In addition to the pressure that registered nurses face to work overtime, many are required to be on call, especially those in specialized units. There is also anecdotal evidence that 24-hour shifts are becoming more common, particularly in emergency departments and on units where nurses self-schedule.

Beyond long work shifts and mandatory overtime, nurses face other scheduling issues that cause fatigue and stress as a result of being shift workers in a 24-hour-a-day industry. Nurses working night shifts struggle against their circadian rhythm, our biological tendency to sleep at night and be active during the day. The circadian rhythm makes it difficult to get enough restorative rest during the day and often requires night shift workers to miss out on activities with family and friends. Bureau of Labor Statistics injury data indicate that the risk of injury for all workers is substantially higher during the night shift than during the day or evening shifts. Risk of injury is nearly three times greater very early in the morning than at mid-afternoon, the low and high points of the circadian cycle.

Nurses have an even harder time if they work rotating schedules which prevent them from getting adequate rest between shifts. They are not just tired from not having enough sleep between shiftsótheir bodies have not had enough time to recuperate from the previous shift.

So what happens to these nurses who work such long hours and difficult schedules? We know that long hours of work, night shifts, or rotating shifts increase nursesí risk of musculoskeletal injuries by reducing the recovery time between shifts that nurses need to allow their backs to rest and heal. Nurses develop musculoskeletal injuries through the cumulative effect of repetitive actions, lifting

transferring patients, moving heavy, awkward equipment, and stretching to work in poorly designed spaces. The Bureau of Labor Statistics, which ranks occupations sustaining the most musculoskeletal injuries, ranked registered nursing eighth among all jobs in 2003. Fifty-two percent of registered nurses have chronic back pain and 38 percent have pain severe enough to require leave from work. Research by Lipscomb, Trinkoff, Geiger-Brown, and Brady in 2002 found that:

- Registered nurses working twelve or more hours per shift were at increased risk for musculoskeletal disorders compared to those working eight-hour shifts.

- Registered nurses working twelve or more hours per day and 40 or more hours per week doubled their odds of getting a back, neck, or shoulder injury.

- Registered nurses working nights or weekends also significantly increased their risk of musculoskeletal injuries, due in part to lower staffing levels on those shifts.

- Registered nurses working rotating shifts had twice the number of reported accidents as those working day or night shifts only.

- Another study by Gold found that nurses working rotating shifts had twice the number of reported accidents or errors related to sleepiness than nurses who worked only a day or an evening shift.

Of course, nurses face a number of occupational hazards beside musculoskeletal disorders. In one study by Macias, the number of needlestick injuries and incidents of biological fluid exposure increased in the last two hours of twelve-hour shifts, but no increase in these incidents was found in the last two hours of eight-hour shifts.

Other research indicates that as health care workersí work hours increase, car crashes and occupational accidents increase. Ninety-six percent of Intensive Care Unit nurses reported car crashes or near misses while driving home

after a night shift in a study by Novak and Auvil-Novak in 1996.

We know less about the cardiovascular impacts or psychological stress caused by inadequate staffing and long working hours among nurses, although there has been research indicating that shifts longer than eight hours increase the incidence of smoking. Overtime has been associated with unhealthy weight gain among nurses. Overtime, shifts over eight hours, and night shifts and rotating shifts longer than eight hours have been associated with higher alcohol consumption among nurses.

However, we do knowóbecause nurses have been voting with their feet, whether through strikes or by leaving hospital employment or the professionóthat the environment they work in is stressful. In a 1999 study by the Minnesota Nurses Association, an affiliate of United American Nurses, registered nurses expressed escalating frustration and concern about their ability to provide safe care to patients under short staffing situations. They reported a decrease in organizational support and peer support.

What is the solution? Hospitals are not going to solve this problem on their ownóotherwise, it would already be fixed. Nurses who are on the frontlines must be part of the solution and have a voice in decision-making. UAN nurses have negotiated a variety of remedies through contract language, such as:

- a prohibition on mandatory overtime,
- specific nurse-to-patient ratios,
- the authority to close a department to new admissions when staffing ratios are too high to be safe for patients,
- and the power to determine staffing levels based on patient acuity rather than just the number of patients.

However, contract language is not enoughówe need a legislative solution for all nurses, not just those who have

[redacted]n representation, and the state [redacted]islatures are beginning to address the issues.

Ten states have passed laws prohibiting the use of mandatory overtime for registered nurses and 14 other states have introduced legislation or are considering legislation on mandatory overtime. Illinoisí law ensures that a nurse will work no longer than four hours beyond the scheduled shift and requires an eight-hour rest period between shifts. Oregonís law prohibits hospitals from mandating nurses to work beyond 48 hours in a week or more than 12 consecutive hours in a 24-hour period.

Legislation requiring hospitals to develop and implement nurse staffing plans and include input from nurses has been passed in five states. Going beyond staffing plans, California enacted a nurse-to-patient ratio law in 1999, requiring one nurse for every six patients in medical-surgical units when it which went into effect in 2001. The law also provided that the ratio would be strengthened to one nurse for every five medical-surgical patients in 2005.

The United American Nurses supports two federal bills which would prohibit mandatory overtime and create minimum staffing ratios. The Safe Nursing and Patient Care Act of 2005, introduced by Senator Edward Kennedy, Democrat of Massachusetts and Representative Pete Stark, Democrat of California, would set strict limits on mandatory overtime for nurses. Nurses could not be forced to work beyond their scheduled shift, except in the event of a state of emergency declared by a local, state, or federal government. The bill also provides nurses with whistleblower protections.

UAN also supports the Nurse Staffing Standards for Patient Safety and Quality Care Act of 2005, sponsored by Representative Janice Schakowsky, which would establish federal minimum staffing nurse-to-patient ratios in all hospitals that receive federal funding, except during a declared emergency. This bill gives registered nurses and other health care workers a real voice in providing quality, safe health care. The bill also provides real penalties to hospitals that fail to comply and nurse whistleblower protections.

There are some people who say that staffing ratios wonít workóthat hospitals canít hire nurses who donít existóand that employing more registered nurses will increase health care costs even faster. But preliminary evidence from California and the state of Victoria in Australia, where ratios have been implemented, show that nurses who left

the profession will return, students will apply for nursing school, and nurses who are stressed will stay.

And a 2006 study by Needleman with Buerhaus, Stewart, Zelevinsky, and Mattke indicates that there is a business case for staffing ratios. They found that increasing the use of RNs to care for patients reduced costs by reducing patient complications and deaths and reducing patientsí time spent in the hospital.

Nursing, unlike other professions that impact public safety such as pilots and air traffic controllers, has been operating for generations without rules preventing them from working under unsafe conditionsóworking understaffed and fatigued. That needs to changeóconditions have only been getting worse due to the huge changes in health care and will worsen even more with the shortage of nurses. Nurses have been pushed too faróand we will no longer tolerate working understaffed and exhaustedóit is unsafe for our patients and it is unsafe for us.

Link to other years' news releases and statements:

- **2007**
- **2005**
- **2004**
- **2003**
- **2002**

United American Nurses, AFL-CIO
8515 Georgia Ave. Suite 400 | Silver Spring, MD 20910 Tel: 301.628.5118 | Fax: 301.628.5347

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UAN
UNITED AMERICAN NURSES, AFL-CIO

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Legislative Issue Brief

Safe Nursing and Patient Care Act of 2005 (H.R. 791/S. 351) -- Legislation to Strictly Limit Mandatory Overtime

ISSUES: Strictly limiting mandatory overtime for nurses is a critical step in improving the quality of health care and reducing medical errors. In its 1999 report "To Err is Human", the Institute of Medicine (IoM) estimated that as many as 98,000 hospitalized Americans die each year as a result of errors in their care. In a recent IoM study (2003) of nurses' role in patient safety, the report concluded that "evidence revealed that typical work environment of nurses is characterized by many serious threats to patient safety." The IoM report identifies long hours for nurses as one of the critical problems – "the long hours of some nurses represents on of the most serious threats."

Unlike many other major industries where public safety is a concern, health care is exempt from regulations which limit the use of overtime as a staffing tool. Mandatory overtime puts patients and nurses at risk for medical errors, as well driving registered nurses out of patient care. The effects of mandatory overtime were central issues in major RN strikes in Washington, D.C., Minnesota, Ohio, New York and Hawaii.

The UAN supports and is working on legislation that would eliminate mandatory overtime for registered nurses except in true emergencies.

STATUS: Senator Edward Kennedy (D-MA) and Representative Pete Stark (D-CA) have introduced the **"Safe Nursing and Patient Care Act of 2005" (H.R. 791/S. 351)** in the House and Senate. This legislation would:

- Set strict, new federal limits on the ability of health facilities to require mandatory overtime from nurses. Nurses would use their own professional judgment in deciding to volunteer for overtime But, forced mandatory overtime would only be allowed when an official state of emergency was declared by federal, state or local government;

- Provide HHS with the authority to investigate complaints from nurses about violations. It also grants HHS the power to issue civil monetary penalties of up to $10,000 for violations of the act and to increase those fines for patterns of violations;
- Require facilities to post notices explaining these new rights and to post nurse schedules in prominent workplace locations. Nurses would also receive anti-discrimination protections against employers who continue to force work hours for nurses beyond what a nurse believes is safe for quality care;
- Require the Agency on Healthcare Research and Quality to report back to Congress with recommendations for developing overall standards to protect patient safety in nursing care.

ACTION NEEDED: For those members of Congress who have not cosponsored H.R. 791/S. 351 as of yet, the UAN strongly urges them to do so. If members have already cosponsored this legislation, the UAN urges them to work for the final passage of H.R. 791/S. 351.

POLICY RATIONALE:

- A 2001 report by the General Accounting Office, Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors, concluded: [T]he current high levels of job dissatisfaction among nurses may also play a crucial role in determining the extent of current and future nurse shortages. Efforts undertaken to improve the workplace environment were reduce the likelihood of nurses leaving the field and encourage more young people to enter the nursing profession.....

- Current projections are that the nurse workforce in 2020 will have fallen 20 percent below the level necessary to meet demand.

- There currently exist government standards that limit the hours that pilots, flight attendants, truck drivers, railroad engineers and other professions can safely work before consumer safety is endangered. However, no similar limitation currently exists for our nation's nurses who are caring for patients.

I

109TH CONGRESS
1ST SESSION

H. R. 791

To amend title XVIII of the Social Security Act to provide for patient protection by limiting the number of mandatory overtime hours a nurse may be required to work in certain providers of services to which payments are made under the Medicare Program.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 14, 2005

Mr. STARK (for himself and Mr. LATOURETTE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title XVIII of the Social Security Act to provide for patient protection by limiting the number of mandatory overtime hours a nurse may be required to work in certain providers of services to which payments are made under the Medicare Program.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Safe Nursing and Patient Care Act of 2005".

(5) The dangers with mandatory overtime are made clear by numerous studies. A November 2003 Institute of Medicine report, Keeping Patients Safe: Transforming the Work Environment of Nurses, concluded that limiting the number of hours worked per day and consecutive days of work by nursing staff, as is done in other safety-sensitive industries, is a fundamental safety precaution. The report went on to specifically recommend that working more than 12 hours in any 24-hour period and more than 60 hours in any 7-day period be prevented except in case of an emergency, such as a natural disaster.

(6) Another study published in the July/August 2004 Health Affairs Journal, The Working Hours of Hospital Staff Nurses and Patient Safety, found that nurses who worked shifts of twelve and a half hours or more were three times more likely to commit an error than nurses who worked standard shifts of eight and a half hours or less. The study also found that working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled.

(7) That same study also illustrates how nurses are being forced to work more and more overtime. The majority of nurses surveyed reported working

Patrick M. Nolan, D.O., F.A.C.E.

ENDOCRINOLOGY/ INTERNAL MEDICINE

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Comments on SB 12 & HB 50: "An act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities." Patient Safety Act

To Whom It May Concern:

Thank you for listening to my comments. As a physician, specializing in endocrinology, I am distressed at the physical alterations that can occur in an aging nursing workforce while their hours and demands steadily rise. It is no secret that the population of America is aging. In Alaska the average age of a professional registered nurse is close to 49 years old.

According to John Howard, MD, former director of the National Institute for Occupational Safety and Health, "the average number of hours worked annually by workers in the United States has increased steadily over the past several decades and currently surpasses that of Japan and most of Western Europe." (2004) Dr. Howard continues noting, "the influence of overtime and extended work shifts on worker health and safety, as well as on worker errors, is gaining increased attention from the scientific community, labor representatives, and industry...the volume of legislative activity seen nationwide indicates a heightened level of societal concern and timeliness of the issue." Many states have passed safe patient legislation with its foundation based on research correlating much higher error rates with overtime. The Institute of Medicine identifies long hours for nurses as one of the critical problems in safety studies, and has been advocating for safeguards.

Nurses are critical thinking professionals employed to assess, treat, and evaluate patients, and need a non-mandated work environment to function well. Patients should not be subjected to those who are fatigued, stressed, and forced to work overtime. We all depend on the nurse to be alert and aware.

I encourage the Alaska Legislature to be judicious and rational in its thinking. Regardless of the workforce challenges for institutions, we have no alternative but to follow a strategy of safety for patients and communities. Please limit the overtime and extended hours worked by nurses in the State of Alaska.

I thank you for this opportunity,

Patrick M Nolan, DO, FACE
3300 Providence Drive, Suite 206
Anchorage, AK 99508

February 12, 2009

Re: HB50/SB12

Dear Honorable Legislators

I would like to see mandatory overtime/on call addressed. I was in the hospital from 0645 till 0045 last night then had to return at o645 today. I am on call again this pm 1900 to 0700 tomorrow.

I still have to come to work tomorrow and if I get called in tonight how mentally alert will I be?

Thanks,

JoAnne Zemlicka

To my Legislature regarding patient safety:

February 10, 2009

Ladies and Gentleman,

As a current Registered Nurse in Alaska of 31 years, I must say that patient safety is very important to me as a professional. I would not ever practice as a Nurse if patient safety was an issue for me. Making a Nurse work mandatory overtime puts not only the Nurse at risk of injury, it also puts her patients at risk as well. For 29 years I worked in an Intensive Care Unit full time 12 hour shifts leaving home at 6pm and getting home most mornings at 8:30am if my patients did not go bad on me in the last hour of work, otherwise it might be more like 10am.

Nurses work extremely hard with life and death situations and would not hesitate to help when needed. To make it mandatory for a Nurse to work overtime is not only wrong, it is dangerous.

I feel that Nursing is such a hard job, that it is truly a calling from God himself to accomplish this professional practice every single day.

Sincerely,

Helen Christine Wood, RN, B.S.N.
17535 Santa Maria Drive
Eagle River, Alaska 99577
907 301-2238

Senners * Po Box 102264, Anchorage, AK 99510
907-243-8044 * senfam@acsalaska.net

February 11, 2009

RE: HB 50/SB12

Dear Legislators:

I am writing this letter is support of HB 50/SB 12, acts relating to limitations on mandatory overtime for RNs and LPNs. Having been a nurse for over 25 years I can attest to how physically and mentally draining it is to work a shift as a nurse. A nurse caring for adults lifts over 1.2 tons in an 8 hour shift. The patients are feeling poorly and can become critically ill at any point, medications must be given in correct amounts to avoid toxic effects, families are anxious and often a little short, and there are many other healthcare providers with whom care must be coordinated. Because the consequences of errors can be so serious, this is not the type of work environment where nurse fatigue should be allowed to happen.

Over 30% of the nursing workforce is over the age of 50 years, and many of these nurses plan to retire in the next five years. In Alaska we have worked hard to train new nurses. We do not want to drive these nurses out of the Alaskan workforce because they are being forced to work excessive hours. Remember, Oregon , Washington and California have banned mandatory overtime for nurses making them a very attractive destination for Alaska nurses. Everyone I have talked to has been amazed that there would be any opposition to limiting the hours a nurse can work to 14.

Thank you for considering my views. Hopefully this will be the year that we work to create a work environment in which RNs and LPNs can provide quality patient care without concern of being worked to exhaustion.

Sincerely,

Patricia Senner MS, RN, ANP

February 16, 2009

Re: SB12/HB50

Dear Legislators,

I am currently a nurse educator, but have 25+ years of clinical nursing experience, as well as having recently been a consumer of health care for close family members. I am also a Certified Professional in Healthcare Quality (CPHQ), and in that role in a hospital reviewed medical records and worked to drill down adverse patient outcomes. It has been my personal experience as a bedside nurse in hospital and long term care positions that mandated overtime to cover staffing shortfalls, that the quality of care delivered was adversely impacted.

Exhausted people make poor drug calculations, poor assessments, and are less apt to walk around and check in on their patients frequently. It puts patient care in jeopardy and it also puts nurses at risk for bad practice and subsequent litigation. It is also a major reason why some nurses quit practicing in direct care positions -- and we need those nurses with high standards and clear boundaries taking care of us and our families through critical illnesses.

I ask you to support legislation that would ban mandatory overtime for nurses. Instead, support nursing education opportunities and we will continue to bring bright and motivated caregivers into the healthcare field.

Thank you for your consideration.

Anne Doerpinghaus, MS, RN, CPHQ
Assistant Professor, Allied Health
TVC, University of Alaska
ffaxd@uaf.edu

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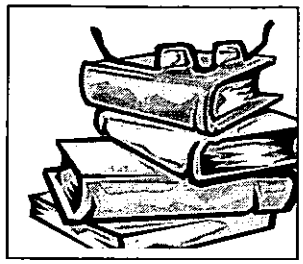

February 16, 2009

Dear Representative Wilson:

Thank you for introducing HB 50, Limit Overtime for Nurses. Nurses perform tasks that require accuracy, quick thinking and sound judgment; each of which is diminished after long consecutive hours of work in stressful environments. Both as a patient myself and as a caretaker for my father and then my mother as they had extended stays in hospital settings, I have seen overworked nurses make mistakes. Fortunately, for us, they were not life-threatening, but it is easy to imagine how they might have been.

Although some nurses may want to work overtime in these tough economic times and hospitals may believe the practice saves money, neither reason should take precedence over patient safety. Nurses need to be alert and ready to handle emergency situations as they arise. We should do everything we can to help ensure the dedicated people who choose to work in the nursing profession can do their jobs safely and well. HB 50 is a good first step.

Sincerely,

Lauree Morton

ALASKA WOMEN'S LOBBY

AWL Mission: To defend and advance the rights and needs of Women, Children and Families in Alaska

P.O. Box 20891
Juneau, Alaska 99802-0891
www.akwomenslobby.org

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Freymiller

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Rose Wysocki

Letter of Support
HB 50, Limit Overtime for Nurses

The Alaska Women's Lobby, a statewide group working to defend and advance the rights and needs of women, children and families, supports HB 50. Limiting overtime for nurses is a patient safety issue. When you are in their care you want someone available to you that is well rested and nourished, can think quickly on their feet, and can interact with patients in a friendly professional manner. You do not want someone responsible for your care that has been working for ten or twelve or more hours straight without a break to be the one in charge of the decisions that can mean the difference between your living or dying. Regardless of how hospitals or nurses posit this bill, patient safety should be paramount to any other concern.

Several studies have found patient safety is at risk when nurses work more than 12 hours in a 24 hour period. The 2004 study, Working Hours of Hospital Staff Nurses and Patient Safety, found that nurses working more than 12.5 consecutive hours were three times more likely to make an error than nurses working shorter hours. Working overtime at the end of a shift also increased the risk of making an error. Possible errors, which also applied to nurses who worked unplanned overtime at the end of a scheduled shift, included giving patients incorrect medications or dosages, according to the study.

According to a 2007 study sponsored by the US Agency for Healthcare Research and Quality (AHRQ), components of working conditions, including a hospital's organizational climate, staffing, and overtime, were found to influence outcomes in the elderly patients in hospital intensive care units (ICUs). Other recent AHRQ-funded studies on nurses' working conditions and patient outcomes have found a significantly greater risk to patient safety when nurses worked beyond their regularly scheduled number of hours.

The Institute of Medicine in its 2003 report, Keeping Patients Safe: Transforming the Work Environment of Nurses recommended that nurses provide direct patient care for no more than 12 hours in any given 24-hour period and less than 60 hours in a 7-day period. AHRQ called for the report in recognition of the key role of nurses in patient safety.

Alaska should do everything possible to ensure patient safety. Limiting overtime for nurses is a solid first step. Support passage of HB 50 this session. Take seriously the charge to keep Alaskans safe as they try and get their health care needs met.

2/11/09

Re: HB50/SB12

To the Honorable Senators and Representatives of the Alaska Legislature,

Please join with your counterparts in 12 other states that have passed legislation to prohibit mandatory overtime for nurses. Join our congressional delegation of Senator Murkowski and Congressman Young who co-sponsored the Safe Nursing and Patient Care Act of 2007 which prohibits mandatory overtime except in cases of states of emergency.

Most people would not choose to fly in a plane with a pilot forced to work beyond what they felt was their safety limit in competence for work hours. In fact, it is illegal. How then has it taken so long to pass this legislation that will contribute to patient safety? This is not a matter of employer rights in staffing. If a nurse tells the employer she or he has worked too many hours and is not safe to practice; why on earth would you not believe him/her? Would you risk your life or a loved one's on the nurse's word or their employers?

The rules for pilots solved this long ago. Similar restrictions in on-call and work hours are even now being addressed for medical residents due to safety reasons in an attempt to reduce medical errors. Alaska will not be the first state to address this problem with legislation but I certainly hope it will not be the last.

Although I no longer work in a hospital myself, I have been a patient in one and may be again. Speaking both as a nurse and a consumer, I urge you to support passage of HB 50 and SB 12.
Sincerely,

Lynn Hartz MSN, FNP-BC
3104 Brookside Drive
Anchorage, AK 99517
ph 907-248-4877
fax 907-222-1498

Re: HB50/SB12

2/11/09

Dear Legislators,

As a registered nurse (RN), I heartily support these two pieces of legislation. Patient safety will be jeopardized if health care facilities are given free reign to impose mandatory overtime.

Patient safety is Job 1 for nurses, to borrow a phrase from different industry. An RN who is required to work overtime beyond a twelve-hour day or even an eight-hour day is physically, mentally, and emotionally fatigued. Thus, her judgment is potentially compromised, her physical strength weakened, and her emotional capacity diminished.

In my institution, on my unit, I care for extremely sick individuals, with co-morbidities that include dementia, confusion, obesity (majority of patients), and often lower extremity amputation.

My unit is already suffering from budget issues that have resulted in less nurse's aide assistance. Hence I am responsible for safely assisting any combination of obese patients with altered mental status who are missing at least one leg to the toilet, with little or no staff assistance. At the end of a twelve-hour day, I am ready to go home. I have reached my daily limit of sharp, focused thought for decision-making, and accurate charting.

I may or may not have had a chance to take a quick break for a snack. Sometimes I am so busy caring for patients I forget to use the ladies room. Our institution's break and meal policy is catch as catch can. So, if mandatory overtime was added, I am not sure I would even get to eat dinner before my next "shift" started.

Mandatory overtime? That's too much to ask. It is not humane, IT IS NOT SAFE FOR THE PATIENT OR THE NURSE. An increase in back injuries in nurses, medication errors, and patient falls are examples of the consequences of mandatory overtime.

I care for renal patients who often have a minimum of a dozen or more scheduled medications in addition to "PRN" or as needed medications. These medications usually include insulin, blood pressure medications, and heparin or coumadin---all high risk medications. At the end of a twelve hour day, I can tell you that I become fatigued, and would be prone to making mistakes.

The health care industry is seriously compromising the public trust with mandatory overtime. The health care industry is exchanging the health and safety of their patients/clients for monetary gain.

Mandatory overtime results in nurses who themselves become patients due to fatigue, stress, and physical deterioration of their feet and legs.

The health care industry, in requiring mandatory overtime, falls in with a crowd that practices human exploitation.

Sincerely, Theresa E. Philbrick, RN

Gary C. Goins, MS,BSN, RN
3301 Eureka Street
Anchorage, AK 99503

February 10, 2009

To The Legislative Committee:

It is easy to see that the sacrifices a nurse makes to help the individuals in our communities is a significant one.

We do not take our responsibility lightly nor should we. Privileged to care for the injured and ill, for our neighbors and friends, sharing their moments of triumph and helping them cope with devastating losses.

I want to tell you that a nursing practice ratio makes a patient safer. In that bed that will be you, me, our child or our loved one. By focusing on each person we care for, we are able to see signs of problems early, catch them, alert the doctors and fix them. If we are exhausted from no breaks or seeing to many patients we can, like all good people, fail.

In practice for 20 years I have seen hundreds of these cases. I can tell you that patients in California are safer due to support to nurses for adequate breaks and established rules.

These laws most likely cost more but please believe me, if that was your child or your mom, you would sacrifice your life savings and more to secure their well being. I would too. No amount of tears can solve an error caused by lack of adequate and safe staffing. I have sat with people as those tears flow like mountain streams with family and clinicians devastated by the simple lack of prudence in health care planning.

I urge you, the noble men and women to adequately consider what effects are created by adequate staffing or the lack thereof.

Very truly yours:

Gary C. Goins MS, BSN, RN.

Staff Nurse
Adult Critical Care Unit Providence Alaska Medical Center
Emergency Department Alaska Regional Hospital
Recipient Congressional Certificate of Appreciation. United States Congress. 1987

February 11, 2009

RE: House Bill 50 Senate Bill 12

Dear Legislator,

My name is Debbie Thompson, I am a Registered Nurse certified in the Operating Room and Peri-Operative nursing and I am the Executive Director of the Alaska Nurses Association. In this role I act as a spokesperson for not only the public safety at large but just as importantly for the nurses of Alaska.

I would like to express my support in both House Bill 50 and Senate Bill 12. As a long time operating room nurse I can tell you that these bills address a serious public safety issue within the health care industry. Each citizen in the state of Alaska deserves to have a well rested nurse taking care of them. The government has stepped in made requirements for the airplane pilots, truck drivers and train conductors and engineers. Why would anyone put the lives of their loved ones or themselves at risk for potentially fatal medical errors.

Thank you for consideration to this matter.

Debbie Thompson, BSN, RN, CNOR

February 13, 2009

Re: Support for HB50/SB12

Dear State Legislators,

I am a registered nurse of over 14years now. I am in total favor of supporting HB50 and SB12. It is absolutely imperative that registered nurses and licensed practical nurses be able to provide safe patient care, this is why we became nurses, to care for patients. Patient care will without a doubt, be in jeopardy when nurses are forced against their better judgment to work excessive hours in health care facilities. Any overtime should be done out of personal choice and professional judgment. With mandatory overtime, we are placing the patients, whom have entrusted us to take care of them at one of the most vulnerable times in their life in danger.

Nurses are compassionate, caring individuals. It takes a special person to become a nurse, and then stay one for any length of time. Many nurses do not make it through the first year. That is not due to the fact that they suddenly do not care anymore. It is due to increased workload demands, workplace stresses, long working hours, and a complete lack of respect in general by administrative personnel who run hospitals.

Can you imagine what it is like to have to walk out of one patients room who is dying of cancer and may be at the end of their life and then be able to go on to the next patient with a smile on our face and deal with a whole new set of circumstances. We are not only caring for that patient we are caring for their family members as well. This routine gets played out several times just in one shift.

Nurses are burning out at a high rate and there is not going to be another nurse just around the corner to replace them. By the year 2020 there will be a nursing shortage of estimated 500,000 nurses. We cannot continue to look the other way. We must make a positive step, not only to make nursing a honored profession to the newcomer, but also retain the experienced knowledgeable nurses we have.

A nurse's bottom line is patient care and safety. Please help support HB50 & SB12, the very life it may save may be your own.

Thank you,

Janet Hilleary RN

February 21, 2009

Re: Support for HB 50 & SB 12

Dear Legislators,

I know how important this bill is for the future of nursing experience. I do 12 hour nights and I know there's no way in the world I'd want to be responsible for patients beyond my shift time. I'm sure our malpractice insurance won't cover that kind of stupidity!

Thanks.

Ginny Weisman
242-9254

Feb. 22, 2009

Re: HB50/SB12

Dear Honorable Legislators,

My name is Barbara Quaid and I have been a registered nurse since 1970. Currently I am employed as a recovery room nurse at a local Anchorage hospital. Because I work in an O.R. setting we must take call. Recently I worked for 21 hrs, and that wasn't the first time. If it is your call night and things run late, or emergency cases are added, we must stay.

It is definitely a safety issue. A nurse at hour 3 of her shift is not the same nurse at hour 16, etc. With hospitals running at full capacity, be it due to a shortage of floor RNs or available beds, we must at times manage patients all night and all day in the recovery room. More times than not these are ICU/CCU patients.

We definitely need legislature governing the amount of hours a nurse is allowed to work, because it is not being safely managed the way it runs now. I testified via teleconference this past summer regarding this issue, and would be most willing to testify again. I hope this will be of assistance in your endeavor to keep nursing at a safe level.

Sincerely,

Barbara M. Quaid, R.N. CPAN.

February 13, 2009

Re: HB50/SB12

Dear Honorable Legislators,

My name is Ginger Spohr and I am an Emergency Room nurse. This is my first time getting involved in the legislative process and I am doing so because HB 50 and SB 12 are important bills for both myself and my co-workers. I strongly want to encourage support for both of these bills.

Right now there is a great opportunity for those in the House and Senate to help us continue the hard work that we do every day and help insure that we do so in a safe way.

My husband recently retired after working 20 years on the slope. He went back to school and earned a degree in nursing. After his first week of work, he told me, "I've never worked so hard in my entire life." Nursing is hard work at any age but with more and more people retiring and entering the field as a "second" profession, we must insure a safe and welcoming environment for them.

In closing, I would also like to ask anyone considering blocking these bills to imagine being a patient of a nurse who has just been told he/she must stay and work late. Imagine your boss telling you that you had to miss a birthday party of child or friend and that it would cost you your job if you didn't stay and work.

Please help keep nursing a respected profession. Most of the nurses I know are proud of what they do, please help us continue take pride in the work we do and help to ensure we are rested and willing to work.

Please support HB 50 and SB 12.

Sincerely,

Ginger Spohr, RN.

February 19, 2009

Re: SB12/HB50

I am a registered nurse at providence hospital. I want to tell you how important it is for nurses to be well rested & alert when caring for sick people. We make critical decisions, often at a moment's notice, that affect the lives of our patients. The giving of medications also is a critical event, considering the risk of making a mistake. Patients depend on us to make the right decisions for them. They have to trust us to do the job safely. That is dangerously hard to do when you are over tired & needing sleep.

Most of us work twelve hour shifts. The thought that employers can insist that we continue to work beyond that is scary. Likewise, working more than 3 days in a row, I feel, puts us at risk to make mistakes. When human lives are at stake, this could be a critical mistake. Only the individual knows how they feel, how tired, how sleepy, etc. nurses need to have the option to say no to mandatory overtime, to agree to that only if they feel fresh enough.

I'm hoping that we can get HB50SB12 passed this session.

Thank you for your help.

Sincerely,

Connie Lynch RN

2/19/09

Re: HB50/SB12

Dear Legislators,

Please support HB50 and SB 12. I believe RN's will provide overtime when we can. For our 36 week, we do what we can, as the population gets sicker. Management is getting more illogical.

Scott Young, RN

258-1861

2/14/09

Re: HB50/SB12

Dear State Legislator,

I am against mandatory overtime in any form. When we are subjected to mandatory overtime it leads too more mistakes in medication administration because we are tired. At one of my jobs; I work a 12 hour shift at a local hospital and find that the longer I am required to stay to finish required paperwork or patient care the more I have problems focusing on the task at hand and thus the more potential for a mistake. At another job that I work 8 hours; if I am mandated to work an extra shift The more I feel unsafe as I work in a psychaitric facility where patient safety and staff safety are imperative. Being tired I have problems with determining when patient's are feeling unsafe or threatened and thus there is more potential for violent and threatening outcomes.

Again I am very against manditory overtime. I just hope with the nursing shortage coming it is not made worse by mandating overtime in unsafe jobs as it will lead to more nurses rethinking this line of career choice thus increasing the nursing shortage.

Thank you for allowing me to air my opinions,

Barbara Popken RN

February 14, 2009

Re: HB50/SB12

Dear Legislatures,

I am an active member of the AaNA organization. I send this message in support of HB 50 and SB 12. Upon review of the last years (2008) activity around these two Bills, I stand behind all of the nurses in support of the passing of these two Bills.

As a nurse, I am in support of protecting the nursing professional at the bedside (and elsewhere as it applies) in being able to conduct a full day's work without the intimidation of mandatory overtime on their shoulders.

Thank you for all the work you do.

Sincerely,

Shirley LaForge, RN, MSN

2/11/09

Re: HB50 and SB12

Dear Honorable Senators and Representatives,

I am not in favor of mandatory overtime for nurses. Any overtime should be the nurse's choice. In addition I am not in favor of a nurse working more than 14 hours in a row. That allows for a 12 hour shift and any follow-up charting, etc. I know too many nurses who cannot recall how they even got home after working too long. Also, though 15 minute breaks are great, what concerns me is someone who doesn't even have time for lunch.

Thank you,

Mary Ann Wilson, RNC

2/12/09

Re: HB50/SB12

Dear Honorable Senators and Representatives,

I support the passage of HB 50 and SB 12. Please work on my behalf as well as my colleagues and patients to see that these bills are passed. Mandatory overtime for nurses has the potential for creating a more severe shortage of nurses in areas already in desperate need of licensed staff. Mandatory overtime and inflexible scheduling has the potential for deterring students from selecting nursing as a career option.

Please seek options that enhance the appeal of nursing as a career option, increase the nurse's ability to provide safe and effective care at the bedside, and decrease the attrition of nursing staff related to excessive work hours and work load. Please vote yes on HB50/SB12.

Thank you,

Janice McGraw, MS, RN, CNRN

February 10, 2009

Re: HB50/SB12

Dear Legislators,

As a Registered Nurse in the State of Alaska, I find it critically important that we have a say in our work scheduling and who dictates our professional practice. As a Registered Nurse, I make it my prime responsibility to be the advocate of patients. Because of this and the importance of our profession, I am supportive of House Bill 50 and Senate Bill 12.

Sincerely,

Joshua Meals, RN, BSN.

2/11/09

Re: HB5/SB 12

To the Honorable Senators and Representatives:

This is a letter of support for HB 50 and SB 12. As a working nurse in the Operating Room at Providence Hospital, I feel it is important for me to share my support for legislation that ends the practice of mandatory overtime for nurses in Alaska. Such practices are unfair to nurses, and unfair to the patients who deserve top-notch care from nurses who are properly rested and satisfied in their work environment. Currently, I am obligated to be available for over 24 hours of mandatory overtime each month.

Sincerely,

Paul Bryner

2/11/09

Re: HB50/SB12

Dear Honorable Legislators,

I am asking for your support on House Bill 50 & Senate Bill 12. I have been a registered nurse for 16 years and have been personally affected by both mandatory overtime and insufficient rest between shifts. We have tried to address these safety concerns with our employer; however, there is no incentive for hospital administrations to change current practice. It becomes financial, and the bottom line is it is cheaper to work a nurse extended hours than it is to provide safe working conditions. I have worked in other states with this type of legislature and it does have a positive impact. Therefore, I ask for your support from a state level. If the employer won't self regulate, then someone needs to for the sake of quality patient care and safe working conditions for the nurses. .

Thanks you for your time.

Wendy Conradi, RN, CNOR

2/11/09

Subject: Support for HB 50 and SB12

I urge house and senate members to support HB 50 and SB 12 to protect the rights of our patients and the welfare of our nurses.

Patricia Peacock, RN, BSN, CURN, CHPN.

RE: HB50/SB12

2/11/09

Dear Legislator,

As an RN of 30+ years, I am writing to support HB 50 and SB 12. I recently returned to bedside nursing after working outside of the hospital for the past 14 years. I find it astounding that the legislature wants to continue to require mandatory overtime for nurses.

After working 3, 12 hr. shifts in one week, I find I need a day to recovery and then have 3 days "off" to enjoy things other than my job, which allow me to have the energy to return to the bedside for 3 more days the next week. While I have worked overtime in the past year, it was done by choice. If overtime is to be required, it will decrease morale in nursing staff, thereby compromising patient care. Perhaps a meat packing plant or other assembly line type job sees the benefits of mandatory overtime. When one is caring for the human spirit and body, it is definitely not in the best interests of the patient to be cared for by a nurse who is working mandatory overtime.

Thank you for your work on our behalf.

Sincerely Yours,
Jeanne Kemp RN, BSN

February 10, 2009

Dear Honorable Senators and Representatives:

I have been a Registered Nurse for the past 30 years. Twenty-nine of those have been spent in the Intensive Care Unit in various hospitals across the US. I have been contributing to the care of Alaskans for the past 15 years. I have shared in some very intense and uncertain times for many families. I know that nurses do not let patients or their families know when staffing is short, or when we are exhausted or hungry. We really try to make people feel secure when they are in our care.

The Institute of Medicine (IOM) report has identified how long hours and fatigue contributes to errors in healthcare. These errors can cost lives, or increase length of stay in the hospital which in turn adds to the already ballooning cost of healthcare.

I urge you to support HB 50 & SB 12. When patient are at their most vulnerable, is not the time they or their families should be concerned at the number of hours the nurse caring for them has worked. Long hours, fewer resources and higher patient acuity drive nurses from staying at the bedside in today's hospitals. Nurses will only last so long, when they go home after 12.5 hours concerned about what they might have missed because they are so exhausted and hungry. The University of Alaska is doing a great job educating tomorrow's nurses. I encourage you to do what you can by passing this legislation that will help to keep the nurses of the future working in hospitals.

Thank you,
Donna Phillips, RN
Girdwood, AK

Date: 2/11/09

Re: HB50/SB12

Dear Legislators,

I have just been informed of the ASHNA's position regarding legislation to block any regulations regarding employer rights to address such issues as nurse and patient safety. It seems to me that this is not in the best interest of any of the parties that participate in direct patient care, much less the person who is being cared for. I seriously doubt that the public knows anything regarding this and would that be known, there would be an abundance of objections from both parties. The only persons who this would benefit would be the people managing the books of these employers and their board of directors. That is, unless it was their family or themselves who was receiving this care. This issue has been going on for too long and as one of those people who work long shifts for the sickest of these patients, it would be akin to whipping a horse who has plowed the fields too long in the day. It just can't be done without consequences. These consequences would have implications for public health and in the long run risk increasing hospital days for the patients who got marginal care from the employees forced to do this work. It is also comparable to asking for volunteers, then picking them anyway, should no one raise their hand. It is one thing for someone to use their judgement in working overtime, but another to cut costs and recruiting people to do this extra work, such as travelors who have no intention to stay in this area. The answer to the higher paid travelers would be make the lower paid employees do this work. It is also like bringing in employees from out of the country, give them lower wages, and make them do a job, whatever that job is. Thankfully, we have the union here to prevent such nonsence, but then the ASHNA position is just as ridiculous. The term "Magnet Hospital" has been tossed around as a buzz word for quite some time now, and it is laughable that forcing employees to do something that not only would affect their life outside of work, but to risk their license as well, would somehow make a difference in obtaining that status. It is words on paper and a status that looks good but really means nothing if employees are not happy. Please know that even though you may not have hundreds of comments regarding this, that it is due to not many people knowing the position of this board. I have been in critical care for close to 30 years and have seen my job get harder, despite the experience I have. This risks everything that health care has to offer, despite breakthroughs in disease prevention and treatment.

Sincerely Yours,

Debbie O'Brien, RN, CCRN
Anchorage, Alaska

Position Statements

Assuring Patient Safety: The Employers' Role in Promoting Healthy Nursing Work Hours for Registered Nurses in All Roles and Settings

Effective Date:	December 8, 2006
Status:	New Position Statement
Originated by:	Congress on Nursing Practice and Economics
Adopted by:	ANA Board of Directors

Purpose: This position statement articulates the American Nurses Association's position with regard to patient[1] safety and encourages employers of registered nurses[2] to establish policies and procedures that promote healthy nursing work hours and patterns that do not extend beyond the limits of safety for both nurses and patients.

ANA Position: Given the well-documented relationship between nurse fatigue and an increased risk of nurse error with the potential for compromising patient care and safety, it is the position of the American Nurses Association that all employers of registered nurses should ensure sufficient system resources to provide the individual registered nurse in all roles and settings with:

1. a work schedule that provides for adequate rest and recuperation between scheduled work; and
2. sufficient compensation and appropriate staffing systems that foster a safe and healthful environment in which the registered nurse does not feel compelled to seek supplemental income through overtime, extra shifts, and other practices that contribute to worker fatigue.

It is intended that this position statement be used in conjunction with ANA's position statement on the responsibility of the individual registered nurse to make decisions consistent with her or his ethical obligation to decline work assignments when fatigue may compromise her or his ability to deliver safe patient care, "*Assuring Patient Safety: Registered Nurses' Responsibility in All Roles and Settings to Guard Against Fatigue" (in press).*

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[1] ANA, in its *Nursing's Social Policy Statement,* "recognized the importance of clearly identifying the recipients of professional nursing care, be they individuals, groups, families, communities, or populations." The *Social Policy Statement* notes that "[t]o date, professional nursing has not yet selected ... the term best depicting the healthy or ill recipients of professional nursing care." Therefore the term "patient" was selected to be used "throughout the text to provide consistency and brevity"... and readers are asked "to keep in mind that the breadth of nursing practice always includes the various recipients of care," be they the individual, the group, the family, the community, or the population. *Nursing's Social Policy Statement (2nd edition),* 2003, American Nurses Association, p. v & 22.

[2] While ANA's membership is limited to registered nurses, it is ANA's belief that employers of health care personnel have a similar obligation to these employees to establish policies and procedures regarding employee fatigue and patient safety.

3117

History/Previous Position Statements: In 2000, the American Nurses Association (ANA) House of Delegates adopted an action "Opposing the Use of Mandatory Overtime as a Staffing Solution" (CNPE-2). Embedded in this and other statements on related issues, ANA has consistently reiterated its position that registered nurses have a responsibility to reject any work assignment that puts patients or themselves in jeopardy (1995 ANA Position Statement, *"The Right to Accept or Reject an Assignment"*). Further, ANA's consistent position has been that such a principled rejection does not constitute "patient abandonment;" on the contrary, it is the only ethical option for the fatigued nurse.

Then, in 2004, the House of Delegates adopted a resolution entitled "Transforming the Work Environment for Nurses," based largely on the recommendations set out in the exhaustive Institute of Medicine (IOM) report of the same year, *Keeping Patients Safe: Transforming the Work Environment of Nurses.* The report described the central role of registered nurses in protecting patient safety and achieving better patient outcomes; and it discussed the frequent mismanagement of the nurse's work environment that often threatens these integral contributions. Among those issues highlighted in the report, the IOM focused on institutional support and structures for maintaining nurse staffing at levels sufficient to avoid patient safety issues cause by nurse fatigue.

The ANA 2005 House of Delegates overwhelmingly passed a resolution regarding the "Implications of Fatigue on Patient and Nurse Safety." That resolution built on the above described significant work that ANA has pursued for several years linking patient safety with a host of workplace environmental and staffing factors that affect the number of hours registered nurses work. It acknowledged the impact of nurse fatigue on patient safety, quality of care and nurse safety and urged individual nurses, nurse managers, nurse administrators, employers of nurses, trustees and other stakeholders to fulfill their legal and ethical obligations to assure that registered nurses' work hours and patterns do not extend beyond the limits of safety for both nurses and patients.

Supportive Material: The 2004 IOM report, *Keeping Patients Safe: Transforming the Work Environment of Nurses,* recognized that creating a healthy work environment for registered nurses that is most conducive to patient safety will require fundamental change within a health care organization.

Strong evidence links prolonged work hours (more than 12 hours in a 24-hour span, or more than 60 hours in 7 days), rotating shifts and insufficient breaks to:

- slowed reaction time,
- lapses of attention to detail,
- errors of omission,
- compromised problem solving,
- reduced motivation, and
- decreased energy for successful completion of required tasks (IOM, 2004, p.12).

Further, Rogers, Hwang, Scott, Aiken, and Dinges (2004) found that the likelihood of making an error was three times higher when nurses worked shifts lasting 12.5 hours or more, and that

nurses, indeed, worked longer than scheduled on a daily basis, and generally worked more than 40 hours a week. Research examining consecutive hours worked by medical interns and residents also found that after extended work shifts there was an increased risk for both patient errors while at work and motor vehicle crashes leaving work (Landrigan, et al., 2004; Barger, et al., 2005).

Recent research with 2,273 RNs by Trinkoff, Geiger-Brown, Brady, Lipscomb and Muntaner (2006) documented that more than half of the hospital nurses in their study typically worked 12 hours or more per day and more than 50 hours per week. Further, nurses were likely to work many days consecutively, without sufficient rest between shifts and during scheduled time off.

Excessive total hours worked puts nurses and patients at risk; in addition, *rotating* shifts can also threaten patient safety. Research by Circadian Technologies Incorporated has found that the number of accidents for all shift workers is 1.2 times greater than that for traditional workers and the resulting incremental cost to business is $8.5 billion (BNA, 2003).

Given this risk, the individual nurse's ethical responsibility to consider her or his level of fatigue when deciding whether to accept a patient assignment is addressed in the ANA's complementary position statement, "*Registered Nurses' Responsibility in All Roles and Settings to Guard Against Working When Fatigued.*" In the present statement, *"Assuring Patient Safety: The Employers' Role in Promoting Healthy Nursing Work Hours for Registered Nurses in All Roles and Settings,"* ANA urges employers of registered nurses to acknowledge their responsibility to assure a safe workforce, and to initiate fundamental change in their staffing and salary policies so as to create incentives for a rested and safe nursing workforce.

At the institutional or organizational level, the risk that fatigue poses to both nurse and patient safety mandates that nurse managers and administrators actively promote changes in the work environment of nurses. Provision Six of *the Code of Ethics for Nurses with Interpretive Statements* clarifies:

> *The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action* (p. 20).

Interpretive Statement 6.3 further delineates the ethical responsibilities of nurse managers and administrators to take action to curtail extended work hours and insufficient rest time between shifts:

> *Acquiescing and accepting unsafe or inappropriate practices, even if the individual does not participate in the specific practice, is equivalent to condoning unsafe practice* (p. 21).

Nurse managers and administrators, bound by this ethical code of practice, may feel torn by conflicting professional obligations. Hospitals and other health care entities, not similarly bound, are clearly under pressure to reduce expenses; the managers of these institutions and organizations may not recognize the connections between their budget and nurse fatigue. Their

response to market pressures has often been an "adhocracy" of registered nurse understaffing, patched with excessive overtime, expensive agency nurses and rotating shifts that further deteriorates working conditions for already overworked nurses, thereby threatening patient safety.

Administrators need to be educated to the larger costs to their institutions of nurse fatigue as well as the costs of excessive overtime and agency nurses. The most obvious cause-and-effect may be seen in the reduction of adverse patient outcomes when an adequate, appropriate, and *rested* nursing staff is available. Study after study has concluded that nursing care, specifically, and appropriate staffing in general, is central to improved patient outcomes. This directly affects the institution's bottom line.

For example, ANA's 2000 study, *Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting*, describes five adverse outcomes measures that respond favorably to adequate nurse staffing: hospital length of stay, nosocomial pneumonia, postoperative infections, pressure ulcers, and nosocomial urinary tract infections. Each of these might cost a hospital or health facility money that it would otherwise not spend. Appropriate nurse staffing that permits time for thorough patient assessment and timely interventions ultimately improves outcomes, and has the potential for significantly reducing these types of expensive risks.

Risks to nurses in the health care environment, only amplified by the fatigue factor, can similarly affect the cost of doing business for employers of nurses. Health care jobs are already among the most hazardous occupations. In a 2004 survey, the U.S. Bureau of Labor Statistics noted that, of the fourteen private industry sectors with the highest reported number of cases of injury or illness, three were in the health care and social assistance sector. In fact, "hospitals and nursing and residential care facilities have *led* [italics added] the list of industries reporting [the highest number of] cases for the past two years" (p. 8). The rate of illnesses experienced by workers in the hospital industry was almost three times that of workers in private industry as a whole.

Knowing all of this, and supported by the extensive research linking human fatigue with error, institutions that persist in policies supporting a culture where overwork, understaffing and underpay are the norm may ultimately find themselves facing extensive accountability for their short-sightedness. The consequence of institutional intractability is even more stark as the evidence accumulates specifically linking nurse fatigue with errors in clinical judgment that have the potential to harm patients or nurses themselves.

Employers may begin to experience the legal implications of the mounting research on fatigue, as well. For example, a registered nurse successfully claimed workers' compensation for injuries from a motor vehicle accident that occurred when she fell asleep while driving home after working back-to-back double shifts, at the behest of her manager and against her own judgment. The court ruled in her favor because it deemed the hospital's systematic abuse of overtime as a foreseeable and avoidable cause of the accident (Deland v. Hutchings, 1994). As hospitals and other health care institutions increasingly look to *institutional systems* to assure patient safety, as opposed to a model that only looks at individual responsibility, it is possible

that courts will follow the trend in finding institutional liability for those lapses in *institutional* policy that foreseeably result in harm to patients or staff.

Institutions also accrue the secondary costs of nurse fatigue that must be paid in time, and that ultimately affect the *entire* health care system. Clearly, nurse fatigue and the factors contributing to it are not isolated from the larger issues of health care workforce and access to care. In its 2001 report, "Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors," the US General Accountability Office cites "inadequate staffing, heavy workloads, the increased use of overtime, a lack of sufficient support staff, and the adequacy of wages" as key factors in the emerging registered nurse shortage (p. 2). When all the related factors are considered, fairer wages for registered nurses may be, at a minimum, cost-neutral for hospitals and other entities.

The drive for "organizational efficiency," when its proponents fail to balance it with other values, continues to backfire in industry after industry. Increasingly, businesses must balance the cost of assuring a rested workforce against the regrettable cost of *not* having rested workers. The shift and duty times of airline pilots and truck drivers are regulated for precisely these reasons. In health care, teaching hospitals can be denied their accreditation for graduate medical education if they routinely ignore resident work hour limits. Although the application of this logic has been slow to reach the rest of the health care community, employers need to make the connection between nurse fatigue and safety of both the patient and the nurse.

The management of hospitals and other healthcare entities must be accountable for making the changes necessary to align their rewards systems with their espoused value of high quality patient care and safety. Nursing can support this mission by generating specific recommendations as to what institutions can do differently to address the factors that contribute to nurse fatigue.

Several nursing specialty organizations have addressed how their members might best balance work and rest to optimize safety, and how their employers might support their doing so. The Association of periOperative Registered Nurses (AORN), an organizational affiliate of the American Nurses Association (ANA), offers several strategies in its 2005 Position Statement on Safe Work/On-Call Practices, to promote patient and perioperative personal safety. Those strategies that directly target action by institutions and organizational systems include:

- Perioperative Registered Nurses should not be required to provide direct patient care for more than 12 consecutive hours in 24 hours and not more than 60 hours in a seven-day period.
- Off-duty periods should be scheduled to provide for an uninterrupted eight-hour sleep cycle.
- Arrangements should be made to relieve a perioperative registered nurse who has worked on-call and is scheduled to work the following shift to allow for adequate off-duty recuperation time.
- The type of facility and possible number of sustained work hours should be taken into consideration when making on-call shift assignments.

- The individual's ability to be able to meet the potential work demands should be considered when making on call assignments.
- Employers should support perioperative registered nurses to change cultural attitudes so that fatigue is recognized as an unacceptable risk to patient and worker safety rather than a sign of their dedication to their job.

AORN's full position statement and guidance statement on Safe On-Call Practices in Perioperative Practices can be found on the AORN web site at the following link: http://www.aorn.org/about/positions/default.htm.

The American Association of Critical Care Nurses has explored how "mental and physical fatigue can contribute to errors and 'near-misses' with medications and case-related procedures" in its position statement opposing mandatory overtime. Without the ability to resort to mandatory overtime, "hospitals and health care institutions will have to look at real remedies for understaffed facilities, such as: 1) hiring more RN's, and 2) utilizing strategies to recruit and retain more nurses" (http://www.aacn.org/AACN/pubpolcy.nsf/vwdoc/pmp, ¶ 7).

A 2006 study by Scott, Rogers, Hwang and Zhang targeted at this critical care nursing population generally affirms earlier studies, showing respondents "worked longer [hours] than scheduled and for extended periods," and that "longer work duration increased the risk of error and near error and decreased nurses' vigilance" (p. 1). It also supports the IOM's recommendations to minimize the use of 12-hour shifts and to limit nurses' working hours to 12 consecutive hours during any one 24-hour period. The authors were particularly persuaded by the potentially dire consequences of a fatigue-induced mistake in critical care, where "patients are not only exposed to more medications and treatments than are patients in general care areas but are also seriously ill, with little natural resilience or ability to defend themselves from the consequences of healthcare mishaps" (Scott, 2006, p. 1).

This evidence, highlighting the detrimental effects of nurse fatigue on patient and nurse safety, as well as on institutional and organizational accountability, leads ANA to recommend the following actions for registered nurses, employers, researchers and educators.

Recommendations: As a means of implementing this position statement, the ANA recommends the following eleven specific actions:

Practicing Registered Nurses:

1. Individual registered nurses should consistently exercise their ethical obligations as articulated in the ANA's position statement on *Registered Nurses' Responsibility in All Roles and Settings to Guard Against Working When Fatigued (ANA, in press).*

2. Nurse managers and administrators have a responsibility to examine and institute scheduling practices that promote safe work hours, adequate break time, and minimal rotation of shifts.

Employers/Health Care Agencies:

3. All employers should provide fair compensation that encourages the elimination of the need for such strategies as excessive overtime or rotating shifts. The ANA recommends a thorough examination of overtime pay expenditures and a reassignment of those dollars toward both the additional staff necessary to eliminate overtime and subsequent increases in registered nurses' base compensation. These steps should be cooperatively pursued and negotiated in an open and equitable process that includes both registered nurses and healthcare administrators.

4. Registered nurses' salaries must be adjusted to appropriately reflect their education, training, experience and the value they add within the health care entity for which they work. In particular, "wage compression," or the stagnation of salary growth relatively early in a nurse's career, should be eliminated and experience rewarded so that the health care system retains its nursing workforce. Salaries should be such that registered nurses do not feel compelled to seek supplemental income through rotating shifts, overtime and other voluntary practices that contribute to worker fatigue.

5. All employers of health professionals should provide ongoing education to employees concerning the impact of consecutive and total hours worked and employee fatigue on patient safety, quality of care, and the personal safety of employees.

6. Employers should institute policies, including whistleblower protections, permitting the free exchange of ideas and information about staffing and quality of care issues among their staff without fear of reprisal or retribution.

7. Employers should adopt as official policy, the position that registered nurses have the right to accept or reject a work assignment based on fatigue; that such rejection does not constitute patient abandonment; and that registered nurses should not suffer adverse consequences in retaliation for rejecting in good faith a work assignment based on fatigue.

8. Employers should have a system in place for evaluating instances of registered nurses rejecting assignments in order to evaluate causes and effectiveness of staffing patterns.

Education:

9. Schools of Nursing should add to their curricula information on the impact of hours worked, rotating shifts, and neglecting to take meal and rest breaks on patient safety and harm to self and peers. In addition, the ethical obligation of the individual registered nurse to monitor fatigue and to decline assignments that put patients at risk should be

stressed, relying on Provisions and Interpretive Statements from the *Code of Ethics for Nurses* (ANA, 2001).

10. Academic education and training programs for health care administrators should include curricula content regarding the impact of nurse and health care worker fatigue on patient and staff safety, and the importance of supporting a healthy workplace for registered nurses and other employees.

Research:

11. ANA should partner with specialty nursing organizations and other stakeholders to assure that the following subjects are included on the research agendas of various funding entities:
    - Determinants of registered nurse fatigue
    - Impact of nurse fatigue on the health and well-being of nurses
    - Impact of registered nurse fatigue on patient safety
    - Patient classification/acuity systems
    - Staffing patterns and nursing-sensitive patient outcomes
    - Salaried registered nurse-staffing models

12. Schools of Nursing, as well as Schools of Public Health, Occupational Health, Health Services Research and Economics, should develop graduate research foci around the areas of patient acuity, nurse staffing patterns, nurse fatigue and quality of care.

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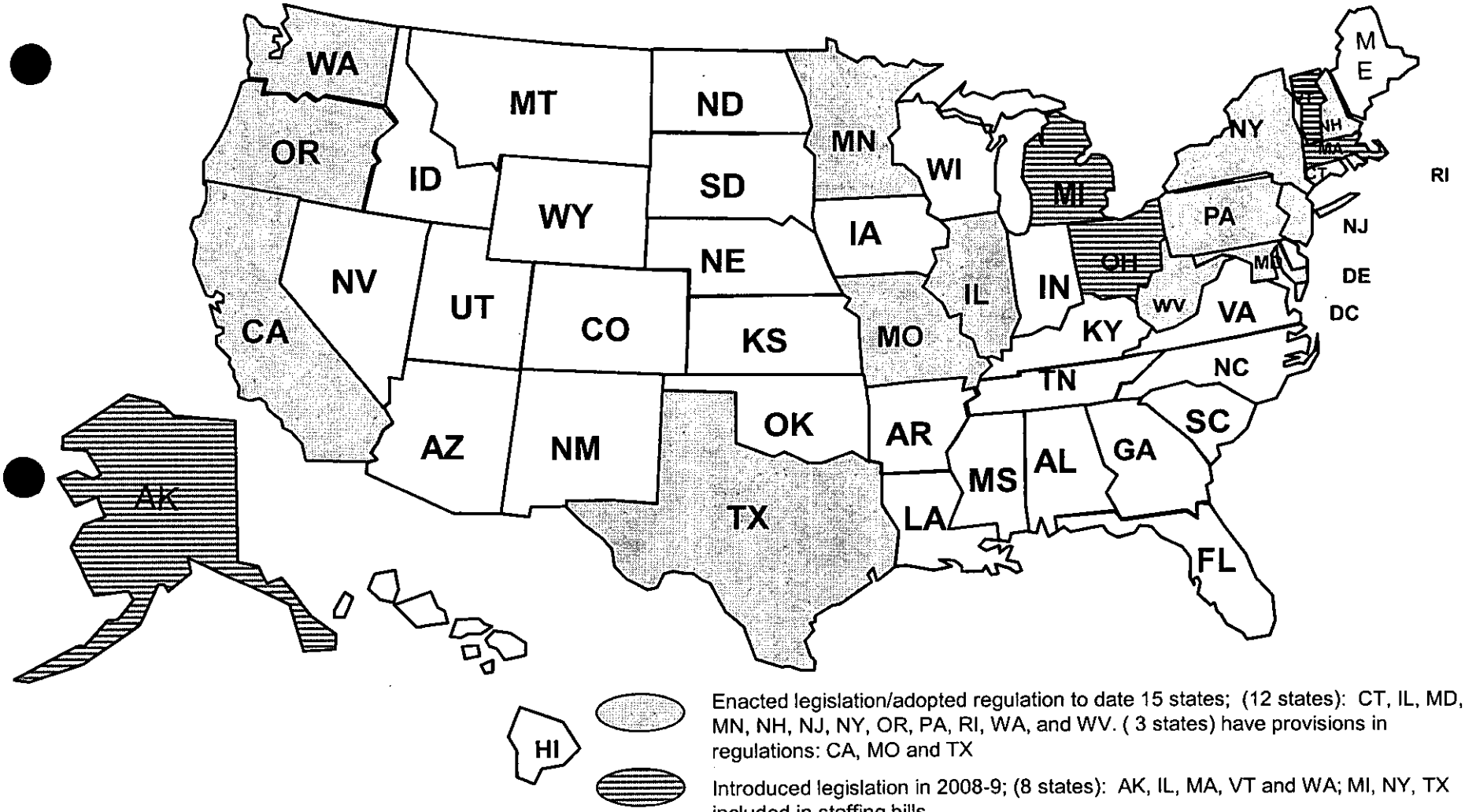
The American Nurses Association's Nationwide State Legislative Agenda

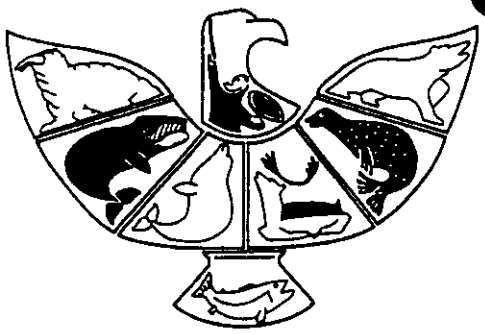
PROHIBITION OF MANDATORY OVERTIME



Enacted legislation/adopted regulation to date 15 states; (12 states): CT, IL, MD, MN, NH, NJ, NY, OR, PA, RI, WA, and WV. (3 states) have provisions in regulations: CA, MO and TX

Introduced legislation in 2008-9; (8 states): AK, IL, MA, VT and WA; MI, NY, TX included in staffing bills.

February 2009



Alaska Native Health Board

1840 Bragaw Street, Suite 220
Anchorage, Alaska 99508

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March 6, 2009

Senator Bettye Davis, Chair
Senate Health & Social Services Committee
State Capital Building, Room 30
Juneau, Alaska 99801-1182

Dear Senator Davis,

We write to express our deep reservations over SB 12, limiting mandatory nurse overtime.

The Alaska Native Health Board appreciates and values the services nurses provide to patients in Alaska, especially our Alaska Native patients, whom we consider to be our customer-owners.

It is the experience of Tribal health providers that nurses are highly dedicated, caring providers who will give their last ounce of skill to care for their patients. Tribal health providers expend a great deal of effort and expense to recruit and retain good nurses to provide care and cover all necessary shifts. Providing adequate and safe nurse staffing is an important part of Tribal health providers' overall responsibility to provide high-quality care to our patients. It is out of this responsibility to care for our patients that we express our concerns over SB 12, as follows:

SB 12 will hurt patient care, especially in rural Alaska

In healthcare, the guiding principle is "do no harm." However, with SB 12, in many remote Tribal health locations, all it would take to leave a shift uncovered would be for one or two nurses to decide, for any reason or no reason at all, that they don't want to work overtime.

The rural Tribal health provider would in many cases have no choice but to simply not cover the shift and put patients at risk, because rural Tribal health providers do not have the urban luxuries of (1) calling in other off-duty nurses, (2) getting temporary "agency" nurses to cover shifts on short notice or (3) re-directing patients to other nearby facilities.

In practice, SB 12 would make it impossible for Tribal health providers to make sure all shifts were covered, particularly in the remote rural parts of the State. Perhaps this is why almost no rural States have adopted legislation similar to SB 12.

SB 12 is an unfunded mandate that will unnecessarily drive up costs

Many Alaska Tribal health providers are having a tough time financially due to sky-high fuel and other costs commonly associated with running a facility in rural Alaska. They have had no choice in some cases but to lay off healthcare workers and reduce services.

Under SB 12, even in a situation where a Tribal health provider might be able to cover a shift when one or more nurses were to choose not to work overtime, the Tribal health provider would likely only be able to do so at GREAT COST, e.g., (1) over-hiring extra regular-shift nurses ahead of time (assuming a sufficient labor pool) and hoping one of the new hires is willing to pull non-scheduled shifts; (2) flying in temporary "agency" nurses from an urban area at the last

minute (expensive), or (3) transferring / referring patients to an urban provider (adding an additional expensive travel cost to providers and to the Medicaid program).

Laws such as SB 12 are intended to solve urban problems not applicable in Alaska

Legislation such as SB 12 has been adopted in only 15 States, nearly all urban, out of concerns that hospitals might be (1) under-hiring and then abusing mandatory overtime in order to control payroll/benefits costs, or (2) abusing mandatory overtime rules as a collective bargaining tactic.

There is no evidence that these conditions exist in Alaska. While there are well-documented chronic challenges in nurse staffing, particularly among Tribal health providers, these staffing challenges are no different than the staffing challenges we experience with all the healthcare professional categories. And while we cannot speak for others, we can say unequivocally that Alaska Tribal health providers are not purposely understaffing as an abusive labor practice. The reality is that to the degree we have nurse staffing challenges, it is because of the tight national nurse labor market, compounded by the never-ending challenge of figuring out how to get good nurses, doctors, technicians, administrators, etc. to live and work in remote locations in Alaska.

SB 12's proponents agree *that "there are few official overtime complaints by nurses..."*, and that there are *"low numbers of complaints and benign exit interviews...."*

We acknowledge that nursing is a tough profession. The work itself is challenging enough, in addition to the difficult shift scheduling that of necessity must put patients' needs first. But those challenges come with the territory in healthcare: Physicians, administrators, technicians, clerks, etc. also must adjust the scheduling of their work to meet the needs of the patients.

SB 12 is unnecessary because mandatory nurse overtime can be addressed by other means

Because of the well-documented nurse shortage in Alaska, there is a very tight labor market for nurses. Nurses have significant leverage in negotiating the terms and conditions of their employment. Hours and shifts to be worked, shift-swapping flexibility, on-call requirements and how to handle anticipated overtime are all commonly agreed to in employment agreements.

In reality, the tight labor market for nurses in Alaska, combined with well-established avenues and procedures for nurses to negotiate the terms and conditions of employment, give nurses more than sufficient leverage to address any concerns they might have with regard to mandatory overtime, or for that matter, any other terms or conditions of employment.

The result, acknowledged by SB 12's proponents, is that *"there are few official overtime complaints by nurses..."*, and *"low numbers of complaints and benign exit interviews...."*

Senator Davis, we thank you for efforts on behalf of Alaska Tribal health providers. We appreciate this opportunity to express our concerns with SB 12, and we look forward to working with you in a cooperative manner on the many other important healthcare issues pending this session.

Respectfully,

Evangelyn Dotomain
President/CEO

Alaska Native
Tribal Health Consortium

Administration · 4000 Ambassador Drive · Anchorage, Alaska 99508 · Phone: (907) 729-1900 · Fax: (907) 729-1901 · www.anthc.org

POSITION PAPER

SB 12/HB 50 – "An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

CONTACT: Valerie Davidson, Senior Director
Legal and Intergovernmental Affairs
through Pat Jackson, State Liaison for Alaska Native Health
523-0363 – pajackson@anthc.org

DATE: March 9, 2009

POSITION: Oppose

The Alaska Native Tribal Health Consortium (ANTHC) is a tribally controlled, non-profit, statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. It is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. We employ 500 nurses. In January of this year ANMC was recognized for a second time as a Magnet Hospital, a highly prized award given by the American Nursing Association. Only five percent of all U.S. hospitals achieve Magnet Status, and even fewer are designated a second time. ANMC is the first and only Alaska hospital to receive Magnet Status. Magnet hospitals have demonstrated that they meet a set of criteria designed to measure the strength and quality of their nursing, including the ability of its nurses to contribute to patient outcomes, and where nurse job satisfaction, low turnover rates and appropriate grievance resolution are part of the standard.

We value our nurses, but we do not support SB 12 or HB 50, bills that seek to legislate work schedules and tie the hands of managers who are constantly juggling the demands of patient care against workforce availability and rising costs/chronic underfunding in the tribal health care system. We have three primary concerns about the bill as currently written:

1) *It would have a disproportionate and detrimental impact on patients in rural Alaska*
2) *It conflicts with Alaska's longstanding policy of supporting access to health care through allowing health care facilities an appropriate degree of flexibility in scheduling direct health care providers.*
3) *It creates the inaccurate impression that it applies to federal and tribal facilities and programs that comprise the Alaska Tribal Health System*

1) Disproportionate and Detrimental Impact on Patients in Rural Alaska

The bill provides no new resources and no new options. In rural Alaska recruiting and retaining qualified nurses is not merely a challenge, as it is for all of Alaska and much of the United States; it is a constant struggle. Vacancy rates, recruitment costs and staff turn-over continually plague these providers, especially tribal health providers.

This bill restricts the ability of hospital managers to work with their nursing staff to craft options in a health system that is already stretched to its limits in both staffing and financial resources. There is a real risk that the bill would lower nurse/patient ratios and decrease the quality of care patients receive by tying the hands of providers to balance patient needs with available workforce, including nurses. In rural Alaska, when nurses are not available, then patients must be diverted to another facility. Since there are no other options in rural Alaska, patients typically get diverted to the Alaska Native Medical Center. Because ANMC, as a statewide facility, serves all regions, then we experience a compounding effect at ANMC, a facility that is already too small to meet patient care needs. When ANMC is at capacity, we too are forced to divert patients to other facilities in Anchorage. This is an every day challenge, but is especially problematic during public health outbreaks. Diverting patients disrupts the continuity of care for our patients and imposes an additional financial burden on our already under-funded health system.

The bill also sets forth a reporting requirement to the State Department of Labor. Because tribal health facilities are not licensed by the state, as explained below, we believe we would not be subject to the reporting requirements. To the extent a tribal provider did comply, it would create a new, costly system of collecting data and preparing reports. ANMC employs nurses who are licensed by the state and nurses who are part of the Commissioned Corp under the federal Public Health Service, further complicating any perception of what would be required under a state law.

2) Conflict with Longstanding State Policy of Supporting Access to Health Care

The Alaska Legislature has recognized the necessity of promoting access to health care through appropriate limitations to wage and hour requirements since at least 1962 when it enacted the "hospital employee" exemption.[1] From 1962 to 1983, all employees of *non-profit hospitals* were exempt from that law. While the exemption was narrowed slightly in 1983 to cover only those employees who provide "medical services," the Legislature also expanded the exemption to the employees of *all hospitals*, not just those employed by non-profits.[2] This change addresses the "interest in keeping medical facilities open and providing more flexible schedules for employees whose extended hours of labor were needed to maintain the hospital in operation at all time" and more generally the need to "enhanc[e] access to health care" in Alaska.[3]

[1] AS 12.10.060 (1962); *Hutka v. Sisters of Providence*, 102 P.3d 947, 952 (Alaska 2004).
[2] *Hutka*, 102 P.3d at 952-53.
[3] *Hutka*, 102 P.3d at 953.

3) Applicability to Federal and Tribal Health Providers

Providing health care services to Alaska Natives and American Indians is a federal function that contributes to the fulfillment of the federal government's trust responsibility to Alaska Natives and their Tribes.[4] A federal facility performing a federal function is not subject to state regulation, even if the function is carried out by another entity, unless Congress clearly authorizes such regulation.[5] Congress has not authorized state regulation of federal health facilities serving Indian tribes and their members or of tribal facilities that fulfill this federal function pursuant to the Indian Self-Determination and Education Assistance Act.

Rather, Congress has taken pains to promote self-determination and self-governance by ensuring that Tribes and tribal organizations have sufficient flexibility to address the unique needs of Native Americans and the extraordinary challenges of providing quality, culturally appropriate health care with very limited resources, often in extremely remote locations. This is because one of the purposes of the ISDEAA is to provide

> a meaningful Indian self-determination policy which will permit the orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services.[6]

For similar reasons, Congress has provided an explicit exemption for Tribes and tribal organizations from the operation of most federal employment law, including Title VII of the Civil Rights Act of 1964, the American with Disabilities Act, and the Davis-Bacon prevailing wage rate requirements.[7] Courts have also recognized tribal exemptions with respect to other federal laws, like the Age Discrimination in Employment Act (ADEA), that do not specifically address their applicability to Tribes and tribal organizations.[8] One federal appellate court ruled that other federal laws and interests must give way to ISDEAA's overriding objectives when it

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[4] *See, e.g.*, 25 USC § 1616*l*; S. Rep. No. 102-392 at 2 (1992), *as reprinted in* 1992 USCCAN 3943, 3944. *See, also,* note 2, *supra.*

[5] *Goodyear Atomic Corporation v. Miller*, 486 U.S. 174, 181 (1988).

[6] 25 USC § 450a(b).

[7] 42 USC § 2000e(b)(1); 42 USC § 12111(5)(B)(i); 25 USC § 450e(a). *See also, Pink v. Modoc Indian Health Project*, 157 F.3d 1185, 1188-89 (9th Cir. 1998) (non-profit corporation created by two tribes qualified as an "Indian tribe" under Title VII where corporation was formed to deliver health care services under an ISDEAA agreement, even though services were provided outside the boundaries of a reservation), *Setchell v. Little Six, Inc.*, No. C4-95-2208, 1996 WL 162560, at *2 (Minn.App. April 9, 1996), *cert. den.* 521 U.S. 1124 (1997).

[8] 29 USC§ 626(d). *E.g.*, *EEOC v. Karuk Tribe Housing Authority*, 260 F.3d 1071, 1081 (9th Cir. 2001) (ADEA inapplicable to tribal housing authority that "occupies a role quintessentially related to self-governance"); *Taylor v. Alabama Intertribal Council*, 261 F.3d 1032 (11th Cir. 2001) (employee's race discrimination claim concerned tribal self-governance and intramural Indian matters). *See also Penobscot Nation v. Fellencer*, 164 F.3d 706 (1st Cir. 1999) (employment of a non-Native in federally funded public health nurse position is an "internal tribal matter" and not subject to state regulation).

addressed the potential applicability of the National Labor Relations Act to the Yukon-Kuskokwim Health Corporation.[9]

Congress and the federal courts have thus essentially deemed the Fair Labor Standards Act (FLSA) to be sufficient protection for tribal employees.[10] Because of the unique nature of nursing care, however, some nurses are exempt from FLSA's wage and hour requirements while others are protected through special provisions that specifically accommodate the need for scheduling flexibility. The Act's implementing regulations were recently revised with the benefit of comprehensive comments from nursing associations, patient advocacy groups, and health care facilities and they continue to recognize the need and appropriateness of allowing for this degree of flexibility. Alaska's own wage and hour laws and regulations are quite similar to the federal scheme in this respect.

At the same time, the Indian Health Care Improvement Act (IHCIA) and the Indian Self-Determination and Education Assistance Act (ISDEAA) provide a comprehensive framework for regulating tribal health care. Their broad language, together with the exemption from most federal employment law, provide a clear indication that Congress did not intend to allow federal agencies to impose their own rules on Tribes and tribal organizations, much less subject them to potentially overlapping and less flexible requirements enacted by individual states. Otherwise state law would "obstruct[] the execution of the purpose of the federal [law]."[11] The Supremacy Clause and the federal preemption doctrine prohibit this, especially in areas like Indian health care that has been a federal responsibility for centuries.[12]

"The Alaska courts have noted that the provision of Indian health care services is an area that is "comprehensively and pervasively regulated by the federal government which is manifested in both the ISDEAA and the IHCIA."[13] Once the federal government has thus occupied the field, there is no allowance for state regulations, even if it is consistent with statutory purposes.[14]

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[9] *YKHC v. NLRB*, 234 F.3d 714, 718 (D.C. Cir. 2000) ("NLRA must make in order to accommodate federal Indian law, as reflected in [ISDEAA]").. The Board concluded that it was inappropriate to exercise jurisdiction over YKHC in light of its role in fulfilling federal government's trust responsibility to provide free health care to Alaska Natives. *See also* 29 USC § 151, *et seq.; YKHC and International Brotherhood of Teamsters, Local 959, AFL-CIO, CLC*, 341 NLRB No. 139, May 28, 2004 (declining to exert jurisdiction over off-reservation tribal health organization fulfilling federal trust responsibility to provide free health care to Alaska Natives, even though organization employs many non-Natives and provides health care services to a small number of non-Natives).

[10] 29 USC § 201, *et seq.*

[11] *The Alaska Dental Society, et. al. v. State of Alaska, et. al*, 3AN-0604797 CI, 12 (June 27, 2006), *quoting Catalina Yachts v. Pierce*, 105 P.3d 125, 128 (Alaska 2005).

[12] *Alaska Dental Society* at 15, *citing Wachovia Bank, N.A. v. Burke,* 414 F.3d 305, 313 (2d Cir. 2005) (no presumption against federal preemption in fields substantially occupied by federal authority for extended time); *United States v. Locke*, 529 US 89, 108 (2000) (no presumption against preemption is triggered when significant history of a federal presence,).

[13] *Alaska Dental Society* at 15, *citing Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, 75 P.3d 1043, 1049 (Alaska 2003). *See also, id.* at 1048 (majority setting aside issues of whether tribal health clinic is "subject to comprehensive and pervasive federal oversight.")

[14] *E.g., National Audubon Society v. Davis*, 307 F.2d 835, 851 (9th Cir. 2002).

In addition to this existing federal law, CMS quality standards and Joint Commission standards impose high quality standards on federal and tribal facilities that participate in the Medicare and Medicaid programs. In Alaska, this includes all of the major IHS and tribal health facilities.

Together, these federal laws address the same concerns intended to be addressed by SB12/HB50. However, they do so in a way that allows facilities more flexibility. While they impose certain performance and quality standards, they do not dictate the means for accomplishing them by imposing rigid requirements that may or may not lead to the same level of performance or quality (or, in the case of rural Alaska, undermine the very goals that the bill sponsor is trying to promote).

Conclusion

We understand that the bill sponsors and supporters are trying to protect nurses from being overworked and patients from accidental errors that may occur as a result. However, we don't believe legislating hours is the right solution. ANTHC and our partner tribal health facilities work very hard to recruit and retain quality nurses. We place high value on the nurses who work for us, and are actively involved in programs like the University of Alaska's Rural Nursing Program. We have been innovative in crafting solutions where physician and nursing services have been non-existent—principal among them, the Community Health Aide Program.

We also value the partnerships we have with many of our non-tribal hospitals/health system partners. We understand the value of flexibility in workforce negotiations. Legislation, of course, takes discussion regarding choices off the table. We in the tribal health system have our own history of suffering unintended consequences from legislation that started with the best of intentions. Today, through our compact with the Indian Health Service, we engage each year in a very formal negotiation, where challenges for everyone involved are brought to the table and worked through to the point of consensus. We support the request of our partners that this legislation be held and to let the process of labor negotiations to proceed.

Thank you for your careful consideration of these issues. We would be happy to provide any further information upon request.

AaNA
Alaska Nurses Association

3701 E. Tudor Rd., Suite 208, Anchorage, AK 99507

Dangers of Mandatory Overtime:

FATIGUE and ERRORS

Support Senate Bill 12

Referred to as the Alaska Safe Nursing and Patient Care Act

Danger: Might As Well Of Had a Drink!

The long hours worked by some nurses pose some of the most serious threats to patient safety. Prolonged periods of wakefulness can produce effects that are similar to the effects produced by alcohol intoxication. This may include decreases in reaction time and the speed of mental processing.

Danger – Close to Intoxication

Periods of wakefulness in excess of 16 hours can produce performance decrements equivalent to a blood alcohol concentration (BAC) level of .05 percent. Alcohol intoxication is defined as .08 to .10 varying among the individual states. Do you want an exhausted nurse taking care of you or your family members?

Danger – Patient Safety at Risk

The impact of hours worked, duration of work, and overtime in this study were shown to have a statistically significant impact on patient safety as well as nurse satisfaction and retention in the profession.

Source

Michigan Nurses Association Public Policy Associates, Incorporated –

The Costs of Mandatory Overtime for Nurses,

August 2004

Danger –

likely to make at least one error

"The likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting 12.5 hours or more…." and "working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled."

Link Found

The authors of this study conclude that these findings imply a link between poor working conditions (long hours and overtime, mandatory or otherwise) and patient safety. In response to this and other admonitions concerning the elimination of mandatory overtime for nurses, almost half of the states in the nation have either enacted or introduced legislation concerning this issue.

Danger – PATIENT SAFETY AT RISK!

Threats to patient safety that are likely to result from extensive nursing overtime include the following:

- **Nurses being less alert to changes in patients' condition**
- **Nurses having slower reactions**
- **Medication errors – adverse drug events**
- **Increase in nosocomial infections**
- **Increase in decubiti**

Institute of Medicine Report

The Institute of Medicine estimates that approximately 100,000 hospital deaths can be attributed to medical errors each year. Mandatory overtime is a serious contributing factor to medical errors. The final recommendation of the IOM is that all overtime, voluntary and mandatory/ involuntary done by nurses should be curtailed.

Not A "Bargaining Issue"!

This is a Public Safety Issue

The Alaska public has a right to expect when they walk into a healthcare facility, that the nurse taking care of them is properly rested and alert.

(And that their RN hasn't been working 16 hours that day already.)

Not A "Bargaining Issue"!
This is a Public Safety Issue

- At registration, a member of the public should not have to request a copy of the most recent Collective Bargaining Agreement to see how successful their nursing staff has been in negotiating reasonable working conditions.
- Not all nurses are represented by a union. What do we do for these nurses' patients and themselves?

Washington State Passes Law in 2002

Anne Piazza, lobbyist for WSNA testified before Representative Peggy Wilson's special House HESS committee in January 2006:

"The State of Washington passed a law to prohibit mandatory overtime for nurses with the cooperation of the WSNA, other nursing unions, and the Washington Hospital Association."

Washington State

Mandatory overtime puts patients, nurses and the profession at risk. Many health care facilities have turned to the use of mandatory overtime as a common practice to fill longstanding staffing and scheduling problems.

Shifting the entire burden to employees when there is a labor shortage is not the answer to attracting qualified persons to the profession.

Washington State

One of the reasons that the nursing shortage as it exists today is because qualified nurses are not working in the field or leaving the profession because they can no longer work the long hours or safely take care of their patients. Forced overtime is adding to this shortage.

Massachusetts Study

Research from the University of Massachusetts shows a strong link between working overtime and sustaining a work-related injury. This was found to be true for all occupations… working longer hours (12 hours a day or more) was associated with a 37 percent increase in risk.

(Chantal Britt, Bloomberg, "Overtime, Long Houses Increase Illness, Injury Risk, Study Shows," August 22, 2005.)

States Which Ban or Limit Forced Overtime

California
Connecticut
Illinois
Maine
Maryland
Minnesota
Missouri
New Hampshire
New Jersey
New York
Pennsylvania
Oregon
Texas
Washington
West Virginia

Additional States Lining Up

There is legislation banning the use of mandatory overtime pending in the following states:

Alaska	**Florida**	**Georgia**
Hawaii	**Iowa**	**Michigan**
Nevada	**Ohio**	**Rhode Island**
Tennessee	**Vermont**	

States that have passed a Mandatory Overtime Bill & States with legislation pending

The American Nurses Association's Nationwide State Legislative Agenda

PROHIBITION OF MANDATORY OVERTIME

February 2009

Support Alaska Senate Bill 12

Your nurse will always be there for you in time of an unforeseen emergency situation, disease outbreak, natural or man-made disaster.

Your nurse will be able to voluntarily work overtime so long as the work is consistent with professional standards of safe patient care and does not exceed 14 consecutive hours.

Support Alaska Senate Bill 12

But with SB 12, a nurse will be able to say, "I have worked my shift; I'm tired; and possibly I'm not as swift as I would otherwise be if I had some rest. My patients could possibly be at risk if I push on any longer."

Knowing his or her own limits, the nurse can refuse to be assigned the forced overtime in the first place. Our nurse would now be able to do this without fear of reprisal or loss of job.

Questions for you as Law Makers

- Where is the law that says as a nurse you lose your right to basic human rights? Time off, time to rest, to eat and to have time off for family?
- The Federal Government has passed laws to limit the number of hours that pilots can safely fly, truckers can safely drive, conductors and engineers can drive a train and a ship - all for public safety. Why would we not try to do the same for people when they are at their most vulnerable?

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Questions for you as Lawmakers

- Do you think nurses should have the right to refuse an overtime assignment if they feel either the patient's or nurse's safety is in jeopardy other than during an unforeseen emergency?
- When you answer these questions, I hope that you will not only support SB 12, but also the nurses that have come forward with risk of their job and livelihood to provide quality patient care to you and your loved ones at one of the most vulnerable times.

We Urge Your Support for SB12

It will protect the individual patient.

It will protect the Registered Nurse.

It will protect the healthcare facility.

It will enhance the nursing profession.

It will help recruit nurses.

It will help retain nurses.

It's good public policy.

It's common sense.

Thank you.

AaNA
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ASHNHA
Alaska State Hospital and Nursing Home Association

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TESTIMONY ON SENATE BILL 12

ASHNHA represents 27 private, federal, state, and tribal health care facilities located throughout Alaska. The testimony presented here has been approved by ASHNHA's general membership (see detailed member list at bottom of testimony).

Senate Bill 12 sponsor Senator Bettye Davis is well respected by *ASHNHA's* members for her commitment to improving health care access and quality in Alaska. We share Senator Davis' passion for increasing eligibility levels for Denali Kid Care to at least 200% of the federal poverty level, and in seeking creation of an Alaska Health Commission to address Alaska's health care issues.

However, *ASHNHA's* membership does not believe that Senate Bill 12 is needed to assure continued delivery of excellent patient care throughout the State, and therefore does not support Senate Bill 12. *ASHNHA's* members have had and will continue to have a strong commitment to respect the individual importance of each nurse in our health care delivery mission, and to treat each nurse fairly in the work place. We believe our annual nurse overtime survey demonstrates that this commitment to our nursing staff and to our patients is being met.

ASHNHA has conducted a facility survey on mandatory overtime for the last four years to gain a better understanding of the frequency with which 'mandatory' overtime is used by our member facilities. 'Mandatory' in this context is overtime that is not willingly worked by a nurse and does not include 'on-call' overtime hours. As displayed in the latest survey for 2007 and 2008 calendar years (copy attached), the number of mandatory overtime hours imposed is minimal and only occurs in a few facilities. Most of that mandatory overtime occurs at the State operated Alaska Psychiatric Institute but even that level of mandatory overtime usage is down substantially from 2006.

ASHNHA member facilities have taken a number of steps over the years to minimize the need to use mandatory overtime to fill gaps in nursing shifts. Some examples include:

1. Financially contributing to the University of Alaska expansion of their nursing program from 100 nurses each year to over 200 nurses each year.
2. Creating clinical experiences for student nurses and recently graduated nurses to gain hands-on nursing experience required to complete their education, or to achieve the patient care experiences necessary to become employed in a hospital setting.
3. Providing distance learning opportunities so local residents can take nursing courses in their own community with minimal need to spend large amounts of time out of town to achieve their clinical experiences.
4. Purchasing tens of thousands of hours of temporary nursing hours to fill staffing gaps to minimize use of mandatory overtime.

3160

Even with these initiatives approximately half of the facilities reporting on this year's survey believe the nursing shortage situation has worsened, and the solutions to address this shortage become more complex.

RECAP OF ASHNHA's CONCERNS with SB 12:

- *ASHNHA's* data shows Alaska's hospitals and nursing homes are not routinely relying on mandatory overtime to fill staffing gaps. On the contrary *ASHNHA's* data shows that use of mandatory overtime is a rare occurrence with all but 4 facilities reporting **ZERO** use of mandatory overtime in 2008 (see attached chart). Most of this is at the State operated Alaska Psychiatric Institute. No employee grievances on overtime were reported for 2008 by facilities.

- *ASHNHA* believes work hours and scheduling are appropriately a local employer responsibility to negotiate with its employees. This is being done in every community in a responsible manner with equal concern to employee and patient concerns. Work force challenges vary significantly from one community to the next making a single approach to addressing this challenge unworkable. A number of facilities are either in negotiations with nursing staff or will begin those negotiations shortly. These negotiations should be given an opportunity to address any concerns from nursing staff.

- With respect to overtime required to meet on-call requirements, these understandings are locally developed between management and nursing in each community based on the unique needs and staffing challenges each face.

- The ongoing monitoring systems operated by federal, state or independent private agencies that review patient care show Alaska health care quality is excellent. None of these organizations has identified use of mandatory overtime as a problem related to delivery of excellent patient care in Alaska.

- ASHNHA's members have worked diligently to reduce the nursing shortage problem in Alaska by contributing substantial funding over the last four years to help support an expanded nursing program at the University of Alaska. This program is now graduating 200 nurses annually compared to 100 nurses before the program's expansion.

- SB 28 would impose a new reporting burden for Alaska facilities. These reports would have to be filed semi-annually and must contain detailed work hour information for each staff nurse employed by the facility as well as each contract nurse.

Contact for more information: rbetit@ashnha.com

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Bartlett Regional Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, North Star Behavioral Health, Wildflower Court Nursing Home.

ASHNHA 2007 and 2008 NURSE OVERTIME SURVEY RESULTS -
(March 6, 2009)

Facility	Nurses in Union?	Shortage Better, Worse, Same	Length of Shift (Hrs)	Nurse Vacancy Rates as %		Mandatory OT Usage- Total Hrs		On-call Policy		Temp Nursing Hours Needed to Fill Vacancy		# of OT grievances filed 2008
				2007	2008	2007	2008	Require	# times /month	2007	2008	
Alaska Regional Hospital	Yes	Same	12	19%	15%	0	0	OR only	3x	44,349	30,542	0
Alaska Native Medical Center	No	Data Not Available at This Time										
Alaska Pioneer Homes (All Six Facilities)	Yes	Same	7.5,10,15	n/a	n/a	0	0	n/a	n/a	0	0	0
Alaska Psychiatric Institute	Yes	Same	8.10,12	19%	14%	468.5	285.5	No	n/a	n/a	n/a	0
Bartlett Regional Hospital	Yes	Worse	12	14%	5%	108	104	OR only	56hr/mo	19625	18518	0
Central Peninsula General Hospital	Yes	Worse	8,12	10%	2%	37	36	Surgery	7x	1230	0	0
Cordova Community Medical Center ✔	No	Same	12	10%	11%	0	0	Certain Units	3x	2673	2452	0
Denali Center Nursing Home	No	Data Not Available at This Time										
Fairbanks Memorial Hospital	No	Data Not Available at This Time										
Heritage Place Nursing Home	No	Response Combined with Central Peninsula Hospital										
Kanakanak General Hospital ✔	No	Data Not Available at This Time										
Ketchikan General Hospital ✔	Yes	Better	8,9,10,12	7%	8%	0	0	Certain Units	1 to 10x	11,700	15,000	0
Manilaq Health Center ✔	No	Data Not Available at This Time										
Mt. Edgecumbe SEARHC Hospital	No	Better	8,9,10,12	25%	12%	0	100+	Certain Units	1 to 10x	27,960	15,421	0
North Star Behavioral Health System	No	Same	8,16	10%	10%	0	0	No	n/a	0	0	0
Norton Sound Regional Hospital ✔	No	Data Not Available at This Time										
Petersburg Medical Center ✔	No	Same	12	13%	12%	0	0	Yes	8	3000	2650	0
Providence Alaska Medical Center	Yes	Worse	8,10,12	8%	12%	0	0	Certain Units	n/a	102,438	85,103	0
Providence Extended Care Center	No	Worse	8,10,12	9%	13%	0	0	No	n/a	188	0	0
Providence Kodiak Island Medical Center ✔	Yes	Worse	8,10,12	8%	16%	0	0	Certain Units	n/a	2192	0	0
Providence Seward Medical & Care Center ✔	No	Worse	8,10,12	11%	4%	0	0	No	n/a	2318	905	0
Providence Valdez Medical Center ✔	No	Worse	8,10,12	36%	22%	0	0	No	n/a	2193	4853	0
Sitka Community Hospital ✔	No	Better	8,12	21%	6%	0	0	No	n/a	5100	2748	0
South Peninsula Hospital ✔	Yes	Same	8,10,12	3%	8%	0	0	Certain Units	4-13x	840	4920	0
Wildflower Court Nursing Home	No	Same	8,10,12	0%	0%	0	0	Yes	1	0	1000	0
Wrangell Medical Center ✔	No	Worse	8,12	0%	10%	0	0	Yes	4hr - 14X	0	500	0
Yukon Kuskokwim Regional Hospital	No	Same	10,12	n/a	n/a	0	0	Certain Units	n/a	n/a	12,600	0
TOTAL	9Y 18N	8S9W3B		12.4%	10.0%	613.5	425.5			225,806	197,212	0

Lynda Zaugg

From: Patrick Higgins [Patrick.Higgins@uhsinc.com]
Sent: Tuesday, March 24, 2009 1:50 PM
To: Thomas Obermeyer
Cc: Sen. Bettye Davis; raygillespie@ak.net
Subject: nurses overtime bill SB 12

Tom, our nurses love our Baylor plan and we use it at both our hospital and residential treatment centers. This plan is used for both full and part-time employees. An employee who regularly works only one weekend Baylor shift (16 hours) receives 20 hours pay and part-time benefits. If they work two Baylor shifts (32 hours) they receive 40 hours pay and full time benefits. I provided language earlier and at one time last year Senator Davis' bill exempted our Baylor plan.

I would propose the following language.

"A nurse at a psychiatric treatment hospital or residential treatment center who agrees to work two consecutive eight hour shifts on weekends, provided the employer provides pay and benefits equivalent to twenty hours for each two consecutive shifts. A nurse that works four eight hours shifts cannot work more than 16 consecutive hours on duty without a break of at least eight hours. In this paragraph, a weekend means Friday at 5:00 p.m. and ends Monday at 8:00 a.m."

Thanks. Feel free to call me on my cell, 952-5871, if you have any questions.

Pat

Patrick Higgins
HR Director
Northstar Behavioral Health
2530 DeBarr Rd.
Anchorage, Alaska 99508

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SB

13

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Finance

Date of 5-Day Notice: 2/4/09
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/9/09

Health and Social Services Committee considered SENATE BILL NO. 13

SB 13 MEDICAL ASSISTANCE ELIGIBILITY

"An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS	2/1/09	$			1
DHS	2/1/09	$			2
DHS	2/4/09	$			3

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
Jerry Thomas	THOMAS	✓			
Jim Ellis	ELLIS	✓			
Dave Parkinson	PARKINSON	✓			
CHAIR: Betty Davis	DAVIS	✓			

Alaska State Legislature

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Senator Bettye Davis

SB 13 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Sponsor Statement

SB 13 increases the qualifying income eligibility standard for the Denali KidCare Program to 200% of the Federal Poverty Line (FPL) and makes health insurance accessible to an estimated 1300 more uninsured children and 225 pregnant women in Alaska. Denali KidCare is an "enhanced" reimbursement program with up to 70% matching funds under the federal government's State Children's Health Insurance Program (SCHIP), which was created in 1997. Congress reauthorized the SCHIP program for five years and President Obama just signed into law on February 4, 2009 with expanded coverage for 4 million more children.

Alaska as one of the nation's richest states is only one of 7 states which funds its SCHIP program below 200% FPL. Increasing Alaska Denali KidCare to 200% FPL only brings it to the level at which it was established 10 years ago. Consider the following information from the Kaiser Commission on Medicaid and the Uninsured, January, 2009:

- 44 states, including D.C., cover children in families with incomes at 200% FPL or higher.
- 33 states cover children in families with income between 200% and 250% FPL.
- 19 states including D.C., cover children in families with income at 250% or higher. 10 of these states cover children in families with income at 300% FPL or higher.
- 35 states allow premiums, enrollment fees, or co-payments for selected services in SCHIP programs on a sliding scale of FPL.

Denali KidCare serves an estimated 7600 7900? Alaska children and remains one of the least costly medical assistance programs in the state at about $1,700 per child with full coverage, including dental, which is about 20% of the cost of adult senior coverage.

Early intervention and preventative care under SB 13 will greatly increase Alaska children's health and yield substantial savings to the state and public and private sector hospital emergency rooms which must admit indigent and uninsured patients for non-emergency treatment. It is estimated that uninsured children with a medical need are five times as likely not to have a regular doctor as insured children and four times more likely to use emergency rooms at a much higher cost.

There are still an estimated 18,000 uninsured children in Alaska, or about 9% of the children age 18 and under. Private health care coverage for children has declined over 30% in the last ten years, and the deepening recession is pulling more children and families into the uninsured ranks. The reauthorized SCHIP program and "Stimulus Package" should help, and Alaska should do its share and take advantage of federal matching funds by insuring its low income children up to and including 200% FPL under SB 13.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 22, 2009

SUBJECT: Sectional Summary (SB 13; Work Order No. 26-LS0076\A)

TO: Senator Betty Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Amends the medical assistance eligibility provisions for persons under 19 years of age and for pregnant women by increasing the household income limit from 175 to 200 percent of the federal poverty line.

Section 2. Increases the household income limit from 175 to 200 percent of the federal poverty line for requiring premiums and cost-sharing contributions from medical assistance recipients who are under 19 years of age.

Section 3. Provides for an immediate effective date.

JMM:ljw
09-039.ljw

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB013
() Publish Date:

Identifier (file name): SB013-DHSS-BHMS-02-01-09
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Behavioral Health
Component: Behavioral Health Medicaid Services
Sponsor: Davis
Requester: Unknown
Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	430.0	0.0	467.0	507.1	550.7	598.1	649.5
Miscellaneous							
TOTAL OPERATING	**430.0**	**0.0**	**467.0**	**507.1**	**550.7**	**598.1**	**649.5**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	284.0		305.7	330.7	359.1	390.0	423.6
1003 GF Match	146.0		161.3	176.4	191.6	208.1	226.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**430.0**	**0.0**	**467.0**	**507.1**	**550.7**	**598.1**	**649.5**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare (DKC) program was originally created.

Between October 2003 and July 2007, the upper income limit for these individuals was "frozen" at an amount equivalent to the 2003 federal poverty guideline (FPG). By April 2007, that income amount was calculated by the department to correspond to about 150% of the 2007 FPG. Senate Bill 27, implemented in summer 2007, made the upper income standard for children and certain pregnant and postpartum women equal to 175% of the

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 907-269-7827
Division: Health Care Services
Date/Time 1/22/08 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/1/2009
Finance Management Services

ANALYSIS CONTINUATION

prevailing federal poverty guideline (FPG) for Alaska, as published annually in the federal register, and effectively raised the income level from 150% to 175% FPG. However, children and pregnant women with incomes between 176% and 200% of the prevailing FPG did not regain eligibility.

Between 2003 and 2006, the number of enrolled children with household incomes between 151% and 200% FPG dropped by 2,553 and the number of enrolled pregnant women with incomes between 134% and 200% dropped by 436. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY 2010 and that enrollment will resume normal growth (about 2% per year) thereafter.

Further assumptions are that participation, i.e. the proportion of enrollees that obtain services during the year, will not change with implementation of this bill and will remain the same throughout the projection period. First year costs are based on an estimate for the number of new enrollees times the average cost per enrollee for the affected eligibility subtypes in 2008. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Costs projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XIX, or Title XXI rates during 2008 and our best estimates for federal medical assistance percentages (FMAPs) between 2010 and 2015. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2010 and 2015;, however, the program is currently funded under a continuing resolution. Title XXI funding for the balance of SFY 2009 after March 30, 2009 and for SFY 2010 will not be established until Congress takes additional action to reauthorize and fund the SCHIP program.

Expenditures for the Behavioral Health Medicaid Services component were determined based on the component's share of expenses for the affected eligibility subtypes in 2008. Behavioral Health paid about a quarter of the costs for affected DKC children in 2008. No charges for services for DKC pregnant women were paid by this component in 2008.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB013
() Publish Date:

Identifier (file name): SB013-DHSS-MS-02-01-09
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Health Care Services
Component: Medicaid Services
Sponsor: Davis
Requester: Unknown
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	2,105.0	0.0	2,286.0	2,482.6	2,696.1	2,928.0	3,179.8
Miscellaneous							
TOTAL OPERATING	**2,105.0**	**0.0**	**2,286.0**	**2,482.6**	**2,696.1**	**2,928.0**	**3,179.8**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,448.7		1,561.0	1,689.5	1,834.8	1,992.6	2,164.0
1003 GF Match	656.3		725.1	793.1	861.3	935.4	1,015.8
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**2,105.0**	**0.0**	**2,286.0**	**2,482.6**	**2,696.1**	**2,928.0**	**3,179.8**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200 percent of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare (DKC) program was originally created.

Between October 2003 and July 2007, the upper income limit for these individuals was "frozen" at an amount equivalent to the 2003 federal poverty guideline (FPG). By April 2007, that income amount was calculated by the department to correspond to about 150% of the 2007 FPG. Senate Bill 27, implemented in summer 2007, made the upper income standard for children and certain pregnant and postpartum women equal to 175% of the
(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 907-269-7827
Division: Health Care Services
Date/Time 1/22/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/1/2009
DHSS Finance Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB013

ANALYSIS CONTINUATION

prevailing federal poverty guideline (FPG) for Alaska, as published annually in the federal register, and effectively raised the income level from 150% to 175% FPG. However, children and pregnant women with incomes between 176% and 200% of the prevailing FPG did not regain eligibility.

Between 2003 and 2006, the number of enrolled children with household incomes between 151% and 200% FPG dropped by 2,553 and the number of enrolled pregnant women with incomes between 134% and 200% dropped by 436. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY 2010 and that enrollment will resume normal growth (about 2% per year) thereafter.

Further assumptions are that participation, i.e. the proportion of enrollees that obtain services during the year, will not change with implementation of this bill and will remain the same throughout the projection period. First year costs are based on an estimate for the number of new enrollees times the average cost per enrollee for the affected eligibility subtypes in 2008. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Costs projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XIX, or Title XXI rates during 2008 and our best estimates for federal medical assistance percentages (FMAPs) between 2010 and 2015. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2010 and 2015; however, the program is currently funded under a continuing resolution. Title XXI funding for the balance of SFY 2009 after March 30, 2009 and for SFY 2010 will not be established until Congress takes additional action to reauthorize and fund the SCHIP program.

Expenditures for the Health Care Services Medicaid component were determined based on that component's share of expenses for the affected eligibility subtypes in 2008. Health Care Services Medicaid paid 100% of the costs for DKC pregnant women and about three quarters of the costs for affected DKC children in 2008.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB013
() Publish Date:

Identifier (file name): SB013-DHSS-PAFS-02-04-09
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Public Assistance
Component: Public Assistance Field Services
Sponsor: Davis
Requester: Unknown
Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	134.4		134.4	134.4	134.4	134.4	134.4
Travel							
Contractual	17.6		17.6	17.6	17.6	17.6	17.6
Supplies	1.0		1.0	1.0	1.0	1.0	1.0
Equipment	14.4						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**167.4**	**0.0**	**153.0**	**153.0**	**153.0**	**153.0**	**153.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	83.7		76.5	76.5	76.5	76.5	76.5
1003 GF Match	83.7		76.5	76.5	76.5	76.5	76.5
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**167.4**	**0.0**	**153.0**	**153.0**	**153.0**	**153.0**	**153.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time	**2.0**		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare(DKC) program was originally created.

This fiscal note represents the additional administrative costs needed to support the increased eligibility determination workload resulting from more pregnant women and children applying for medical assistance, using the assumptions from the companion fiscal notes for the Division of Health Care Services and the Division of Behavioral Health.

(continued on Page 2)

Prepared by: Ellie Fitzjarrald
Phone 907-465-5847
Division: Division of Public Assistance
Date/Time 2/4/09 12:00 AM

Approved by: Alison Elgee, Assistant Director
Date 2/4/2009
DHSS Finance Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB 013

ANALYSIS CONTINUATION

The eligibility decision includes verifying information and determining whether a pregnant woman or child qualifies for DKC when they apply, acting on changes, and periodically re-examining a household's eligibility.

We assume that 218 pregnant women and 1,277 children will enroll in Medicaid if the qualifying income limit is revised to 200% FPG, and that implementation will begin July 1, 2009. We estimate two additional Eligibility Technician I (Range 13) positions will be needed to manage this additional work in FY2010.

Total Administrative Costs for ET I Positions:

Personal Services: Two Eligibility Technician I Range 13 at a cost of $134.4, including benefits, for 12 months.
Contractual: Annual cost for office space, phones, etc. will be $17.6.
Commodities: Annual cost for the office supplies will be $1.0.

Additional Cost of FY2010:
Equipment/Supply: A one time cost of $14.4 for desktop computer, software, printer, and work stations will be needed for the new positions.

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http://www.akdemocrats.org

Senator Bettye Davis

SB 13 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Background of SCHIP/Denali Kid Care

- SCHIP was created in 1997 to reduce the number of uninsured children by providing subsidized insurance to children of those parents who are too poor to afford insurance but make too much to receive Medicaid coverage. About 1/3 of all children in America get health services through Medicaid or the State Children's Health Insurance Program (SCHIP), which is administered in Alaska through the Denali KidCare Program.
- The Denali KidCare Program is 70% funded by the federal government up to the state's allocated funding level. After that, the reimbursement rate declines to slightly over 50%. In fiscal year 2006 the cost of Denali KidCare was $25.9 million, of which $18.2 million was paid by the federal government.
- Denali KidCare provides health insurance for children age 18 and pregnant women who meet income guidelines. There is no cost to eligible children, teens and pregnant women. However, youth who are 18 may be required to contribute a limited amount for some services.
- Roughly 7,600 children were covered by Denali KidCare as of December, 2006.
- The cost per child of Denali KidCare is about $1,700 annually, compared to over $12,000 for an elderly person who qualifies for federal aid.
- By comparison, private health insurance for a family of three, *e.g.*, a pregnant woman with two children, is estimated at $8,000-$17,000 annually. Unlike Denali KidCare, this insurance may require a $1,000 deductible, 20% co-pay, and no vision, dental or hearing benefits.
- Alaska remains one of the lowest eligibility rates in the nation. Forty-one states allow participation by families at or above 200% of the FPL. Seven have rates at or above 300% of the FPL. The US and state governments' rationale for higher eligibility for children's health insurance is that it will save huge sums in transfer costs and improve health in the future through early detection and care.

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Senator Bettye Davis

SB 13 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Repercussions of the unmet health needs of Alaska's uninsured children

---

- The number of uninsured children in Alaska is estimated to be about 18,000 or 9% of the population age 18 and under (Urban Institute and Kaiser Commission on Medicaid and the Uninsured).
- Over the last 10 years Alaska has seen a 31% decline in the number of children covered by private health insurance (Robert Wood Johnson Foundation).
- Nationally, more than 80% of uninsured children are from working families (Kaiser Commission on Medicaid and the Uninsured).
- Uninsured children have much higher health risks than do covered children. The receive less preventative care and are diagnosed at more advanced stages of illness (Kaiser, *supra*).
- Uninsured children are more likely to develop throat, eye, and ear infections, serious dental problems, and chronic conditions such as asthma and diabetes. They are more than five times as likely as insured children to have an unmet need for medical care and nine times more likely not to be examined by a regular doctor. They are also four times more likely to use emergency rooms which are much more costly than care in physicians' offices (*Pediatrics* 105, 113; "Care for Children," *New England Journal of Medicine*, 330).
- Almost 1/3 of uninsured children received no medical treatment during a 1-year period between 2002 and 2003 (*Health Affairs* 23, no. 5, September-October 2004).
- Uninsured children are 25% more likely to miss school than insured children (Children's Defense Fund, Minnesota). Continued illness affects school performance and, in the long run, workforce participation (Southern Institute on Children and Families). A National Institute of Medicine study indicates that lack of insurance results in lost national economic productivity of $65-$130 billion annually.

Why Coverage for Pregnant Women is Important In Alaska

- Alaska has one of the nation's highest documented pregnancy-associated mortality ratios – 58 per 100,000 live births during 1990-1999 (DHSS). National data indicate that women who receive no prenatal care are al increased risk of pregnancy-related death.
- Only 58% of women in Alaska receive adequate prenatal care, compared with 75% nationally.
- Mothers having late or no prenatal care are more likely to have low birth weight or pre-term infants and are at increased risk fro pregnancy-related mortality and complications of childbirth (DHSS).
- The average cost of hospital care for a premature baby was $75,000 in 2001, compared with $1,300 for a healthy, full-term infant. The March of Dimes Prenatal Data Center reports that premature babies cost about $13.1 billion annually.

Alaska State Legislature

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http://www.akdemocrats.org

Senator Bettye Davis

SB 13 **"An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."**

Suggested List to Testify

- Rod Betit – Pres/CEO ASHNHA, AK State Hosp. & Nursing Home Assn. rodbetit@msn.com
- Janice Tower, Exec. Dir., AK Chapter Pediatricians
- ~~Regan Mattingly, State Affairs Coordinator~~ Shelley Hughes Gov. Affairs Dir 929-2725, Alaska Primary Care Association
- Walter Majoros, Juneau Youth Services (Mental Health –per Caren Robinson 321-2551)
- Matt Felix – National Counsel on Drugs and Alcohol
- Pat Senner – Legis. Chair – Alaska Nurses Assn, and Covenant House
- Anchorage Neighborhood Health Clinic
- Providence Family Medicine Center in Anchorage
- Social Workers
- Others – throughout the state will call in

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Alaska State Chapter
3209 Denali Street, Suite 200
Anchorage, AK 99503
(907) 276-4111
1-800-478-5245
Fax: (907) 276-3375

marchofdimes.com/alaska

RECEIVED
FEB 0 6 2009

February 3, 2009

The Honorable Bettye Davis
State Capitol, Room 30
Juneau, AK 99801-1182

RE: Support for Senate Bill 13

Dear Senator Davis:

I am writing to you to express the support of March of Dimes for **Senate Bill 13.** The mission of March of Dimes is to improve the health of babies by preventing birth defects, premature birth and infant mortality can best be achieved if all women of childbearing age, infants and children have access to comprehensive health coverage.

Senate Bill 13 reinstates Medicaid and Denali KidCare (DKC) for children and pregnant women in Alaska up to 200% of Federal Poverty Level (FPL). This was the original eligibility level when DKC was established in 1997. The eligibility threshold was reduced and frozen at 175% FPL by the Legislature in 2003. This bill will help reinstate eligibility to many of Alaska's 19,000 uninsured children.

The Institute of Medicine has found that health coverage is the single most important factor in determining whether or not a child receives needed health services. Coverage also plays a key role in access to maternity care services for pregnant women.

Women who receive maternity care are more likely to have access to screening and diagnostic tests that can help to identify problems early; services to manage developing and existing problems; and education, counseling, and referral to reduce risky behaviors like substance use and poor nutrition. Such care may thus help improve the health of both mothers and infants. For example, singleton infants born to mothers who received late or no prenatal care in 2004 were nearly twice as likely to be low birth weight (less than 5 1/2 pounds) as infants born to mothers who received early prenatal care —9.9 percent compared with 5.9 percent.

In addition to pregnant women, health insurance status is the single most important influence in determining whether health care is accessible to children when they need it, according to another Institute of Medicine study. Though uninsured newborns are more likely than insured babies to be sick, they receive fewer hospital services.

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marchofdimes.com/alaska

Uninsured children are the most likely to have no usual source of medical care - 28.8 percent, compared with only 2.3 percent of privately insured youngsters and 4.6 percent of children in public insurance programs. March of Dimes is a leading nonprofit organization for maternal, infant and child health. With chapters nationwide and its premier event, March for Babies, March of Dimes works to improve the health of women, infants and children. **Thank you for sponsoring Senate Bill 13.**

Sincerely,

Janie Odgers
State Director

march of dimes

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
and ALASKA MENTAL HEALTH BOARD

SARAH PALIN, GOVERNOR

P.O. BOX 110608
431 N. Franklin Street, Suite 200
JUNEAU, ALASKA 99811-0608
PHONE: (907) 465-8920
FAX: (907) 465-4410
TOLL FREE: (888) 464-8920

February 9, 2009

Senator Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room 30
Juneau, Alaska 99801

Re: Support for Expanding Eligibility for Denali KidCare

Senator Davis:

The Alaska Mental Health Board and Advisory Board on Alcohol and Drug Abuse appreciate your recognition of the need for quality health care for Alaska's children. An estimated 19,670 of Alaska's children live in poverty. For them, Denali KidCare is an important safety net – and the way we can insure that our children grown to be healthier and happier adults.

Medicaid-enrolled children who are up-to-date on their well-child checkups through age two years are 48% less likely to experience an avoidable hospitalization. Children with incomplete care are 60% more likely to visit an emergency department for any cause compared to children who are up-to-date on their well-child care. By providing regular preventative care to our children, we save on the cost and trauma of unnecessary hospitalizations.

Denali KidCare is especially important for children with serious emotional disturbances and other mental health needs. In Alaska, more than 75% of children with special health care needs who have Denali KidCare receive the mental health services they need. This is far better than the national rate for uninsured children: only 56.8% of uninsured children with special health care needs receive the necessary mental health services.

Children of families whose income exceeds the current 175% FPIG ceiling, but who still lack resources or insurance to pay for their children's health care, go without necessary health care. The costs of health care have continued to rise, and with that the number of uninsured children who go without care rises. In 2007, nearly 16% of uninsured children in the United States went without necessary care because the costs were prohibitive.

Thank you for your work, and please let us know if the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse can assist in the effort to pass this important legislation.

Sincerely,

Debi Keith, Chair
AMHB

Lonnie Walters, Chair
ABADA

Lynda Zaugg

From: Don Burrell
Sent: Monday, February 09, 2009 8:48 AM
To: Thomas Obermeyer; Lynda Zaugg
Subject: Support for SB 13 & SB 87

Karen McBride called in today at 8:42am to express her support for both SB 13 & SB 87 which will be heard in H.S.S. this afternoon.

Just passing the word along.

MCBRIDE, KAREN L
8981 RENDON DR
ANCHORAGE AK 99507
District: 30-840 Party: D Sex: F

Don Burrell Jr.
Legislative Aide
Office of Senator Bettye Davis
State Capitol Building, Rm. 30
Juneau, Alaska 99801
P 907-465-3822
F 907-465-3756
don_burrell@legis.state.ak.us

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Monday, February 09, 2009 9:01 AM
To: Lynda Zaugg
Cc: Fuller, Jerry (HSS)
Subject: Senate HSS hearing today

Lynda, this is to let you know that Jerry Fuller, DHSS Medicaid director, will be calling in for today's Senate HSS hearing. He will be available for questions.
w.

Lynda Zaugg

From: Thomas Obermeyer
Sent: Monday, February 09, 2009 8:26 AM
To: Lynda Zaugg; Sen. Bettye Davis; Don Burrell
Subject: FW: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

NCSL staff heard attend in via telecon

From: Jennifer Saunders [mailto:jennifer.saunders@ncsl.org]
Sent: Monday, February 09, 2009 7:50 AM
To: Thomas Obermeyer
Cc: Martha King; Jennifer Breshears
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Martha King and I will be on the call this afternoon to answer questions.

As we discussed on the phone on Friday, Alaska's SCHIP program is a Medicaid expansion program and therefore must comply with Medicaid's cost-sharing rules as specified under the Deficit Reducation Act of 2005.

The following document summarizes these requirements and I would refer you to the summary on page 1 under the heading "Options for Premiums and Cost-sharing" and the "Important Links" on the bottom of page 2.
See the document here: http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf

Under provisions of the Deficit Reduction Act of 2005, states generally cannot impose cost sharing on children in families with income below 150 percent of the federal poverty guidelines except in certain circumstances. In addition, even at more moderate-income levels, federal rules exempt some special services from any cost sharing requirements.

To create cost sharing requirements that differ from the Medicaid requirements, states can do so by submitting a waiver to and obtaining approval from the Centers for Medicare and Medicaid (CMS) or by creating a stand-alone SCHIP program.

For more information about cost sharing and SCHIP, please see the following CMS website:
http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp
(Scroll down to see the information under the heading "Cost Sharing.")

Best regards,
Jennifer

Jennifer B. Saunders, MSW
Research Analyst
Health Program
National Conference of State Legislatures
7700 East First Place

January 26, 2009

Martha King, Group Director,
Health Programs, NCSL - Denver
303-364-7700 main line
303-364-7800 fax
303-856-1448 – direct line
E-mail: Martha.king@ncsl.org

RE: Request for:

A) review and comments concerning Alaska Senate Bill 13 (attached), and
B) request for NCSL staff to testify at Senate HESS hearing concerning SB 13, Denali KidCare, Alaska SCHIP program February 9, 2009 at 1:30-3:00 pm (3:30-5:00 pm Mountain/Denver time). **Call in number is 888-295-4546**

Dear Ms. King,

Please read the attached **Alaska Senate Bill No. 13,** 26th Legislature, sponsored by Senator Bettye Davis, regarding **increasing income eligibility** under the Denali KidCare -State Children's Health Insurance Program (SCHIP) **to 200% Federal Poverty Guidelines (FPG)**. It was raised to 175% last year under SB 27, 25th Legislature.

Senator Davis, Chair, Senate HESS Committee (and Vice-Chair NCSL Health Committee) is considering an amendment at hearing to extend optional coverage to applicants over 200% FPG not to exceed 250% FPG with provisions of premiums or co-payments . You will note that there is no asset test in the bill.

Your comments in return e-mail to me as soon as possible before the hearing would be particularly helpful in the following areas:

1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review, and
2. if asset tests, payments, and co-payments are common, and if other matters of eligibility other than income and household size under federal poverty guidelines are codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits.
3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.
4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines..

Please have NCSL staff call in to the hearing teleconference line on February 9, 2009 noted above at 888-295-4546 to testify and/or field questions.

Sincerely,

Thomas S. Obermeyer
Legislative Assistant
Office of Senator Bettye Davis
907-465-3822 office
907-465-3762 direct line
907-465-3756 fax
Thomas_Obermeyer@legis.state.ak.us

Lynda Zaugg

From: Jennifer Saunders [jennifer.saunders@ncsl.org]

Sent: Thursday, February 05, 2009 10:03 AM

To: Thomas Obermeyer; Lynda Zaugg

Cc: Martha King; Jennifer Breshears

Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Yes, the following Kaiser report indicates that 7 states have SCHIP eligibility levels below 200 percent of the federal poverty guidelines (FPG):
Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009
http://www.kff.org/medicaid/7855.cfm
(See page 10, Figure 1.)

The 7 states are:

Alaska	175 percent FPG
Idaho	185 percent FPG
Montana	175 percent FPG
Nebraska	185 percent FPG
North Dakota	150 percent FPG
Oklahoma	185 percent FPG*
Oregon	185 percent FPG

* Oklahoma passed legislation to increase the income eligibility guideline to 300 percent of the federal poverty line under its current section 1115 waiver. However, the currently proposed expansion has been scaled back to 217 percent of the federal poverty line and the future expansion of 218 percent to 300 percent of the federal poverty line is pending further CMS guidance and SCHIP reauthorization.

Sources:
Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009
http://statehealthfacts.org/comparemaptable.jsp?ind=203&cat=4

Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009
http://statehealthfacts.org/comparemaptable.jsp?ind=204&cat=4

Would you still like for NCSL to participate by phone in the Senate HESS hearing concerning SB 13 on February 9, 2009?
If yes, what are you expecting from us (a presentation, or just being available to answer questions, etc.)?

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
Research Analyst
Health Program
National Conference of State Legislatures

Lynda Zaugg

From: Rep. Les Gara
Sent: Thursday, February 05, 2009 10:46 AM
To: Rep. Les Gara
Subject: PRESS RELEASE: Affordable Medical Care For Every Alaska Child - Using New Federal Law To Benefit Alaskans

PRESS RELEASE • February 5, 2009

Alaska State Legislature

Reps. Les Gara, Scott Kawasaki & Bob Buch
Web: http://gara.akdemocrats.org • Contact: David Theriault • Phone: 465-2647 • Fax: 465-3518
E-mail: representative.les.gara@legis.state.ak.us • Mail: State Capitol Bldg. Room 500, Juneau, AK 99801

GARA, WIELECHOWSKI, KAWASAKI AND BUCH CALL FOR AFFORDABLE, UNIVERSAL KIDS HEALTH COVERAGE.

FEDERAL LAW SIGNED THIS WEEK HELPS STATES EXPAND CHILDREN'S HEALTH PLANS

JUNEAU – Today legislators presented a plan to provide affordable medical care to every child in Alaska. The Democratic legislators' "No Child Left Uninsured" plan follows on the heels of the children's health care expansion President Obama signed this week. Under the enhanced federal plan, states can choose to extend low cost health coverage to their children.

"Denying low cost medical care to children who need it would be failure, not leadership," said Rep. Les Gara (D-Anchorage).

"This is a cost-effective way to provide needed medical care to children of working families," said Rep. Scott Kawasaki (D-Fbks.). Rep. Bob Buch of Anchorage is the third co-sponsor.

Alaska's children's health plan ranks second worst in the nation, and roughly 10,000 Alaska children of working families receive no private or public health coverage. Current Alaska law cuts off coverage to families that earn more than 175% of the federal poverty level, or roughly $30,000 for a single parent with one child. Alaska had a flagship state plan in the 1990's under Governor Tony Knowles.

"Private plans cost upwards of $3,000 - $4,000 or more for a child. That's a significant cost to parents. Roughly half of Alaska's small businesses aren't able to offer employer health insurance, leaving parents and children without medical coverage" said Gara.

In 2007, Rep. Gara and Sen. Bill Wielechowski (D-Anchorage) proposed similar legislation. The new federal law that passed this week will enable states to provide universal children's health coverage at a low cost to families, and to the state.

Under the new federal law, Alaska will qualify for federal funding that would cover 60-70 percent of the cost of this insurance. No Child Left Uninsured:

- provides no-cost coverage for families that earn up to 200% of the poverty level ($34,000/year for a single parent with one child);

- allows families to purchase this health coverage at higher incomes up to 350% of the poverty level.

- Higher income families would be charged the full state cost of the plan.

"The Anchorage Neighborhood Health Center supports expansion of Denali KidCare that allows more parents the peace of mind in knowing they can access quality health care when they need it," said Joan L. Fisher, Executive Director of Anchorage Neighborhood Health Center.

"American Academy of Pediatrics supports this effort to help working families. Maximizing the health of children is the basis for success in school and an active lifestyle," said Dr. Jody Butto, a prominent Anchorage pediatrician.

For more information, contact Representative Gara (465-2647) or Scott Kawasaki (465-3466).

STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

With Congress debating the reauthorization of the State Children's Health Insurance Program (SCHIP), this *State Health Policy Briefing* seeks to inform the federal legislators and other policymakers working on reauthorizing legislation, as well as others who are concerned about the program's future, about the views of state SCHIP program directors. The brief, first published in April 2007, has been updated and is being re-issued to address changes in the policy landscape that have occurred since that time. The brief was developed by the National Academy for State Health Policy (NASHP) through a workgroup of state SCHIP directors, and was reviewed by all directors. NASHP's work with SCHIP directors, including the development of this brief, is made possible through the generous support of the David and Lucile Packard Foundation as part of broader efforts to provide assistance and report on state SCHIP programs since the program's inception.

NATIONAL ACADEMY *for* STATE HEALTH POLICY

Briefing

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

JANUARY 2009

REAUTHORIZING SCHIP: Principles, Issues And Ideas From State Directors

Updated January 2009

The State Children's Health Insurance Program (SCHIP) deservedly enjoys broad support as a successful program. That success rests on a legislative foundation enacted as a result of careful bi-partisan compromise. Title XXI of the Social Security Act established a federal-state partnership program with a delicate balance of state flexibility and core program requirements. SCHIP was created with the goal to provide health coverage for low-income uninsured children. This essential program, now serving over seven million annually, is again up for reauthorization this year.

Reauthorizing SCHIP, first published in April 2007, was developed to inform federal policymakers then working on legislation to renew SCHIP, as well as others concerned with the program's future, about the views of state SCHIP directors. The April 2007 brief built upon the 2005 report *"Perspectives on Reauthorization: SCHIP Directors Weigh In."* The present publication updates the April 2007 brief primarily to address changes in the policy landscape that have occurred since that time. These reports have been developed by the National Academy for State Health Policy (NASHP) in conjunction with state SCHIP directors through the generous support of the David and Lucile Packard Foundation as part of broader efforts to provide assistance and report on state SCHIP programs since the program's inception.

This document describes the views of SCHIP directors on key issues at stake in the reauthorization process. The April 2007 brief was the product of a workgroup of 15 states

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representing varying SCHIP program types from across the country, convened by NASHP to identify important issues, review information and recommendations from other key stakeholders, and discuss commonly held as well as differing views. The group met by phone and communicated electronically from January through March 2007. The results of the workgroup discussions were summarized in a draft brief, shared with all SCHIP programs across the country, and discussed at a March 2007 meeting attended by the majority of state programs. The April 2007 brief was finalized based on this meeting.

With SCHIP reauthorization delayed but now again on the horizon, NASHP reconvened the original workgroup in September 2008. Members of the workgroup reviewed the April 2007 brief to recommend updates. The workgroup's recommendations were discussed with all SCHIP directors attending the Annual Preconference Meeting for SCHIP directors held by NASHP in October 2008. Final revisions were subsequently recommended by the workgroup and sent to all SCHIP directors for feedback in December 2008. This revised edition of *Reauthorizing SCHIP* is the result. This updated brief reflects added emphasis on a few issues raised in the April 2007 brief as well as a small number of new issues that have surfaced since that time. These revisions address changes in federal policy after the April 2007 brief was published. While the brief does not capture all of the views of all of the states on all issues relevant to reauthorization, it does represent the views of most state SCHIP directors on issues of priority concern to them.

1. SCHIP FUNDING SHOULD BE RENEWED AND INCREASED SUBSTANTIALLY TO PROVIDE SUFFICIENT AND PREDICTABLE FUNDS FOR STATES TO EFFECTIVELY MANAGE PROGRAMS AND REDUCE THE NUMBER OF UNINSURED.

States responded to federal options in implementing programs to address state objectives. State SCHIP programs now cover over 7 million individuals annually. Most enrollees are children. But some states also provide coverage to pregnant women and parents, and a number have provided coverage to childless adults. (The Deficit Reduction of Act of 2005, however, mandated that coverage of childless adults be phased out, and the Centers for Medicare and Medicaid Services (CMS) no longer approves waivers for such coverage.) Over the past decade, states have used the flexibility afforded them to cover these individuals through different pathways and on different timetables. The structure of SCHIP – including the statutory redistribution mechanism and other federal policies, such as federal encouragement to use and approval of waivers to cover more of the uninsured – strongly influenced the decisions states made. States successfully utilized the flexibility inherent in SCHIP to initiate and build programs in ways that fit the needs of their states' children and families – both when states started up their programs and as their needs changed over time. The result today is a successful program nationwide, which reflects the diversity of state responses to federal policies and to their own residents' needs and circumstances.

State SCHIP programs have evolved to fit with the economies, health care systems, values, politics, and fiscal capacities of their states. Most states have been able to raise income eligibility for children up to at least 200 percent of the federal poverty level (FPL), although many eligible children in these states remain unenrolled. Six states, most of which are spending all of their allotted funds, have not yet been able to set eligibility levels high enough to reach children with family incomes up to that level. Over one-third of all states reach uninsured children in families with income over 200 percent FPL, or have covered parents or pregnant women with the intent of improving child coverage and health. State directors share a common vision and many common goals for coverage, access to quality care, and improved health for children and, ultimately, for everyone, but states are at different points along a number of possible pathways to achieving that vision.

Future funding needs to be substantially increased over the course of the next five years. SCHIP directors are united in concluding that SCHIP is a successful program that should be renewed with substantial additional funding that allows the program to grow and meet more of the need in the nation for health insurance coverage. The highest federal annual allotment provided in past years will not support the program today. Future funding levels need to be increased substantially to account for state success over the past decade in covering increasing numbers of children for whom private insurance is either unavailable or unaffordable and in enrolling greater proportions of those who already are eligible but not enrolled.

State directors also strongly agree that funding should be stable and predictable in order to allow them to adequately plan for program maintenance and growth. Annual appropria-

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tions provided many states with more funds than they could spend in the early start up years, and insufficient funds later on as their programs expanded and matured. This funding structure, coupled with the different starting points and pacing of states in developing their programs, led some states to rely on redistributed funding, and more recently, short term federal relief for states experiencing shortfalls. The redistribution system provided little advance notice of amounts that would be available and just one year to spend the redistributed funds, making it very hard for states to plan and manage their programs effectively. The uncertainty surrounding SCHIP reauthorization in 2007, and the ultimate year-end action that provided a short-term extension of the program through March 31, 2009, rendered state planning and management of SCHIP in 2008 and 2009, much less future years, extremely difficult. Without stability in federal funding, states simply are more reluctant to conduct outreach or make program improvements requiring longer-term investment.

Predictability, stability, and growth over time are critical for effective program management. SCHIP directors believe that the total SCHIP appropriation should increase steadily over a five-year authorization period, taking into account population growth and cost increases, including health care cost inflation.

The funding structure needs to be reconsidered. There is fairly broad agreement among state SCHIP directors that the funding formula needs to be revisited. In particular, directors are concerned that use of the number of uninsured children within the current formula can penalize states for being effective in enrolling more children. Collectively, SCHIP directors have identified a number of factors which federal policymakers might consider for inclusion in a revised formula. These potential formula factors include enrollment levels, eligible but unenrolled populations, regional differences in cost of living, and state coverage levels for children at the time of SCHIP enactment. Directors also have concerns about the use of Current Population Survey data in the formula, as these data are often inconsistent with data that many states collect. State directors urge careful analysis and consultation with states in consideration of any alternative funding formulas and data sources.

State SCHIP directors' views vary on the extent to which and how funding should be structured in covering targeted low-income children, other children needing health insurance, pregnant women (whose coverage can improve child health outcomes), parents (whose coverage can boost rates of children's enrollment), or others. As noted previously, six states have not been able to set program eligibility as high as the target level of 200 percent of FPL, while many other states have been able to reach uninsured children above that level, and a number of states do or have covered parents or pregnant women. This variation again reflects the differing circumstances of states at the time of SCHIP enactment and over time, as well as prior federal encouragement and approval for covering parents, pregnant women, and others.

2. SCHIP AND MEDICAID PLAY VITAL, COMPLEMENTARY ROLES IN COVERING CHILDREN AND ADOLESCENTS, AND EACH PROGRAM NEEDS TO BE MAINTAINED AND STRENGTHENED.

SCHIP and Medicaid work in tandem. SCHIP was designed to build on Medicaid, to support states in covering uninsured children not eligible for Medicaid when SCHIP was enacted. States had the choice to implement SCHIP through a Medicaid expansion, a separate program that could work in conjunction with Medicaid to cover more uninsured children, or through a combination of both approaches. In 2005, approximately 29 million children were covered through Medicaid funding and 6.1 million children through SCHIP.

As the nation and states focused attention over the past decade on enrolling children eligible for SCHIP, policy and systems improvements were made in both Medicaid and SCHIP. As of January 2008, for example, almost all states (46) had eliminated the asset test and in-person interviews for children's eligibility in both programs. As more states have implemented separate programs, they also have worked to improve the coordination between Medicaid and SCHIP. As of January 2008, for example, the vast majority of states with a separate SCHIP program (31 of 39) used the same application for both Medicaid and SCHIP. Other common strategies to promote coordination between the two programs include: aligning eligibility criteria and employing the same staff to determine eligibility for both programs; expanding the locations at which, and technologies through which, families can apply for coverage; developing administrative verification capability; and adopting presumptive eligibility. State efforts to simplify eligibility and streamline the application process have been critical to improving enrollment in both programs.

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There should be greater consistency and more options for SCHIP and Medicaid eligibility. SCHIP's successes have been built on the shoulders of the Medicaid program, and SCHIP has driven system improvements in both programs. State directors need continued flexibility to use and combine Medicaid and separate program approaches and to make the interface between them work smoothly for children and families.

State directors see elimination of inconsistent and inequitable federal eligibility rules as important to states and families. Currently, states cannot enroll uninsured children whose parents are state employees in their separate SCHIP programs, although they can enroll such children in Medicaid and they can enroll children of federal employees in both programs. States would like the eligibility rules for separate SCHIP programs aligned with those of Medicaid expansion programs to allow for consistent and equitable treatment of children of state and federal employees.

States also would like the option to cover all legal resident children. The federal welfare reform law barred coverage of such children for the first five years of their residency. Some states cover these children with state funds; other states do not. Including these children as an optional group would enable more states to cover them and promote better health for all children.

Additional flexibilities are needed to enroll or retain specific groups of children who are eligible for Medicaid, in order to make the two programs as seamless as possible for families. Fluctuations in family income mean that children frequently move between the two programs. Policies and procedures to avoid or diminish breaks in coverage are essential to ensuring that children and families maintain access to critical preventive and treatment services, and directors would like increased flexibility to ensure continuity of coverage for children whose family incomes change.

States also would like the option to give families who have children eligible for both programs the choice to enroll all children in a family in one program – either Medicaid or SCHIP – in order to keep the children together in one plan and reduce the burdens on parents. Since states get a higher federal matching rate for children enrolled in SCHIP, state directors propose that they receive the lower Medicaid match for children who are Medicaid-eligible but opt for enrollment in SCHIP. This would eliminate any financial incentive that states might have to encourage families to choose SCHIP over Medicaid. Finally, some states have raised the possibility of having the option to cover youth up to age 21 with SCHIP funds, something that is permitted under Medicaid.

States which expand Medicaid coverage of children should have the option to use SCHIP funds or their regular Medicaid matching rate and funds. States have the option to draw down federal funds from their SCHIP allotment by expanding coverage of children under their Medicaid program or by establishing a separate program. Due to limited SCHIP funds, some states have sought to expand coverage to children under Medicaid and claim regular Medicaid federal funding at their regular federal match, thereby leaving more SCHIP funds available to cover children at incomes higher than the Medicaid levels. The Centers for Medicare and Medicaid Services (CMS), however, recently has interpreted the statute to require that states which expand Medicaid coverage of children above the level covered as of June 1997 (when SCHIP was passed), must draw down funds for such children from their SCHIP allotment. This interpretation has limited these states' ability to cover greater numbers of uninsured children. SCHIP directors believe that CMS' interpretation is inconsistent with the purpose of the program, and states should have the option to use either federal Medicaid or SCHIP funding streams in order to make most effective use of both programs in covering uninsured children.

3. THE PROGRESS THAT STATES HAVE ACHIEVED IN SIMPLIFYING ENROLLMENT FOR CHILDREN AND FAMILIES SHOULD BE SUPPORTED AND NOT HAMPERED BY FEDERAL PROGRAM REQUIREMENTS.

Simplification is a state success story. Some of the greatest state success stories in SCHIP are about the simplifications in enrollment and renewal processes for families. As noted, nearly all states have eliminated the asset test and in-person interview requirement. Over two-thirds of all states allow mail-in applications for children, and increasing numbers accept faxed applications, take applications over the phone, or are developing electronic applications and administrative verification. The majority allow families to apply at provider locations, and a growing number permit providers and other qualified entities to determine whether children are presumptively eligible for coverage, pending a complete review by the state. Most programs also have lengthened the period between renewals to the least frequent (12 months) permitted under federal law,

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thereby reducing the likelihood that children will lose coverage for failing to complete required paperwork.

New documentation requirements for citizens threaten to reverse this enrollment progress. Provisions in the Deficit Reduction Act (DRA) of 2005 require citizens to prove their identity and citizenship in order to obtain Medicaid. The regulations implementing this law include the need to present original (not photocopied) documents, a provision that particularly undermines the effectiveness of mail-in applications and the elimination of the in-person interview. In many states, the new requirements have resulted in major delays, and some states have documented a significant decline in enrollment in public coverage.

These rules directly affect SCHIP Medicaid expansion programs, which must follow federal Medicaid policy. But they also have a major impact on separate SCHIP programs. As noted earlier, most states with separate programs have one application form for both SCHIP and Medicaid. This means that any new requirements attached to Medicaid affect the application process for SCHIP-eligible children, unless the state reverses progress and develops separate applications for each program. In addition, SCHIP programs must refer children potentially eligible for Medicaid to that program, so that these children are affected. Most SCHIP directors believe the citizenship documentation requirements should be rescinded or modified substantially, and should not be applied to separate SCHIP programs.

States need tools to carry out essential outreach, enrollment, and retention activities. State experience has shown that outreach, enrollment, and retention activities are integral to effective program management in achieving the goal of insuring children. Ongoing attention to these functions is critical, as the need to reach, enroll, and retain children and families is continual. Families move in and out of state; they change jobs; their incomes fluctuate; and their access to employer sponsored insurance changes. To ensure effective ongoing strategies, state programs need access to funding, research, and best practices. To effectively manage their programs within capped funding, states need the flexibility to determine when outreach should be increased, and when slowed down. While it should not come at the expense of funding for coverage, funding for outreach is critical. For this reason, state SCHIP directors recommend that outreach funding not be subject to the current 10 percent administrative cap.

Additionally, the directors seek flexibility to implement "express lane" or "auto enrollment" systems that allow enrollment in or income determinations from certain other public programs to count as proof of eligibility for SCHIP. If accompanied by assurances that such "deeming" will not be disallowed in federal audits, such a streamlined approach holds great promise for improving enrollment and retention.

State flexibility in specific areas of program design has been an important component of SCHIP's success and should be supported and enhanced.

4. STATE FLEXIBILITY WAS PART OF SCHIP'S DESIGN AND HAS CONTRIBUTED TO ITS WIDE BASE OF SUPPORT.

The state flexibility that was an integral part of the SCHIP program's design has been key to its success. States have tailored marketing, enrollment, benefits, service delivery systems and other key features of their programs to the circumstances and culture of their states. This state tailoring has led to broad based support at the state and national levels. State directors believe maintaining such flexibility is vital to the continued support and success of SCHIP.

More flexibility to coordinate with private coverage could meet more of children's needs. State SCHIP directors are very concerned with the erosion in employer-based coverage, as well as market trends toward limited-benefit health insurance products that may not address children's needs for preventive developmental services. Additionally, directors are keenly aware of substantial unmet service needs, particularly in the areas of oral health and mental health benefits. The directors would like to have more options to help families keep children and youth enrolled in the private market and have critical health needs met.

One option is providing assistance to families in paying private coverage premiums. While the SCHIP law does allow states to provide such premium assistance, numerous programmatic and administrative requirements make it very difficult to operate a successful and cost-effective program. In 2005, most of the states which had premium assistance programs paid for by SCHIP funds did so through federal waivers; no separate state SCHIP program operated a premium assistance program under a state plan.

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States also would like the option to provide benefits that often are not covered for children enrolled in private plans. This could be accomplished by amending the definition of "targeted low income child" to include children with creditable but less-than-comprehensive coverage, or by allowing states to offer supplemental benefits for children with private coverage that does not include important services, such as dental, mental health, vision, hearing, or prescription drugs. Another option would be to allow states to offer supplemental benefits as a health services initiative, but as a category that is exempt from the 10 percent cap.

Flexibility to set income standards and methodologies appropriate for state circumstances should be maintained. When the federal legislation authorizing SCHIP was first enacted, only eight states provided coverage for children above the levels mandated under Medicaid (133 percent FPL for children under age 6; 100 percent FPL for children ages 6 – 18). Today, all but six states provide coverage for children in families with income up to 200 percent FPL, and over one-third of all states provide coverage at incomes above that level. The varying eligibility levels reflect variations in family income, cost of living, and health care costs across states. As experience with SCHIP has matured and the cost of health insurance has risen, states are finding that private group and individual health insurance coverage is unavailable or unaffordable even for many more moderate-income families. States also are finding that covering children at higher income levels is proving to be an effective strategy to reach eligible but unenrolled children at lower income levels.

Policies announced by CMS during 2007 and 2008, including the August 17, 2007 directive addressing substitution of public for private coverage, have created significant roadblocks to state efforts to ensure that more uninsured children have access to affordable coverage. While SCHIP directors agree that preventing substitution of coverage is a worthwhile goal, the anti-crowd out measures imposed by the August 17 directive are not grounded in an evidentiary base and were not developed in consultation with states. Most SCHIP directors believe that the August 17 directive should be rescinded; that state flexibility to adopt income standards and methods that best fit state circumstances and achieve federal program purposes should be maintained; and that states and the federal government should work together to examine and develop effective strategies for reducing crowd out of private coverage as public coverage is expanded.

5. STATES SHOULD BE SUPPORTED IN THEIR EFFORTS TO IMPROVE PROGRAM PERFORMANCE AND PROMOTE ACCESS TO QUALITY CARE.

The federal-state partnership is the foundation for program improvement. States are committed to effective program management and accountability, operating within the capped funding and program flexibility of SCHIP. The SCHIP statute provides a good framework for state reporting, and states worked cooperatively with the federal government to develop a standard reporting format which has been improved over time. States also worked with the federal government to develop core performance measures to be reported on a voluntary basis. While standard performance measures raise challenging technical and resource issues, within two years a majority of states were reporting on all four core measures. Beginning in FY 2006, states also now report on quality improvement initiatives.

States are implementing quality improvement strategies tailored to their states' systems. States also have implemented various policies to ensure that program participants have access to quality care. These strategies differ by state, and by delivery system: managed care, Primary Care Case Management (PCCM)-based, and fee-for-service. Most SCHIP programs that deliver services through managed care systems consider factors related to access and quality when selecting contractors; have contract provisions, including cultural and linguistic requirements that promote access to quality care; and monitor contractor performance to ensure that program expectations are met. Many of these programs also use program performance data to help participants make a choice of health plans, produce public reports on health plan performance, and conduct quality improvement projects. PCCM-based programs use various reimbursement and provider requirements strategies to promote access. To ensure quality, programs with PCCM-based systems may conduct enrollee surveys to assess access and quality. States with fee-for-service based systems have adopted a variety of strategies to improve quality as well – e.g., surveying participants to gather information about access and quality and promoting medical homes.

Federal oversight is overly focused on payment errors, draining state resources. Recent new federal requirements under the Payment Error Rate Measurement (PERM) system have directed limited administrative resources and state focus toward measuring errors. State directors believe that program

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accountability should continue to focus on performance in reaching and enrolling eligibles, reducing numbers of uninsured, and improving access and outcomes, and not disproportionately on the burdensome and bureaucratic federal payment error measurement system.

PERM has not been implemented through a federal-state partnership approach. Methods were not developed in consultation with SCHIP directors, and have been implemented with little advance notice or technical assistance. As currently structured, PERM represents a significant administrative burden on state SCHIP programs, which is further exacerbated in the current fiscal climate. States have received conflicting and confusing guidance from the Centers for Medicare and Medicaid Services (CMS) and its Regional Offices. Auditors often are unfamiliar with program rules and policies established for SCHIP programs. Definitions of errors often are inconsistent with, and threaten to undermine, progress made in simplifying the program. The rules also do not provide adequate adjustment for services provided in a capitated versus a fee-for-service environment.

SCHIP directors believe that in implementing PERM, CMS has used a bureaucratic hammer in an area where significant problems have not been documented, and implementation has been burdensome and expensive. In the case of SCHIP, which has an administrative cost cap, the resources that must be devoted to PERM audits take away from administrative efforts in outreach, enrollment, quality measurement, and improvement. The costs of PERM audits should be 100 percent federally-funded and outside the 10 percent administrative cap. PERM reviews also should be temporarily suspended and CMS should be required to revisit the PERM implementation requirements, in consultation with state SCHIP directors, and to issue clear, uniform guidance to all states. The different incentives in capitated versus fee-for-service environments should be taken into account in the guidance. CMS also should be prohibited from requiring a uniform sampling platform, as has been required. States included in the 2007 or 2008 reviews should not be penalized for high error rates found as a result of a faulty PERM review process.

States want assistance to strengthen measurement and improve performance and quality. State directors found the federal technical assistance for SCHIP performance measurement that was provided for several years to be very important in helping states develop and improve reporting of core performance measures. Technical assistance, which was discontinued, should be reinstated; the federal-state partnership for performance measurement needs to be renewed. The directors also believe the federal government should strengthen leadership and resources for working in partnership with states to review and develop optional new child health quality measures. These measures should be relevant to and used not only by SCHIP, but also by Medicaid and other programs which fund or provide health services for children. Currently, standard measures are not available, and federal agencies do not have a well-funded or coordinated effort in place to develop them. State SCHIP directors are ready and interested in working with other state and federal partners and experts to develop strategies to improve measurement of child health care quality.

CONCLUSION

State SCHIP directors are committed to working with federal and state policymakers, the private sector, advocates, and other key stakeholders to promote successful reauthorization of the SCHIP program. SCHIP has been resoundingly successful over the past decade in providing coverage to uninsured children, and reauthorization that provides sufficient, stable, and predictable funding and retains and expands the kinds of flexibility that have contributed to SCHIP's success is essential. For more information about state SCHIP programs, go to www.chipcentral.org, or call NASHP at 202-903-0101.

NATIONAL ACADEMY for STATE HEALTH POLICY

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, nonpartisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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Acknowledgments: This briefing, originally written by Catherine Hess to reflect the views expressed by SCHIP directors through a process described in the paper, was updated in 2009 by Sarah deLone and Catherine Hess, again working with the SCHIP directors. NASHP wishes to acknowledge the SCHIP Reauthorization Workgroup and many other SCHIP directors' contributions to the content of this briefing.

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Citation
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NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

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From: Jennifer Saunders
Health Program
303-856-1440
jennifer.saunders@ncsl.org

Date: January 30, 2009

Subject: State Children's Health Insurance Program (SCHIP)

Thomas,

I have compiled some information regarding your questions about the State Children's Health Insurance Program and have included additional resources. At the end of this document, you will find summaries of enacted state legislation that you may find helpful. Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

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1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review.

At least one other state has introduced legislation (as of January 27, 2009) to increase SCHIP eligibility.

North Dakota
2009 Senate Bill 2362
http://www.legis.nd.gov/assembly/61-2009/bill-text/JAVD0300.pdf
Directs the Department of Human Services to establish a buy-in program through which a parent/guardian whose family net income exceeds 250 percent of the federal poverty guidelines

may purchase, on a sliding income scale, a plan of coverage for a child who is uninsured. The bill also would increase the net income eligibility from 150 percent to 250 percent of the federal poverty guidelines. In addition, the bill would direct the Department of Health to seek a federal waiver to increase the income eligibility level to 350 percent of the federal poverty guidelines.
The bill also would establish the children's health insurance program advisory committee.

In previous sessions, many other states have also increased eligibility levels. Please see the list of state examples at the end of this document for the links to such legislation.
In addition, you may also view this information on NCSL's Children's Health Reform webpage: http://www.ncsl.org/programs/health/kidsins.htm

2. Are asset tests, payments, and co-payments common, and are other matters of eligibility other than income and household size under federal poverty guidelines codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits? Are other states allowing payments of premiums or co-payments by those seeking income eligibility over 200% and not over 250% FPG?

As of January 2009, 46 states and the District of Columbia do not require an asset test for children's health coverage.

Sources:

- Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009
  http://www.kff.org/medicaid/upload/7855.pdf
  Kaiser Commission on Medicaid and the Uninsured, January 2009
- See also Kaiser State Health Facts:
  http://www.statehealthfacts.org/comparetable.jsp?ind=228&cat=4

Under provisions of the Deficit Reduction Act of 2005, states generally cannot impose cost sharing on children in families with income below 150 percent of the federal poverty guidelines except in certain circumstances. In addition, even at more moderate-income levels, federal rules exempt some special services from any cost sharing requirements. SCHIP programs that are Medicaid expansions are subject to the same cost sharing rules as Medicaid, but states with separate stand-alone SCHIP programs have more flexibility in imposing cost sharing.

Ten states— Alabama, Arizona, California, Delaware, Florida, Georgia, Idaho, Nevada, Tennessee, and Utah—impose premiums on children in families with income below 150 percent of the federal poverty guidelines, and they can do so because they operate separate SCHIP programs or because they have a federal waiver to do so for their Medicaid population. As of January 2008, 26 states charge premiums at an income level over 150 percent of the federal

poverty guidelines, 29 states at 200 percent of the federal poverty guidelines and 19 states at 201 percent of the federal poverty guidelines.

Sources:

- Cost Sharing for Children and Families in Medicaid and SCHIP
  http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy%20center/cost_sharing_final.pdf
  Center for Children and Families, Georgetown University Health Policy Institute, September 2008
- Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008
  http://www.kff.org/medicaid/upload/7740.pdf
  Kaiser Commission on Medicaid and the Uninsured, January 2008

Additional resources:

- Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences
  http://www.kff.org/medicaid/7322.cfm
  Kaiser Commission on Medicaid and the Uninsured, May 2005
- The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings
  http://www.cbpp.org/5-31-05health2.pdf
  Center on Budget and Policy Priorities, July 7, 2005.

Please see the state examples at the end of this document for links to legislation that define cost-sharing requirements. Additional state examples can be found on NCSL's Children's Health Reform webpage: http://www.ncsl.org/programs/health/kidsins.htm

At least one state, **Colorado**, has cost sharing requirements, but does not specify the cost sharing structure in statute. Instead, the act directs the Colorado Health Department to design and implement a structure of premiums and co-payments. In addition, at least two states—**Louisiana and Washington**—specifically require cost sharing between 200 percent and 250 percent of the federal poverty guidelines.

3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.

The following summary describes the SCHIP eligibility guidelines that states have enacted through legislation. However, these eligibility guidelines may not be implemented in all states.

As of January 1, 2009, five states—Alaska, Idaho, Nebraska, North Dakota and Oregon—have enacted eligibility levels for children below 200 percent of the federal poverty guidelines. Forty-

five states and the District of Columbia have enacted eligibility levels for children with a family income of 200 percent of the federal poverty guidelines or greater. Sixteen states have enacted eligibility levels for children at 200 percent of the federal poverty guidelines. Twenty-six states and the District of Columbia have enacted eligibility levels between 200 and 300 percent of the federal poverty guidelines. Three states—Massachusetts, New Jersey and New York—have enacted eligibility levels above 300 percent of the federal poverty guidelines.

These eligibility levels may not be implemented in all states due to a variety of reasons; for example, the legislation may specify an effective date that is in the future, or the state plan amendment has been denied or is under review by the Centers for Medicaid and Medicare Services. For example, in Colorado, the enacted expansion of SCHIP eligibility to 225 percent of the federal poverty guidelines is anticipated to be implemented in July 2009, but this may be delayed due to the state's budget shortfall.

For more information:

- Eligibility Levels in Medicaid & SCHIP for Children, by State as of January 1, 2009
  Center for Children and Families at Georgetown University Health Policy Institute
  http://ccf.georgetown.edu/index/cms-filesystem-action?file=statistics/eligibility expansions by state.pdf

In addition, some states effectively cover children whose family incomes are above the established eligibility limit of the state's SCHIP program by using income disregards. When determining eligibility, these states do not count certain portions of earnings from a working family's income (e.g., such as earnings used to cover the cost of child care). As of January 2008, SCHIP eligibility levels in 22 states and the District of Columbia are effectively greater than 250 percent of the federal poverty guidelines, and in 16 states eligibility levels are effectively between 200 percent and 250 percent of the guidelines. Six states have set eligibility levels at 200 percent of the federal poverty guidelines, and six are below 200 percent of the federal poverty guidelines.

Source:

- President's FY 2009 Budget and SCHIP, February 2008
  http://www.kff.org/medicaid/upload/7758.pdf

For more information about income disregards and how states use them in Children's Medicaid and SCHIP:

- Determining Income Eligibility in Children's Health Coverage Programs: How States Use Disregards in Children's Medicaid and SCHIP
  Kaiser Family Foundation, May 2008
  http://www.kff.org/medicaid/upload/7776.pdf

See also Kaiser Family Foundation's State Health Facts:

- Income Disregards in Children's Separate SCHIP Programs, 2008 http://www.statehealthfacts.org/comparetable.jsp?ind=630&cat=4
- Income Disregards in Children's Medicaid Programs, 2008 http://www.statehealthfacts.org/comparetable.jsp?ind=627&cat=4

4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines.

For more information about the SCHIP Reauthorizations bills before Congress, please visit the following NCSL webpage:
http://www.ncsl.org/statefed/health/SCHIPreauth.htm

House Majority Leader Hoyer has stated the House will accept the Senate version of the SCHIP reauthorization bill next week, clearing the bill for President Obama's signature.

If you have additional questions about this federal legislation, please contact the following NCSL staff:

Joy Johnson Wilson, Health Policy Director at 202-624-8689 or joy.wilson@ncsl.org or Rachel Morgan RN, BSN, Senior Health Policy Specialist at 202-624-3569 or rachel.morgan@ncsl.org.

Additional NCSL Resources:

- SCHIP overview webpage: http://www.ncsl.org/programs/health/chiphome.htm
- SCHIP Frequently Asked Questions: http://www.ncsl.org/print/health/forum/SCHIPFAQ.pdf
- SCHIP Reauthorization: http://www.ncsl.org/statefed/health/SCHIPreauth.htm
- State Children's Health Reform: http://www.ncsl.org/programs/health/kidsins.htm
- *What's Up With SCHIP?* LegisBrief, August/September 2008: http://www.ncsl.org/legis/lbriefs/2008/08lbaugsep_schip.pdf

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State Examples of Enacted Legislation

For more information about these states, please visit NCSL's Children's Health Reform webpage at:
http://www.ncsl.org/programs/health/kidsins.htm

Colorado

2008 Senate Bill 160
http://www.leg.state.co.us/clics/clics2008a/csl.nsf/fsbillcont3/EE9D222D73A97EF68725736300812716?open&file=160_enr.pdf
Increases SCHIP eligibility from 205 percent of the federal poverty guidelines to 225 percent of the federal poverty guidelines; the law allows that if funding is available, the eligibility level can be raised to 250 percent of the federal poverty guidelines. In addition the law stipulates that it is among the duties of the Health Department to design and implement a structure of premiums and co-payments.

Connecticut
2007 Senate Bill 1484
http://www.cga.ct.gov/2007/ACT/Pa/pdf/2007PA-00185-R00SB-01484-PA.pdf
Increased the HUSKY (SCHIP) program eligibility level from 300 percent federal poverty level to 400 percent federal poverty level.

District of Columbia
Fiscal Year 2007 Budget Support Act of 2006
http://www.dccouncil.washington.dc.us/images/00001/20060727152635.pdf
Expands Medicaid/SCHIP eligibility to 300 percent federal poverty guidelines. CMS approved the expansion in March and the expansion was implemented starting in June 2007.

Indiana
2008 House Bill 1678
http://www.in.gov/legislative/bills/2007/HE/HE1678.1.html
Increases SCHIP eligibility for children in families with incomes up to 300 percent federal poverty level. In May 2008, CMS approved the expansion of eligibility to only 250 percent federal poverty level. The expansion to increase eligibility to 250 percent of the federal poverty level was implemented beginning October 1, 2008.

Iowa
2008 House File 2539
http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=billbook&GA=82&hbill=HF2539
Increases SCHIP eligibility from 200 percent of the federal poverty guidelines to 300 percent of the federal poverty guidelines. Establishes cost sharing guidelines for children whose family income is 150 percent to 200 percent of the federal poverty guidelines; and for families with incomes between 200 and 300 percent of the federal poverty guidelines. The expansion is expected to be effective as of July 1, 2009.

Kansas
2008 Senate Bill 81
http://www.kslegislature.org/bills/2008/81.pdf

Increases SCHIP eligibility from 200 percent of the federal poverty level to 225 percent of the federal poverty guidelines in 2009 and, finally, to 250 percent of the federal poverty guidelines in 2010, subject to appropriations. The law establishes cost sharing provisions on a sliding scale basis

Louisiana
2007 House Bill 542
http://www.dhh.louisiana.gov/offices/miscdocs/docs-119/Act407.pdf
Created the Louisiana Children and Youth Health Insurance Program, expanding Louisiana's SCHIP program, LaCHIP. The act aims to expand eligibility to children in families with incomes up to 300 percent federal poverty level from the former eligibility threshold of 200 percent federal poverty level. A request for approval of the plan was submitted to CMS in September 2007. In February 2008, CMS approved the expansion of eligibility to only 250 percent federal poverty level. The coverage under this expansion will be provided through the State Group Benefits program, which also provides insurance to state government employees. Families will contribute premiums (approximately $50), co-payments and deductibles.

Montana
2007 Senate Bill 22
http://data.opi.mt.gov/bills/2007/billpdf/SB0022.pdf
Increased the SCHIP eligibility level for children in families with income up to 175 percent of federal poverty guidelines--from the current level of 150 percent--provided there is funding available.

New York
2007 Senate Bill 2108
The state budget included an SCHIP eligibility level increase from 250 percent of the federal poverty guidelines up to 400 percent of the federal poverty guidelines and allowed families with incomes above 400 percent to buy-in to the program for their children. Due to the August 17 directive, CMS denied New York's request for this expansion.
http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/NYCurrentFactsheet.pdf
2008 Senate Bill 6808
The 2009 budget was enacted and appropriated state funds for the implementation of the expansion of the Child Health Plus program to 400 percent of the federal poverty guidelines. This expansion was implemented beginning September 1, 2008.

Pennsylvania
2006 Senate Bill 1192
http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2005&sessInd=0&billBody=S&billTyp=B&billNbr=1192&pn=1734
Expanded CHIP coverage from 200 percent of the federal poverty guidelines to 300 percent of the federal poverty guidelines with premiums based on a sliding income scale, ranging from $36

to $57 per child per month. The expansion was approved by CMS in February and the program began implementation in March 2007.

South Carolina
2007 House Bill 3620
http://www.scstatehouse.gov/sess117_2007-2008/appropriations2007/tap1b.htm
A provision in the 2007-2008 budget passed the state legislature and creates a separate State Children's Health Insurance Program, Healthy Connections Kids, that expands eligibility to children with family incomes up to 200 percent of the federal poverty level. This provision was vetoed by the Governor, but the legislature overrode the veto.

West Virginia
2006 House Bill 4021
http://www.legis.state.wv.us/Bill_Text_HTML/2006_SESSIONS/RS/BILLS/HB4021%20ENR.htm
Expanded SCHIP eligibility up to 300 percent of the federal poverty guidelines. In January 2007, the state began enrolling children with incomes up to 220 percent of the federal poverty level. Families with income between 200 and 220 percent of the federal poverty level will be required to pay premiums based on a two-tier system. Families with one child will pay a monthly premium of $35 and families with two children or more will pay $71 per month. Due to the failure of SCHIP reauthorization, the expansion to 300 percent of the federal poverty level was delayed.
http://www.kaisernetwork.org/Daily_reports/print_report.cfm?DR_ID=38314&dr_cat=3
An expansion from 220 percent to 250 percent of the federal poverty guidelines went into effect January 1, 2009.
http://www.wvchip.org/chipnotes.shtml

Wisconsin
2007 Senate Bill 40
http://www.legis.state.wi.us/2007/data/SB-40.pdf
Expands SCHIP eligibility to families with incomes up to 300 percent of the federal poverty guidelines. Due to the August 2007 CMS directive, state-only funds will be used to finance coverage for children with family incomes between 250 and 300 percent of the federal poverty guidelines. Under the BadgerCare Plus program, Wisconsin's SCHIP program, families with annual incomes between 200 percent and 300 percent of the federal poverty level are eligible for health coverage for their children and will be required to pay premiums (approximately $10 to $90.74 per month).

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 13 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Sponsor Statement

SB 13 increases the qualifying income eligibility standard for the Denali KidCare Program to 200% of the Federal Poverty Line (FPL) and makes health insurance accessible to an estimated 1300 more uninsured children and 225 pregnant women in Alaska. Denali KidCare is an "enhanced" reimbursement program with up to 70% matching funds under the federal government's State Children's Health Insurance Program (SCHIP), which was created in 1997. Congress reauthorized the SCHIP program for five years and President Obama just signed into law on February 4, 2009 with expanded coverage for 4 million more children.

Increasing Alaska Denali KidCare to 200% FPL only funds it to the level at which it was established 10 years ago. Consider the following information from the Kaiser Commission on Medicaid and the Uninsured, January, 2009:

- 44 states, including D.C., cover children in families with incomes at 200% FPL or higher.
- 33 states cover children in families with income between 200% and 250% FPL.
- 19 states including D.C., cover children in families with income at 250% or higher. 10 of these states cover children in families with income at 300% FPL or higher.
- 35 states allow premiums, enrollment fees, or co-payments for selected services in SCHIP programs on a sliding scale of FPL.

Denali KidCare serves an estimated 7600 Alaska children and remains one of the least costly medical assistance programs in the state at about $1,700 per child with full coverage, including dental, which is about 20% of the cost of adult senior coverage.

Early intervention and preventative care under SB 13 will greatly increase Alaska children's health and yield substantial savings to the state and public and private sector hospital emergency rooms which must admit indigent and uninsured patients for non-emergency treatment. It is estimated that uninsured children with a medical need are five times as likely not to have a regular doctor as insured children and four times more likely to use emergency rooms at a much higher cost.

There are still an estimated 18,000 uninsured children in Alaska, or about 9% of the children age 18 and under. Private health care coverage for children has declined over 30% in the last ten years, and the deepening recession is pulling more children and families into the uninsured ranks. The reauthorized SCHIP program and "Stimulus Package" should help. Alaska should do its share by insuring its low income children and participating in Denali KidCare at 200% FPL under SB 13.

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

Joe Hackney
Speaker
North Carolina House of Representatives
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Gary VanLandingham
Director, OPPAGA
Florida Legislature
Staff Chair, NCSL

William Pound
Executive Director

To: The Honorable Bettye Davis
Alaska Senate

From: Jennifer Saunders
Health Program
303-856-1440
Jennifer.saunders@ncsl.org

Date: February 11, 2009

Subject: SCHIP Cost Sharing Rules

Senator Davis,

We enjoyed listening to your Health and Social Services committee meeting on Monday. This memo is intended to answer the question posed about the SCHIP cost-sharing rules.

Alaska's SCHIP program is a Medicaid expansion program and therefore must comply with Medicaid's cost-sharing rules as specified under the Deficit Reduction Act of 2005. Under provisions of the Deficit Reduction Act of 2005 (DRA), states generally cannot impose cost sharing on children in families with income below 150 percent of the federal poverty guidelines except in certain circumstances. In addition, even at more moderate-income levels, federal rules exempt some special services from any cost sharing requirements.

Most children under the age of 18 are exempt from premiums and from cost-sharing on most services. However, the DRA rules allow states to require co-payments for prescription drugs and use of the emergency room for non-emergency care on all children in certain circumstances. The DRA also allows states to assess premiums and cost-sharing charges on some children in families with income above the poverty line. The total amount of premiums and cost-sharing charges cannot exceed a cap of five percent of family income, which is calculated on a monthly or quarterly basis at the option of the state.

Please see the following document by the Center on Budget and Policy Priorities for more detailed information about cost-sharing and premiums in Medicaid:
Cost-sharing and Premiums in Medicaid: What Rules Apply? February 28, 2007
http://www.cbpp.org/2-28-07health.pdf

In addition, you may also find the following document by the Congressional Research Service helpful. The table on page 5 compares service-related cost-sharing rules in traditional Medicaid, the DRA options and SCHIP.
Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)

CRS Report for Congress, January 25, 2007
http://assets.opencrs.com/rpts/RS22578_20070125.pdf

The following document by the Centers for Medicare and Medicaid Services (CMS) also summarizes these Medicaid requirements and you may find the "Important Links" on the bottom of page 2 helpful.
See the CMS document here:
http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf

For more general information about cost sharing and SCHIP, please see the following CMS website:
http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp
(Scroll down to see the information under the heading "Cost Sharing.")

To create cost sharing requirements that differ from the Medicaid requirements, states can do so by submitting a waiver to and obtaining approval from the Centers for Medicare and Medicaid Services (CMS) or by creating a stand-alone SCHIP program.

If you have more specific or detailed questions regarding cost-sharing requirements under Alaska's SCHIP program, I would suggest that you contact CMS directly.

Best regards,
Jennifer Saunders

Thomas Obermeyer

From: Jennifer Saunders [jennifer.saunders@ncsl.org]
Sent: Thursday, February 05, 2009 10:03 AM
To: Thomas Obermeyer; Lynda Zaugg
Cc: Martha King; Jennifer Breshears
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Yes, the following Kaiser report indicates that 7 states have SCHIP eligibility levels below 200 percent of the federal poverty guidelines (FPG):
Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009
http://www.kff.org/medicaid/7855.cfm
(See page 10, Figure 1.)

The 7 states are:

Alaska	175 percent FPG
Idaho	185 percent FPG
Montana	175 percent FPG
Nebraska	185 percent FPG
North Dakota	150 percent FPG
Oklahoma	185 percent FPG*
Oregon	185 percent FPG

* Oklahoma passed legislation to increase the income eligibility guideline to 300 percent of the federal poverty line under its current section 1115 waiver. However, the currently proposed expansion has been scaled back to 217 percent of the federal poverty line and the future expansion of 218 percent to 300 percent of the federal poverty line is pending further CMS guidance and SCHIP reauthorization.

Sources:
Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009
http://statehealthfacts.org/comparemaptable.jsp?ind=203&cat=4

Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009
http://statehealthfacts.org/comparemaptable.jsp?ind=204&cat=4

Would you still like for NCSL to participate by phone in the Senate HESS hearing concerning SB 13 on February 9, 2009?
If yes, what are you expecting from us (a presentation, or just being available to answer questions, etc.)?

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
Research Analyst
Health Program
National Conference of State Legislatures

7700 East First Place
Denver, CO 80230
303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org

----- Original Message -----
From: Thomas Obermeyer
To: Jennifer Saunders
Cc: Lynda Zaugg
Sent: Wednesday, February 04, 2009 9:26 PM
Subject: RE: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Jennifer,
In reviewing one of your recommended web sites, the Kaiser Commission on Medicaid and the Uninsured, January 2009 reported that only 7 states, apparently including Alaska, are below 200% FPL. Can you tell me which are the other 6 states?

Tom Obermeyer
Office of Senator Davis
907-465-3762

From: Jennifer Saunders [mailto:jennifer.saunders@ncsl.org]
Sent: Wednesday, February 04, 2009 8:31 AM
To: Thomas Obermeyer
Subject: Fw: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Hi Thomas,

I wanted to follow up with you to check that you received the information about SCHIP that I sent you last week.

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
Research Analyst
Health Program
National Conference of State Legislatures
7700 East First Place
Denver, CO 80230
303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org
----- Original Message -----
From: Jennifer Saunders

To: Thomas Obermeyer
Cc: jennifer breshears ; Martha King ; Senator_Bettye_Davis@legis.state.ak.us ; Lynda_Zaugg@legis.state.ak.us ; Don_Burrell@legis.state.ak.us
Sent: Friday, January 30, 2009 2:05 PM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

In the attached document, I have compiled some information regarding your questions about the State Children's Health Insurance Program and have included additional resources. At the end of the document, you will find summaries of enacted state legislation that you may find helpful. Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
Research Analyst
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7700 East First Place
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303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org

----- Original Message -----
From: Martha King
To: Thomas Obermeyer
Cc: jennifer saunders ; jennifer breshears
Sent: Tuesday, January 27, 2009 9:41 AM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Greetings Thomas!
We're happy to provide the information you've requested in your email and to participate by phone on February 9th, if you continue to think we could be helpful. I am asking the two NCSL staff named in the cc line to work on the specifics you've asked for and we will be getting back to you as soon as possible.
In the meantime, please give our regards to Senator Davis & stay warm up there! martha

----- Original Message -----
From: Thomas Obermeyer
To: martha.king@ncsl.org
Cc: Sen. Bettye Davis ; Lynda Zaugg ; Don Burrell
Sent: Monday, January 26, 2009 2:48 PM
Subject: RE: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

January 26, 2009

Martha King, Group Director,
Health Programs, NCSL - Denver
303-364-7700 main line

303-364-7800 fax
303-856-1448 – direct line
E-mail: Martha.king@ncsl.org

RE: Request for:

A) review and comments concerning Alaska Senate Bill 13 (attached), and
B) request for NCSL staff to testify at Senate HESS hearing concerning SB 13, Denali KidCare, Alaska SCHIP program February 9, 2009 at 1:30-3:00 pm (3:30-5:00 pm Mountain/Denver time). **Call in number is 888-295-4546**

Dear Ms. King,

Please read the attached **Alaska Senate Bill No. 13,** 26th Legislature, sponsored by Senator Bettye Davis, regarding **increasing income eligibility** under the Denali KidCare -State Children's Health Insurance Program (SCHIP) **to 200% Federal Poverty Guidelines (FPG)**. It was raised to 175% last year under SB 27, 25th Legislature.

Senator Davis, Chair, Senate HESS Committee (and Vice-Chair NCSL Health Committee) is considering an amendment at hearing to extend optional coverage to applicants over 200% FPG not to exceed 250% FPG with provisions of premiums or co-payments . You will note that there is no asset test in the bill.

Your comments in return e-mail to me as soon as possible before the hearing would be particularly helpful in the following areas:

1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review, and
2. if asset tests, payments, and co-payments are common, and if other matters of eligibility other than income and household size under federal poverty guidelines are codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits.
3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.
4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines.

Please have NCSL staff call in to the hearing teleconference line on February 9, 2009 noted above at 888-295-4546 to testify and/or field questions.

Sincerely,

Thomas S. Obermeyer
Legislative Assistant
Office of Senator Bettye Davis
907-465-3822 office
907-465-3762 direct line
907-465-3756 fax
Thomas_Obermeyer@legis.state.ak.us

United States Department of Health & Human Services

• Frequent Questions

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THE 2009 HHS POVERTY GUIDELINES

One Version of the [U.S.] Federal Poverty Measure

[*Federal Register* notice, January 23, 2009 (PDF - 3 pages)]
[Prior Poverty Guidelines and *Federal Register* References Since 1982]
[Frequently Asked Questions (FAQs)]
[Further Resources on Poverty Measurement, Poverty Lines, and Their History]

Revised 5/13

There are two slightly different versions of the federal poverty measure:

- The poverty thresholds, and
- The poverty guidelines.

The **poverty thresholds** are the original version of the federal poverty measure. They are updated each year by the **Census Bureau** (although they were originally developed by Mollie Orshansky of the Social Security Administration). The thresholds are used mainly for **statistical** purposes — for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines.) Poverty thresholds since 1980 and weighted average poverty thresholds since 1959 are available on the Census Bureau's Web site. For an example of how the Census Bureau applies the thresholds to a family's income to determine its poverty status, see "How the Census Bureau Measures Poverty" on the Census Bureau's web site.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the *Federal Register* by the **Department of Health and Human Services** (HHS). The guidelines are a simplification of the poverty thresholds for use for **administrative** purposes — for instance, determining financial eligibility for certain federal programs. The *Federal Register* notice with the 2009 poverty guidelines (PDF - 3 pages).

The poverty guidelines are sometimes loosely referred to as the "federal poverty level" (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.

Key differences between poverty thresholds and poverty guidelines are outlined in a table under Frequently Asked Questions (FAQs). See also the discussion of this topic on the Institute for Research on Poverty's web site.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline
1	$10,830
2	14,570
3	18,310
4	22,050

5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add $3,740 for each additional person.	

2009 Poverty Guidelines for Alaska

Persons in family	Poverty guideline
1	$13,530
2	18,210
3	22,890
4	27,570
5	32,250
6	36,930
7	41,610
8	46,290
For families with more than 8 persons, add $4,680 for each additional person.	

2009 Poverty Guidelines for Hawaii

Persons in family	Poverty guideline
1	$12,460
2	16,760
3	21,060
4	25,360
5	29,660
6	33,960
7	38,260
8	42,560
For families with more than 8 persons, add $4,300 for each additional person.	

Go to Further Resources on Poverty Measurement, Poverty Lines, and Their History

Go to Frequently Asked Questions (FAQs).

Return to the main Poverty Guidelines, Research, and Measurement page.

Last Revised: January 23, 2009

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2008 POVERTY LEVEL GUIDELINES

ALASKA

Income Guidelines as Published in the Federal Register on January 23, 2008

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	120%	133%	135%	150%	175%	185%	200%	250%
1	13,000.00	15,600.00	17,290.00	17,550.00	19,500.00	22,750.00	24,050.00	26,000.00	32,500.00
2	17,500.00	21,000.00	23,275.00	23,625.00	26,250.00	30,625.00	32,375.00	35,000.00	43,750.00
3	22,000.00	26,400.00	29,260.00	29,700.00	33,000.00	38,500.00	40,700.00	44,000.00	55,000.00
4	26,500.00	31,800.00	35,245.00	35,775.00	39,750.00	46,375.00	49,025.00	53,000.00	66,250.00
5	31,000.00	37,200.00	41,230.00	41,850.00	46,500.00	54,250.00	57,350.00	62,000.00	77,500.00
6	35,500.00	42,600.00	47,215.00	47,925.00	53,250.00	62,125.00	65,675.00	71,000.00	88,750.00
7	40,000.00	48,000.00	53,200.00	54,000.00	60,000.00	70,000.00	74,000.00	80,000.00	100,000.00
8	44,500.00	53,400.00	59,185.00	60,075.00	66,750.00	77,875.00	82,325.00	89,000.00	111,250.00

For family units of more than 8 members, add $4,500 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	120%	133%	135%	150%	175%	185%	200%	250%
1	1,083.33	1,300.00	1,440.83	1,462.50	1,625.00	1,895.83	2,004.17	2,166.67	2,708.33
2	1,458.33	1,750.00	1,939.58	1,968.75	2,187.50	2,552.08	2,697.92	2,916.67	3,645.83
3	1,833.33	2,200.00	2,438.33	2,475.00	2,750.00	3,208.33	3,391.67	3,666.67	4,583.33
4	2,208.33	2,650.00	2,937.08	2,981.25	3,312.50	3,864.58	4,085.42	4,416.67	5,520.83
5	2,583.33	3,100.00	3,435.83	3,487.50	3,875.00	4,520.83	4,779.17	5,166.67	6,458.33
6	2,958.33	3,550.00	3,934.58	3,993.75	4,437.50	5,177.08	5,472.92	5,916.67	7,395.83
7	3,333.33	4,000.00	4,433.33	4,500.00	5,000.00	5,833.33	6,166.67	6,666.67	8,333.33
8	3,708.33	4,450.00	4,932.08	5,006.25	5,562.50	6,489.58	6,860.42	7,416.67	9,270.83

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.

washingtonpost.com

Senate Passes Health Insurance Bill for Children

Immigrant Clause Opens Rift

By Ceci Connolly
Washington Post Staff Writer
Friday, January 30, 2009; 9:24 AM

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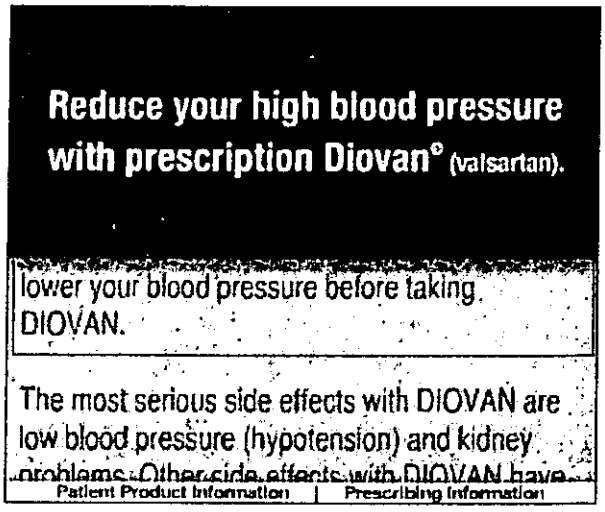

The Senate overwhelmingly approved legislation yesterday to provide health insurance to 11 million low-income children, a bill that would for the first time spend federal money to cover children and pregnant women who are legal immigrants.

The State Children's Health Insurance Program, which is aimed at families earning too much money to qualify for Medicaid but not enough to afford private insurance, currently covers close to 7 million youngsters at a cost of $25 billion.

Lawmakers voted 66 to 32, largely along party lines, to renew the joint state-federal program and spend an additional $32.8 billion to expand coverage to 4 million more children. The expansion would be paid for by raising the cigarette tax from 39 cents a pack to $1.

The House approved similar legislation on Jan. 14, and President Obama is expected to sign a final version as early as next week.

During the presidential campaign, Obama pledged to provide coverage to every American child. Experts estimate that once the program is fully implemented about 5 million youngsters will remain uninsured.

In a statement released this morning, Obama praised the Senate's action as the "worsening economy causes families to lose their jobs and health insurance." He added, "Providing health care to more than ten million children through the Children's Health Insurance Program will serve as a down payment on my commitment to ensure that every American has access to quality, affordable health care."

Democratic lawmakers, noting that President George W. Bush twice vetoed similar legislation, praised the vote as evidence of the changing Washington landscape.

"Low-income, uninsured kids all across America have been waiting for Congress to fulfill the promise of the Children's Health Insurance Program for them," said Senate Finance Committee Chairman Max Baucus (Mont.). The program "works to get low-income, uninsured kids the doctor's visits and medicines they need to stay healthy, and approval of this bill opens the door of the doctor's office to millions of children who live without proper health care today."

But the political victory may come at a price. The rancorous debate -- on a program that once basked in bipartisan popularity -- raised doubts about whether the two parties can unite to pass broader health reform later this year, several moderate Republicans said.

"This is a very unfortunate beginning," said Sen. Charles E. Grassley (Iowa). The top Republican on the Senate Finance Committee, a stalwart supporter of the program, said he was "disgusted" by the way

Democratic leaders handled the debate. "It does not bode well for cooperative work in the coming months," he said. But Grassley emphasized that he did not blame Baucus for the change in substance and style.

As the vote came just one day after the House passed an $819 billion economic stimulus package without a single Republican vote, some longtime lawmakers questioned the president's ability to forge a new era of cooperation in the capital.

"If they wanted a nice signing ceremony that showed bipartisanship and carried through on the president's language, this would have been a good vehicle to do it on," said Sen. Judd Gregg (R-N.H.).

Since its creation in 1997 under a Republican-led Senate, the children's health program has received broad bipartisan support.

"Few government programs in our time have enjoyed such great success, as acknowledged by members of both parties and all bipartisan health-care experts," said Senate Majority Leader Harry M. Reid (D-Nev.).

Governors, business executives and consumer advocates lobbied for the expansion, arguing that more and more families have sought the assistance in this weakened economy.

"During this economic turmoil, it is critical that we maintain and strengthen this important lifeline to our nation's children and that we help financially strapped states respond to the growing need for affordable health-care coverage," said Cindy Mann, executive director of Georgetown University's Center for Children and Families.

In 2007, prominent Republicans such as Grassley and Sen. Orrin G. Hatch (Utah) bucked Bush to support renewal of the program.

"We carried a lot of water and took a lot of flak" for that stand, Hatch said. To push through a different version now is "not only unfair," he said, "but a slap in the face to those of us who worked so strongly with our friends on the other side."

The bill approved last night closely resembles the versions many Republicans supported in the past, countered Democrats.

GOP lawmakers objected to the new provision allowing states to enroll certain legal immigrants. Until now, many immigrants' families have been forced to wait five years for coverage.

"The bottom line is: This is a debate about children's health coverage," said Sen. Richard J. Durbin (D-Ill.). "This is not a debate about immigration."

In more than two days of debate -- in unusually personal and emotional language -- Republicans expressed a sense of betrayal that Democrats had dropped the 2007 compromise.

"We could have had 95 votes," Hatch said. "That would have sent a tremendous, tremendous message that hasn't been sent around here for a long time."

Both sides had hoped, and even predicted, that early bipartisan action on children's coverage would demonstrate that Washington's elected officials can cooperate on critical issues such as health care.

"This is on something for which there is so much agreement and something that almost no one argues about," said Helen Darling, president of the National Business Group on Health, which represents 300 large employers. "For the tough things like real national health-care reform, it unfortunately portends a really rocky road."

Compared to the daunting task of overhauling the entire U.S. health system, the debate on the children's health program should have been easy, said Sen. Olympia J. Snowe (R-Maine).

"You would have thought this issue would have been clear sailing on both sides," she said.

Karen Ignagni, president of America's Health Insurance Plans, agreed that "we're not seeing bipartisanship" but said she is optimistic that the public's overwhelming desire for improvement in the health system will force the two parties to the bargaining table. "People are talking about how to do it as opposed to whether to do it," she said.

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[Federal Register: January 23, 2009 (Volume 74, Number 14)]
[Notices]
[Page 4199-4201]
From the Federal Register Online via GPO Access [wais.access.gpo.gov]
[DOCID:fr23ja09-64]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the HHS poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: Effective Date: Date of publication, unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services (HHS), Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, state, or local office that is responsible for that program. Contact information for two frequently requested programs is given below:

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Office of the Director, Division of Facilities Compliance and Recovery, Health Resources and Services Administration, HHS, Room 10-105, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland

[[Page 4200]]

20857. To speak to a staff member, please call (301) 443-5656. To receive a Hill-Burton information package, call 1-800-638-0742 (for callers outside Maryland) or 1-800-492-0359 (for callers in Maryland). You also may visit http://www.hrsa.gov/hillburton/default.htm. The Division of Facilities Compliance and Recovery notes that as set by 42 CFR 124.505(b), the effective date of this update of the poverty guidelines for facilities obligated under the Hill-Burton Uncompensated Services Program is sixty days from the date of this publication.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I-864, Affidavit of Support, contact U.S. Citizenship and Immigration Services

at 1-800-375-5283.

For information about the number of people in poverty or about the Census Bureau poverty thresholds, visit the Poverty section of the Census Bureau's Web site at http://www.census.gov/hhes/www/poverty/poverty.html or contact the Census Bureau's Demographic Call Center Staff at (301) 763-2422 or 1-866-758-1060 (toll-free).

For general questions about the poverty guidelines themselves, contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201--telephone: (202) 690-7507--or visit http://aspe.hhs.gov/poverty/.

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update, at least annually, the poverty guidelines, which shall be used as an eligibility criterion for the Community Services Block Grant program. The poverty guidelines also are used as an eligibility criterion by a number of other Federal programs. The poverty guidelines issued here are a simplified version of the poverty thresholds that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI-U). The guidelines in this 2009 notice reflect the 3.8 percent price increase between calendar years 2007 and 2008. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The same calculation procedure was used this year as in previous years. (Note that these 2009 guidelines are roughly equal to the poverty thresholds for calendar year 2008 which the Census Bureau expects to publish in final form in August 2009.) The guideline figures shown represent annual income.

2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add $3,740 for each additional person.

2009 Poverty Guidelines for Alaska

	Poverty

Persons in family	guideline
1	$13,530
2	18,210
3	22,890
4	27,570
5	32,250
6	36,930
7	41,610
8	46,290

For families with more than 8 persons, add $4,680 for each additional person.

2009 Poverty Guidelines for Hawaii

Persons in family	Poverty guideline
1	$12,460
2	16,760
3	21,060
4	25,360
5	29,660
6	33,960
7	38,260
8	42,560

For families with more than 8 persons, add $4,300 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. (Note that the Census Bureau poverty thresholds--the version of the poverty measure used for statistical purposes--have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines have sometimes been mistakenly referred to as the ``OMB'' (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as ``the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).''

Some programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-Federally-funded activities can choose to use a percentage multiple of the guidelines such as 125 percent or 185 percent.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census

Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as ``income'' or ``family.'' This is because there is considerable variation in how different programs that use the guidelines define these terms, traceable to the different laws and regulations that govern the various programs. Therefore, questions about how a particular program applies the poverty guidelines (for example, Is income before or after taxes? Should a particular type of income be counted? Should a particular person be counted in the family or household unit?) should be directed to the organization that administers the program; that organization has the responsibility for making decisions about definitions of such terms as ``income'' or ``family'' (to the extent that the definition is not already contained in legislation or regulations).

[[Page 4201]]

Dated: January 16, 2009.
Michael O. Leavitt,
Secretary of Health and Human Services.
[FR Doc. E9-1510 Filed 1-22-09; 8:45 am]

BILLING CODE 4151-05-P

303-364-7800 fax
303-856-1448 – direct line
E-mail: Martha.king@ncsl.org

RE: Request for:

A) review and comments concerning Alaska Senate Bill 13 (attached), and
B) request for NCSL staff to testify at Senate HESS hearing concerning SB 13, Denali KidCare, Alaska SCHIP program February 9, 2009 at 1:30-3:00 pm (3:30-5:00 pm Mountain/Denver time). **Call in number is 888-295-4546**

Dear Ms. King,

Please read the attached **Alaska Senate Bill No. 13,** 26th Legislature, sponsored by Senator Bettye Davis, regarding **increasing income eligibility** under the Denali KidCare -State Children's Health Insurance Program (SCHIP) **to 200% Federal Poverty Guidelines (FPG)**. It was raised to 175% last year under SB 27, 25th Legislature.

Senator Davis, Chair, Senate HESS Committee (and Vice-Chair NCSL Health Committee) is considering an amendment at hearing to extend optional coverage to applicants over 200% FPG not to exceed 250% FPG with provisions of premiums or co-payments . You will note that there is no asset test in the bill.

Your comments in return e-mail to me as soon as possible before the hearing would be particularly helpful in the following areas:

1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review, and
2. if asset tests, payments, and co-payments are common, and if other matters of eligibility other than income and household size under federal poverty guidelines are codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits.
3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.
4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines.

Please have NCSL staff call in to the hearing teleconference line on February 9, 2009 noted above at 888-295-4546 to testify and/or field questions.

Sincerely,

Thomas S. Obermeyer
Legislative Assistant
Office of Senator Bettye Davis
907-465-3822 office
907-465-3762 direct line
907-465-3756 fax
Thomas_Obermeyer@legis.state.ak.us

kaiser commission on medicaid and the uninsured

Challenges of Providing Health Coverage for Children and Parents in a Recession:

A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009

Prepared by:
Donna Cohen Ross
Center on Budget and Policy Priorities

and

Caryn Marks
Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation

January 2009

THE HENRY J. KAISER FAMILY FOUNDATION

3225

Acknowledgments

The authors would like to extend our deep appreciation to the many Medicaid and SCHIP officials throughout the country who participated in this survey and so generously shared their time and expertise with us. We are grateful for their willingness to explain recent program developments -- from the broadest policy change to the most detailed program rule. Their important contribution to improving the health of children and families deserves recognition and our thanks. We also would like to thank our colleagues at the Center on Budget and Policy Priorities, particularly Matthew Broaddus, for their assistance and helpful suggestions as we prepared this report. We also appreciate the assistance of the Center for Children and Families at Georgetown University's Health Policy Institute.

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Executive Summary

Medicaid and SCHIP have been instrumental in covering more low-income uninsured children over the last decade. While much progress has been made, nine million children remain uninsured. As SCHIP reauthorization approached in 2007, states were poised to move forward with efforts to cover more uninsured children. However, federal obstacles, including the Medicaid citizenship documentation requirements, the issuance of a CMS-directive on August 17th 2007 limiting state expansions, and the failure to reauthorize SCHIP have hampered progress. A temporary extension provided funds for SCHIP through March 31, 2009.

When states adopted their budgets for the fiscal year starting July 1, 2008, many were able to include funding for children's coverage expansions. Later, the severity of the unfolding fiscal crisis became clearer and state budget shortfalls are now expected to total $350 billion for the remainder of FY 2009 and through 2011. States face mounting pressure to cut Medicaid and SCHIP just as the need for coverage rises due to climbing unemployment and loss of health coverage. In the last downturn, some states implemented restrictive enrollment procedures and reported dramatic declines in children's enrollment as a result. States may soon feel pushed to take such steps. Key findings from the annual KCMU survey of state Medicaid and SCHIP policies for children and parents that were implemented or authorized between January 2008 and January 2009 in the 50 states and D.C. include:

- **States continued to make progress on improving access to health coverage, particularly for children, but several significant setbacks warn about impending problems.** One-third of states (19) increased access to health coverage, while ten states enacted at least one measure to restrict coverage. The most common restriction was imposing new or higher premiums in SCHIP, but two states also restricted eligibility. California increased the frequency of renewal, a change estimated to affect more than 260,000 children as well as large numbers of parents.

- **The economic crisis is widespread and serious healthcare cuts are looming, but the commitment to children is still strong.** States continued to enact eligibility expansions for children, and state officials in several of those states plan to go forward even though they are facing significant budget shortfalls. Federal constraints, such as the unresolved reauthorization of SCHIP and the August 17th directive, have caused some states to put expansions on hold temporarily. Others are using state funds to pay for coverage precluded by the directive.

- **Parent coverage is still more difficult to obtain than children's coverage.** The median income at which children qualify for coverage is 200 percent of the federal poverty line, but is much lower — 68 percent of the federal poverty line — for working parents. However, for unemployed parents, the median income eligibility for Medicaid is just 41 percent of the federal poverty line, $601 per month for a family of three in 2008. Jobless parents who need coverage may find that unemployment payments put them over the income limit for Medicaid.

- **Outreach budgets were increased in a number of states, however, some are beginning to report that these funds are being curtailed.** Outreach, including community-based application assistance, is critical in a recession, since newly eligible families may be unfamiliar with public programs. But in light of budget shortfalls, some states expressed skepticism for conducting aggressive outreach. About half the states are using technology to implement or develop online applications and to develop more efficient enrollment and renewal systems.

As the economic crisis deepens, states will be under major pressure to contain costs. This may lead them to take steps that not only reverse coverage gains, but intensify the hardships that many families are already facing as a result of losing their jobs and their health insurance. Congress is currently considering SCHIP reauthorization and an economic recovery package that would provide additional federal Medicaid matching funds. These would help states to maintain vital coverage for low-income families, support state efforts to enroll more eligible children, and make program improvements. Strengthening Medicaid and SCHIP in these ways is an essential precursor to the larger task of enacting broad health care reform.

I. Introduction

A commitment to providing health coverage for uninsured children has inspired nationwide efforts that began in earnest with enactment of the State Children's Health Insurance Program (SCHIP) in 1997. Like Medicaid, the chief source of health coverage for low-income families, SCHIP finances coverage through a partnership between the federal and state governments. State measures to expand eligibility and adopt streamlined enrollment procedures in Medicaid and SCHIP have strengthened both of these programs, and they have been instrumental in reducing the percentage of low-income uninsured children by one-third over the last decade.[1] Notably, the number of low-income uninsured parents increased over the same period, since eligibility levels and resources for addressing their health coverage needs do not approach those related to children.

While considerable progress has been made, nine million children in the United States remain uninsured, with nearly two-thirds of them eligible for Medicaid and SCHIP. In 2007, with relatively robust state budgets and the reauthorization of SCHIP at hand, across the country, states came forward to reaffirm their commitment to closing this gap. That year, state efforts to expand children's health coverage represented the most aggressive steps forward since the early years of SCHIP. Of the 20 states that expanded eligibility for children, 12 raised or authorized raising SCHIP income limits to 300 percent of the federal poverty line, more than doubling the number of states that previously had eligibility set at this level. States also made progress on adopting simplified enrollment and renewal procedures in both Medicaid and SCHIP, emphasizing strategies that reduce paperwork and jump-start enrollment.[2]

Despite this burst of activity, efforts to advance children's coverage met unanticipated federal obstacles. The Medicaid citizenship documentation requirement, enacted in 2006 as part of the Deficit Reduction Act, sent state simplification efforts backwards by requiring U.S. citizens applying for Medicaid to present original documents proving their citizenship and identity. States reported that this new rule ushered a deep decline in the enrollment of eligible U.S. citizens, especially children.

The expected reauthorization of SCHIP also encountered roadblocks. Congress passed two versions of legislation to reauthorize SCHIP and President Bush vetoed each of them. And, on August 17, 2007, as SCHIP reauthorization was proceeding, the Centers for Medicare and Medicaid Services (CMS) issued a directive that impeded states' ability to expand coverage.[3] The year ended with these problems unresolved, meaning states were without the infusion of funds they were anticipating, and the new tools to bolster outreach and enrollment did not materialize. A temporary extension provided funds for SCHIP through March 31, 2009.

When states adopted their budgets for the state fiscal year starting July 1, 2008, they were able to include funding for children's coverage expansions. Later, the economy began to show signs of trouble, but it was not until September 2008 that the breadth and depth of the unfolding fiscal crisis became clear as financial markets collapsed and unemployment started to rise sharply. States are now facing an extremely threatening fiscal situation, with state budget shortfalls expected to total $350 billion for the remainder of FY 2009 and through 2010 and 2011.[4]

So far, most states have managed to maintain existing eligibility levels and procedural improvements. For example, despite serious financial pressures, states that enacted earlier children's coverage expansions, such as Iowa and New York, have reiterated their intentions to go forward. But, there are warning signs that this will become more and more difficult.

As in past economic downturns, states will continue to struggle with the mounting pressure to cut health coverage programs just at the time that an increasing number of people need the vital services they provide. Many states have already implemented or announced major cuts to health programs, mainly in the area of provider rates and benefits, which have a significant impact on access and the quality of care. States that have not yet expanded are likely to be deterred from increasing coverage because of the dire economic environment.

Medicaid enrollment and spending growth peaked in 2002 at the same time state revenues dropped sharply. In response, states adopted an array of cost containment strategies to control spending growth. Then federal fiscal relief was made available to states through the Jobs and Growth Tax Relief Reconciliation Act of 2003, increasing the federal share of Medicaid costs, and lifting some of the burden states were carrying. The legislation restricted states from lowering Medicaid eligibility between September 2003 and June 2004, as a condition of receiving relief funds. Thus, no state retracted Medicaid eligibility during this time period. SCHIP eligibility also remained relatively constant, with only a few states cutting back.

However, because they were still grappling with budget shortfalls, nearly half the states put in place enrollment procedures that made it more difficult for children and parents to secure and retain health coverage between April 2003 and July 2004.[5] Some states reported dramatic declines in children's enrollment as a result of these budget-driven changes, and children who were most likely *eligible* for existing programs became uninsured. For example, in Texas, SCHIP enrollment dropped by more than 149,000 children (a 29 percent decline), in large measure, due to reducing continuous coverage from 12 months to six months. Washington state also repealed the guarantee of 12 months of coverage and required parents to renew their child's eligibility every six months as well as report changes in the interim. This, along with other procedural changes, led to a dramatic caseload reduction of more than 40,000 children. In Wisconsin's BadgerCare program, establishing more rigorous documentation requirements resulted in an enrollment decline of 13,000 children and parents in just the first four months of implementation. Several states also froze SCHIP enrollment. In addition to turning away children who qualified for coverage under SCHIP, this strategy adversely affected Medicaid-eligible children not subject to the freeze. Eligible applicants' path to coverage was limited when states stopped taking joint Medicaid/SCHIP applications or because families mistakenly interpreted news reports to mean that all coverage programs were closed to new applicants.[6]

Coming out of the last economic downturn, states worked to eliminate SCHIP enrollment freezes and reverse some of the enrollment barriers they had imposed. This enabled caseloads to recover somewhat. An important lesson learned, however, is that the problematic effects of changing administrative procedures can endure if such changes send conflicting messages to prospective and current program participants.

As this report goes to press, two major developments are within reach. Congress has taken up SCHIP reauthorization once again and is working towards passing a bill that will likely be one of the first pieces of legislation to be presented to the nation's new president, Barack Obama. Next will come a significant economic recovery package that will contain substantial state fiscal relief in the form of enhanced federal matching funds for Medicaid that will reduce the share of the costs states will have to contribute for the program. Passage of both these bills would provide needed relief, as well as the support to move forward on enrolling more eligible, uninsured children. These measures would also help reinforce the federal/state partnership that is fundamental to the viability of health coverage programs. Strengthening Medicaid and SCHIP by making sure they are in a position to provide coverage to more

low-income uninsured individuals, is also an essential precursor to the larger task of enacting broad health care reform.

II. About this Survey

This report presents the findings of a survey of eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP for children and families that were implemented or authorized between January 2008 and January 2009 in the 50 states and the District of Columbia. These policies have a large influence on how effectively Medicaid and SCHIP can deliver health coverage to the eligible children, pregnant women and parents who rely on the vital services these programs provide. They are the driving forces behind efforts to reduce the number of low-income people who lack adequate insurance but cannot afford to pay for it on their own.

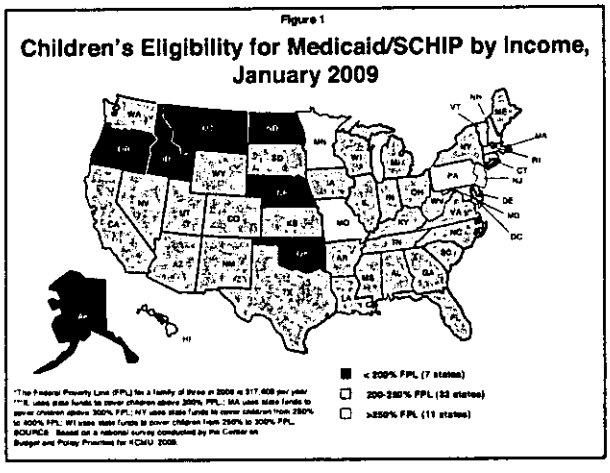
This study, the eighth annual survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, was carried out in the summer and early fall of 2008, through extensive telephone interviews with state Medicaid and SCHIP program administrators. Detailed follow-up interviews proceeded through the end of the year. The findings reflect policies and procedures in effect in the states in January 2009, as well as coverage expansions that were authorized, but were not implemented, by states during the survey period.

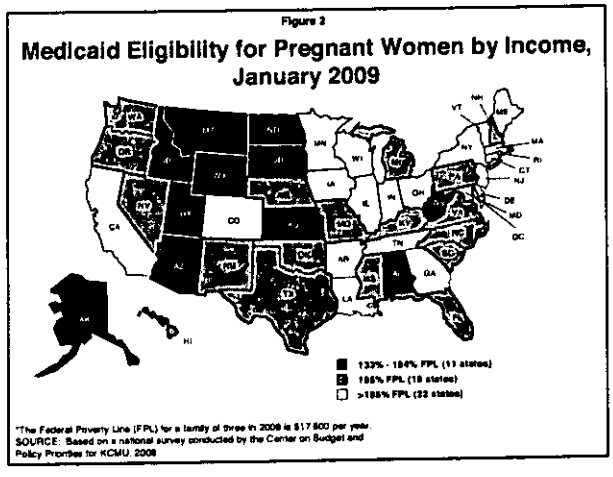
III. Key Survey Findings – Current Status of Coverage for Children and Parents

States continue to make progress on improving access to health coverage for low-income families. As of January 2009, income eligibility levels are as follows:

States provide health coverage for children and pregnant women under Medicaid or SCHIP as follows (Figures 1 & 2):

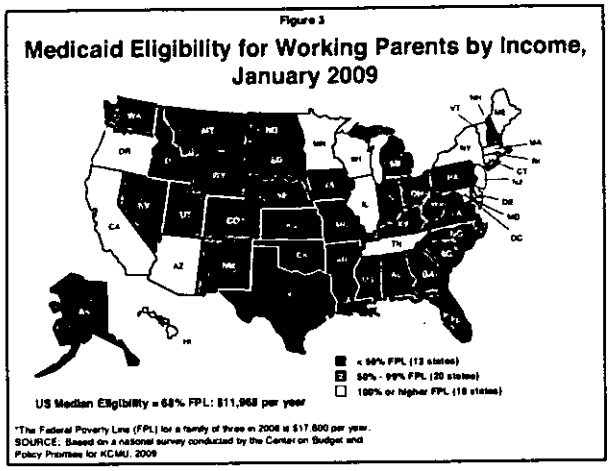
- 44 states, including DC, cover children in families with income at 200% FPL or higher. ($35,200 for a family of three in 2008).
- 33 states cover children in families with income between 200% and 250% FPL. (200%: $35,200 for a family of three in 2008; 250% FPL: $44,000 for a family of three in 2008).
- 19 states, including D.C., cover children in families with income at 250% FPL or higher. 10 of these states cover children in families with income at 300% FPL or higher. ($52,800 per year for a family of three in 2008).
- 40 states, including DC, cover pregnant women with income 185% FPL or higher. ($32,560 for a family of three in 2008).

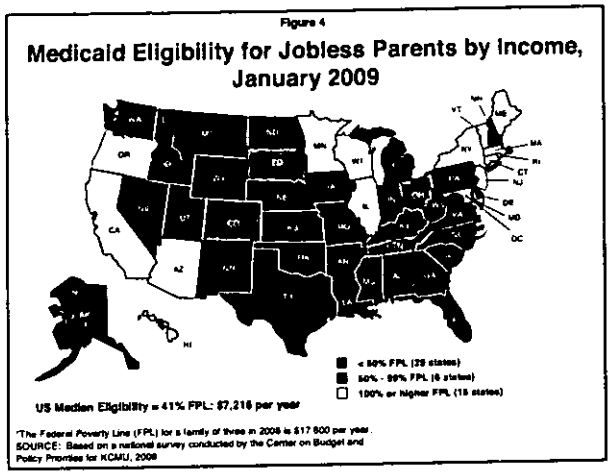




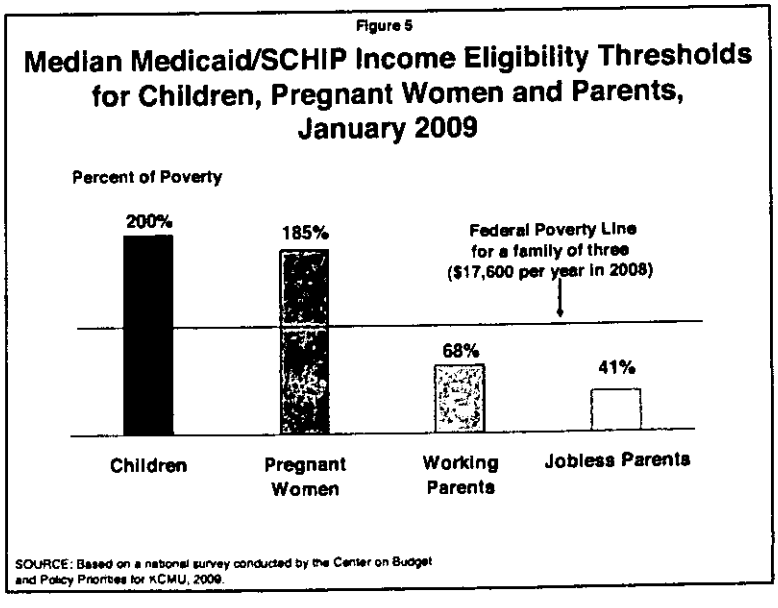
States provide health coverage for parents under Medicaid as follows (Figures 3 & 4):

- In 12 states, family income must be less than half the federal poverty line for a working parent to qualify for Medicaid ($8,700 per year for a family of three in 2008).
- In 29 states, family income must be less than half the federal poverty line for a jobless parent to qualify for Medicaid ($8,700 per year for a family of three in 2008).
- 18 states, including the District of Columbia, cover parents in families with income at 100 percent of the federal poverty line or higher ($17,600 per year for a family of three in 2008).
- In 28 states, a parent in a family of three, working full-time at the minimum wage, earning on average, $1,092 per month, cannot qualify for Medicaid.





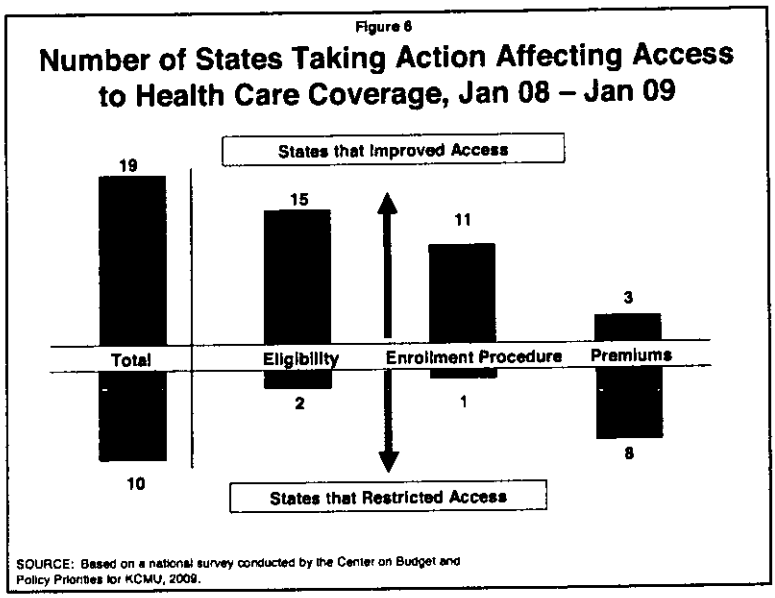
It continues to be more difficult for a low-income parent to qualify for health coverage than for a child (Figure 5). The median income at which children qualify for Medicaid or SCHIP is 200 percent of the federal poverty line, but is much lower — 68 percent of the federal poverty line — for working parents. For jobless parents, the median income eligibility for Medicaid is just 41 percent of the federal poverty line, $601 per month for a family of three in 2008. In an economic downturn, this low income limit can take a serious toll on families. For many individuals who have lost their jobs and also their health insurance, COBRA coverage is likely to be prohibitively expensive or may not be available, and parents may turn to public programs for coverage. However, they may find that the unemployment compensation payments they receive put them over the income limit for Medicaid. (Since unemployment compensation is unearned income, "earnings disregards" that are designed to help working families qualify do not apply.) Jobless parents may eventually become eligible, but in the interim they are subject to health risks and financial exposure that can have deleterious consequences for themselves and their families.



IV. Key Survey Findings – State Actions During 2008

Overall, states continued to make progress on improving access to health coverage, but a few setbacks warn about impending problems (Figure 6).

- **More than one-third of the states (19 states) took steps to increase access to health coverage for low-income children, pregnant women and parents.** Fifteen(15) states authorized or implemented coverage expansions *(CO, LA, IN, KS, LA, MD, MT, ND, NJ, NY, OK, OR, SC, TN, WI)*; 11 states reduced procedural barriers *(AZ, CO, LA, KY, LA, MD, MT, NV, OR, SC, UT)* and three states reduced financial barriers to Medicaid and SCHIP *(TN, WA, WI)*.



- **Ten states (10 states) enacted at least one measure to restrict coverage.** The most common restriction was to increase financial barriers such as new or higher premiums in SCHIP programs. Eight states *(GA, LA, MN, MO, NJ, NV, PA, RI)* went in this direction. *Rhode Island* and *South Carolina* restricted eligibility, the former cutting income eligibility for parents, and the latter establishing a three-month waiting period in its new separate SCHIP program, during which children must remain uninsured before they can enroll. *California*, increased the frequency with which parents and children are required to renew coverage.

The actions taken by *Rhode Island* and *California*, among the first states to feel the effects of the economic downturn, raise concerns about where other states could be headed if their fiscal pressures go unaddressed. The premium increases in *Rhode Island* are steep, coming at a time when families are likely to be financially strapped. Premiums of $45 per child per month are now required for children in families with incomes as low as 133 percent of the federal poverty line ($23,467 for a family of three in 2008), as compared to the previous starting point, 150 percent of the federal poverty line. Premiums for other children range from $86 per month to $114 per month, representing an increase of up to $29 per month for some.

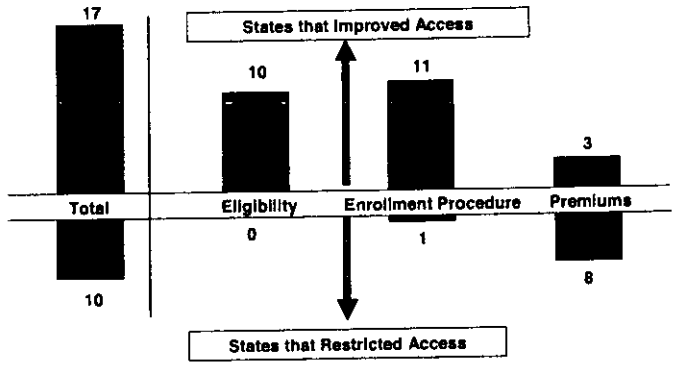
California's retraction of 12-month continuous eligibility for children withdraws the guarantee of full-year coverage, which is critical for children with ongoing medical needs. In addition, the state will

now require children and parents on Medicaid to comply with a semi-annual reporting procedure that is likely to cause otherwise avoidable gaps in coverage for eligible families. It will also create unnecessary and costly administrative burdens, since eligible families dropped from the program are likely to reapply within a short period of time. These changes could result in more than 260,000 children losing coverage by 2011. A large number of parents would be affected as well.[7]

The economic crisis is widespread, and serious health care and other cuts are looming, but states are demonstrating a steadfast commitment to covering children (Figure 7). States continued to enact eligibility expansions for children, and state officials in several of those states, such as *Iowa* and *New York*, plan to go forward even though they are facing significant budget shortfalls. Federal constraints that have dampened states' ability to expand, such as the unresolved reauthorization of SCHIP and the August 17th directive, have caused several states to put expansions on hold or scale back temporarily. Others, such as *Wisconsin* and *New York*, are using state funds to pay for children whose coverage is precluded by the August 17th directive.

Figure 7

Number of States Taking Action Affecting Children's Access to Health Care Coverage, Jan 08 – Jan 09



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2009.

- **One-third of the states (17 states) increased access to coverage for children.** Ten (10) states implemented or authorized eligibility expansions for children. *Iowa* and *Montana* raised children's coverage (scheduled to begin later this year), to 300 percent of the federal poverty line and 250 percent of the federal poverty line, respectively; *Kansas* implemented a children's coverage expansion to 250 percent of the federal poverty line. If the August 17th directive remains in place, these states will be subject to the strict conditions it imposes. Eligibility increases were also implemented, but to more modest levels in *Colorado, North Dakota* and *South Carolina*. *New York* adopted the option to allow children leaving foster care upon reaching age 18 to keep their Medicaid coverage.

  Of the ten states that expanded coverage for children, four were implementing expansions that were authorized last year, but which had been held back by the August 17th directive or by the uncertainty surrounding SCHIP reauthorization. *Louisiana* and *Indiana* increased eligibility to 250 percent of the federal poverty line, rather than 300 percent. *Wisconsin* and *New York* chose to move forward with their full expansions, funding coverage over 250 percent of the federal poverty line with state funds only. *Illinois* has been funding its expansion using state dollars. Planned expansions in five additional states (*NC, OH, OK, WA*, and *WV*) remain stalled.

Iowa Children Get A Coverage Boost

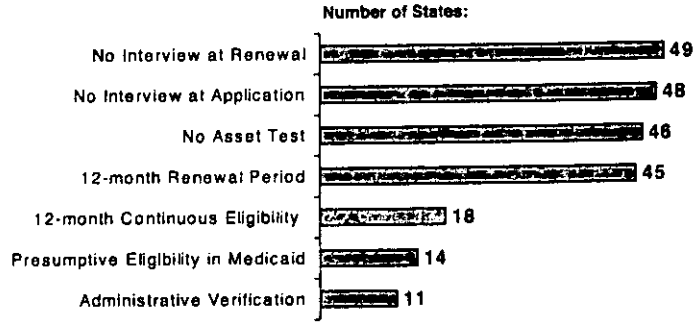
Buoyed by a groundswell of public support for covering children, Iowa Governor Chet Culver, along with state legislators, remain strong in their pledge to expand health insurance to more of the state's uninsured children. In the last legislative session, state legislators passed an expansion of hawk-i, the state's SCHIP program, to 300 percent of the federal poverty line, which will be implemented in July 2009, and cover an estimated 5,000 new children. Program improvements have already proceeded. The state now guarantees children a full 12 months of continuous coverage and is pursuing ways to ease premium payment policies. For example, families new to the program will not have to pay premiums for the first two months of enrollment. Outreach is expected to go forward as well, but may possibly be scaled back. Like many other states, Iowa is in a severe budget crunch, with an expected shortfall of more than $600 million in the coming year. Major spending cuts are being planned, but it appears that the children's coverage expansion will go forward. Senate Majority Leader, Mike Gronstal (D) stated recently, "We committed to providing access to affordable coverage to every kid in the state of Iowa. I'm not interested in backing up on that commitment."

* "Health Promises Persist: Iowa lawmakers reconcile health care goals, budget" The Hawkeye, January 15, 2009.

- **Eleven (11) states took steps to reduce procedural barriers to coverage for children (Figure 8).** *Arizona, Kentucky,* and *Utah* no longer require families to participate in face-to-face interviews to obtain health coverage for their children, and *Colorado* adopted "administrative verification and renewal," meaning the state no longer requires families to provide paper documentation of their income and eligibility workers use existing databases to verify the information families provide on the application. *Maryland, Montana, Louisiana, South Carolina* and *Utah* have revised their applications to allow parents to apply using the same simplified forms that are used for children, a change that benefits both children and parents. *Iowa, North Dakota* and *Oregon* now guarantee 12 months of continuous eligibility, considered to be one of the most effective tools for keeping children covered for as long as they qualify. One serious setback, the changes to the renewal procedures in *California,* was discussed earlier.

Figure 8

Simplifying Enrollment and Renewal: Strategies States are Using in Children's Health Coverage Programs, Jan 09



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2009.

States Explore the Use of Technology to Facilitate Enrollment

Emergence of Online Applications

About half the states reported that they are implementing, or are in the process of designing, on-line applications. Several of these states also report allowing the use of electronic signatures, so that a follow-up signature page does not have to be printed and mailed in. (Other states appear unsure about the permissibility of electronic signatures and point to the lack of clear federal guidance on this subject.) Some states at the forefront of using on-line applications also report that their applications currently interface with existing eligibility systems (or will in the future), so that information from the on-line application does not have to be re-entered by eligibility workers and an eligibility determination can move forward more rapidly.

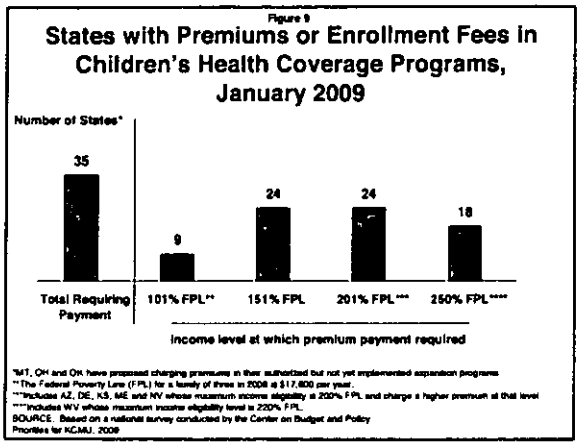
Database Usage

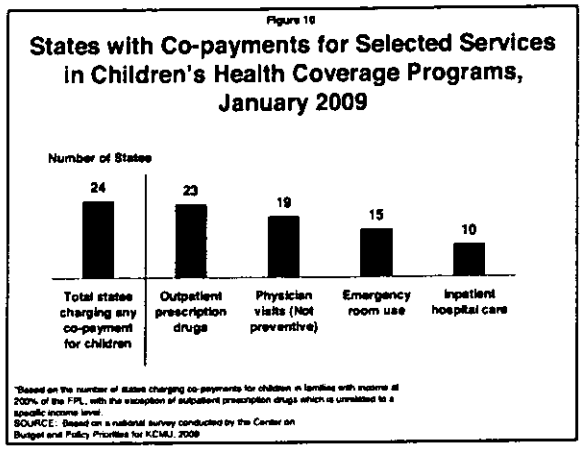
Eleven states (12 states at renewal) report using technology to streamline the enrollment and renewal process. States report conducting matches with existing databases to verify income and other information, as well as eliminating rules requiring families to submit pay stubs or other paper documentation. This procedure is referred to as "administrative verification and renewal." Many states also are conducting data matches with their Vital Records departments to help families comply with the Medicaid citizenship documentation requirement, however, the technological capacity to do this efficiently varies considerably. Finally, states are exploring the use of technology to target outreach, for example, by conducting data matches with existing databases to identify children and parents who are likely to qualify for health coverage but who are not enrolled. States report using matches with food stamp databases for this purpose, and have expressed interest in using state tax system databases.

- **Outreach budgets in a number of states were increased in 2008, however, some states are beginning to report that these funds are being curtailed.** Several states reported increases in outreach funding in 2008, sometimes associated with new expansions, but also for ongoing promotional activities and community-based application assistance. In recent follow-up interviews, some state officials indicated that their outreach budgets have now been cut; others expressed skepticism for conducting aggressive outreach in light of budget shortfalls. Still others said their outreach activities would go forward, with some indicating that activities would emphasize renewal assistance so that already enrolled children do not lose coverage.

- **A few states reduced financial barriers to children's coverage, eliminating or lowering premiums for some children, while other states increased premiums (Figure 9).** *Tennessee, Washington* and *Wisconsin* either reduced premiums or eliminated them for some children. *Georgia, Minnesota, Missouri, Nevada, New Jersey, Pennsylvania* and *Rhode Island* increased premiums for children, with two of these states showing significant increases. *Minnesota* premiums increased by up to $14 per month for some children. Premium increases in *Rhode Island*, discussed earlier, represented the most severe increases for children this year. New premiums implemented in *Louisiana*, apply to the state's new expansion group (children with incomes between 200 percent and 250 percent of the federal poverty line).

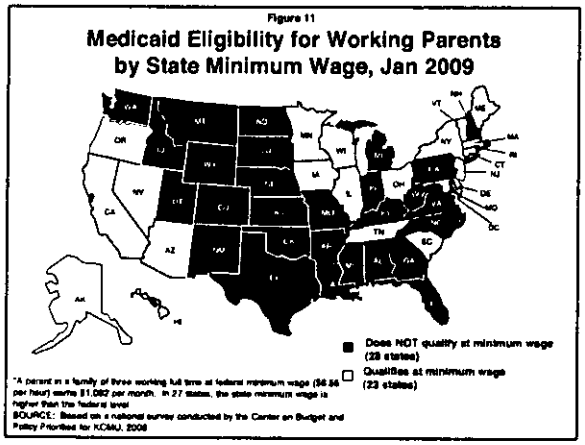
- **Co-payments for health services were adopted in one state and increased in two states (Figure 10).** Currently, 24 states charge co-payments for children's health services. *Wisconsin* adopted new co-payments, and *West Virginia* and *Utah* increased co-payments for prescription drug coverage. Only one state, *Montana* decreased co-payment amounts.

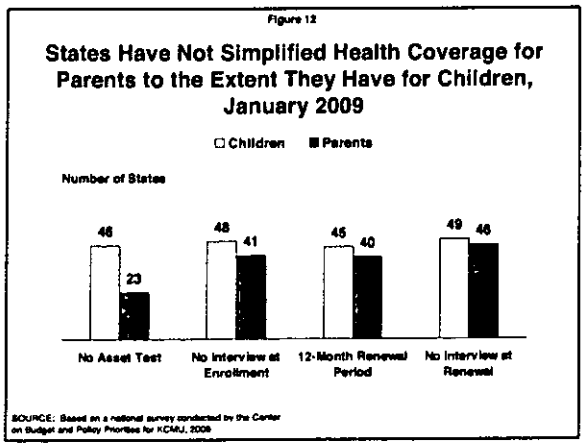




Low-income parents applying for Medicaid coverage continue to face substantially restricted income eligibility and access as compared to their children (Figure 11 and 12).

- **A few states took steps to boost coverage and simplify procedures for parents.** Three states — *New Jersey, Maryland,* and *Wisconsin* — implemented parent coverage expansions. Still, in 28 states, parents working full time at minimum wage cannot qualify for Medicaid. One state, *Rhode Island*, cut parent coverage. *Maryland* also stopped counting assets in determining eligibility for parents, a step that fewer than half the states have taken. Given the restrictive income eligibility levels for parents in most states, the majority of parents applying are not likely to have substantial bank accounts, multiple vehicles of significant value, or other resources that would disqualify them. The burdensome and intrusive paperwork associated with proving that one does not exceed the asset limit often deters eligible parents from completing the application process. Other measures were implemented to reduce procedural barriers for parents, including eliminating interviews and reducing the frequency of renewal (*AZ, MD, UT*), but these practices are still more prevalent in children's coverage programs.





Maryland Expands Medicaid Eligibility for Low-Income Parents

Access to health coverage increased measurably for thousands of low-income Maryland parents this year when an income eligibility expansion and a package of procedural improvements were implemented on July 1, 2008. The state boosted parent eligibility from about 30 percent of the federal poverty line to 116 percent. The state also eliminated the asset test and no longer requires parents to have a face-to-face interview at the Medicaid office. This streamlined the process for parents and also aligned procedures for parents and children to a greater extent so that they can apply using the same simplified application form. Since its implementation, 29,682 adults have enrolled as a result of the expansion.

To achieve this early success, a logical first step was to identify children already in Medicaid whose family income is below 116 percent of the federal poverty line and enroll the parents when they renew their child's coverage. Traditional outreach efforts including TV, print and radio publicity, as well as activities with the Baltimore Ravens football team, also have done much to inform families about the new coverage opportunity. In addition, the Medicaid and revenue agencies coordinated on a new initiative that used the tax system to identify 150,000 people who were potentially eligible. They were sent a letter from the state Comptroller inviting them to call a toll-free number for an application. Between December 1 and December 12, 2008, nearly 1,800 hotline callers were sent applications. Others obtained applications on-line and through other avenues.

Enrollment continues to increase and the recession is apparently a driving force: there were more approvals of parents in the expansion group during the first two weeks in December than there have been since it was implemented in July and state officials say they are seeing people who previously had secure jobs and are seeking help, perhaps for the first time. The budget is tight in Maryland, but in two rounds of cuts, the expansion has not been targeted.

*Conversations with Maryland State Officials, January 2009.

- **Income eligibility for pregnant women remained stable with nearly half the states covering pregnant women at 185 percent of the federal poverty line.** Two states, *Tennessee* and *Wisconsin*, increased eligibility for pregnant women to 250 percent and 300 percent of the federal poverty line respectively. *Oklahoma* and *Oregon* both adopted the option to use SCHIP funds to cover unborn children of pregnant women.

V. Discussion

Recession Jeopardizes States' Ability to Maintain and Advance Coverage for Low-Income Children and Parents

States have made substantial progress in reducing barriers to health coverage for low-income children and families. They continued to do so during the first half of 2008 by further expanding eligibility and streamlining enrollment and renewal procedures. Now, as the economic crisis deepens, states will be under major pressure to contain costs. This may lead them to take steps that would not only reverse critical coverage gains, but would intensify the hardships so many families are already facing as a result of losing their jobs and their health insurance. In the last economic downturn, federal fiscal relief was successful in helping states address budget shortfalls, avoid deeper Medicaid cuts, and preserve eligibility, which was a condition of receiving enhanced federal funds. However, to deal with tight budgets, many states made procedural changes to their programs which blocked eligible children and parents from obtaining coverage at a time when they could least afford health care on their own.

Easing Eligibility and Simplifying Procedures Are Especially Important During an Economic Downturn

Individuals who have lost health coverage due to unemployment need a smooth path to Medicaid and SCHIP.[8] Any period of time without insurance could cause ongoing medical conditions to escalate if it is not possible for families to find or pay for needed medication or other treatment on their own. Parents who are recently unemployed may find that the unemployment compensation payments they receive put them over the income limit for Medicaid. States can choose to disregard these payments or a portion of them in determining eligibility for jobless parents. States can eliminate their SCHIP waiting periods or at least ensure that a job-loss exemption is available. Minimizing documentation requirements and rescinding face-to-face interviews also are important since complicated, burdensome forms and procedures often discourage families from completing the process. Enrolling children for a full 12 months and simplifying renewal helps ensure beneficiaries remain covered for as long as they qualify. In addition to protecting children and families, taking such steps also saves administrative costs by reducing the workload on eligibility workers. Eligibility staff may have been cut at the same time application volume has increased.

Premium Payment Policies Matter

It also is important to ensure that unreasonable out-of-pocket costs do not keep eligible children from obtaining coverage and needed care. When a family has lost income or a job, it will be more difficult to keep up with premium payments on top of regular living expenses. Numerous studies show that premiums for low-income individuals can depress enrollment in health coverage programs.[9] Similarly, burdensome co-payments can be an obstacle to getting needed care or medication. Programs should also avoid imposing strict payment timeframes after which children are disenrolled from SCHIP, as well as lock-out periods that bar children from returning to SCHIP if the lack of a premium payment forces them to lose coverage.

Outreach Is Critical During Economic Downturns

In tight budget times, it may appear sensible to cut outreach funds as states seek ways to contain the costs associated with expanding caseloads. Conducting outreach may also seem counterintuitive when hiring freezes and lay-offs mean there are fewer eligibility workers to process a larger volume of applications. However, families that previously had stable jobs with health insurance are likely to have little or no experience navigating the public benefits system. They may not know where to turn for help when they become jobless, nor are they likely to know much about Medicaid and SCHIP or realize that they may qualify. Community-based organizations and institutions can play a vital role in alerting families to the availability of free or low-cost coverage and in assisting families with application procedures.

States are attempting to balance these competing pressures. For example, although New Mexico has had to make significant cuts to its Medicaid budget, the state will continue to reach out and enroll more uninsured children, a goal Governor Richardson has prioritized. A state Medicaid official explained that, while available funding will continue to be used for outreach, "the state does not have funds to do anything very aggressive or costly. It's difficult to justify spending on outreach when we're cutting elsewhere, however we will conduct some data matches to identify eligible but unenrolled children."[10] Given the demands that outreach generates and the limitations created by personnel cuts, adopting simplified procedures are more important that ever. Streamlining renewal, in particular, protects the investment in outreach since it guards against eligible children and parents losing coverage unnecessarily.

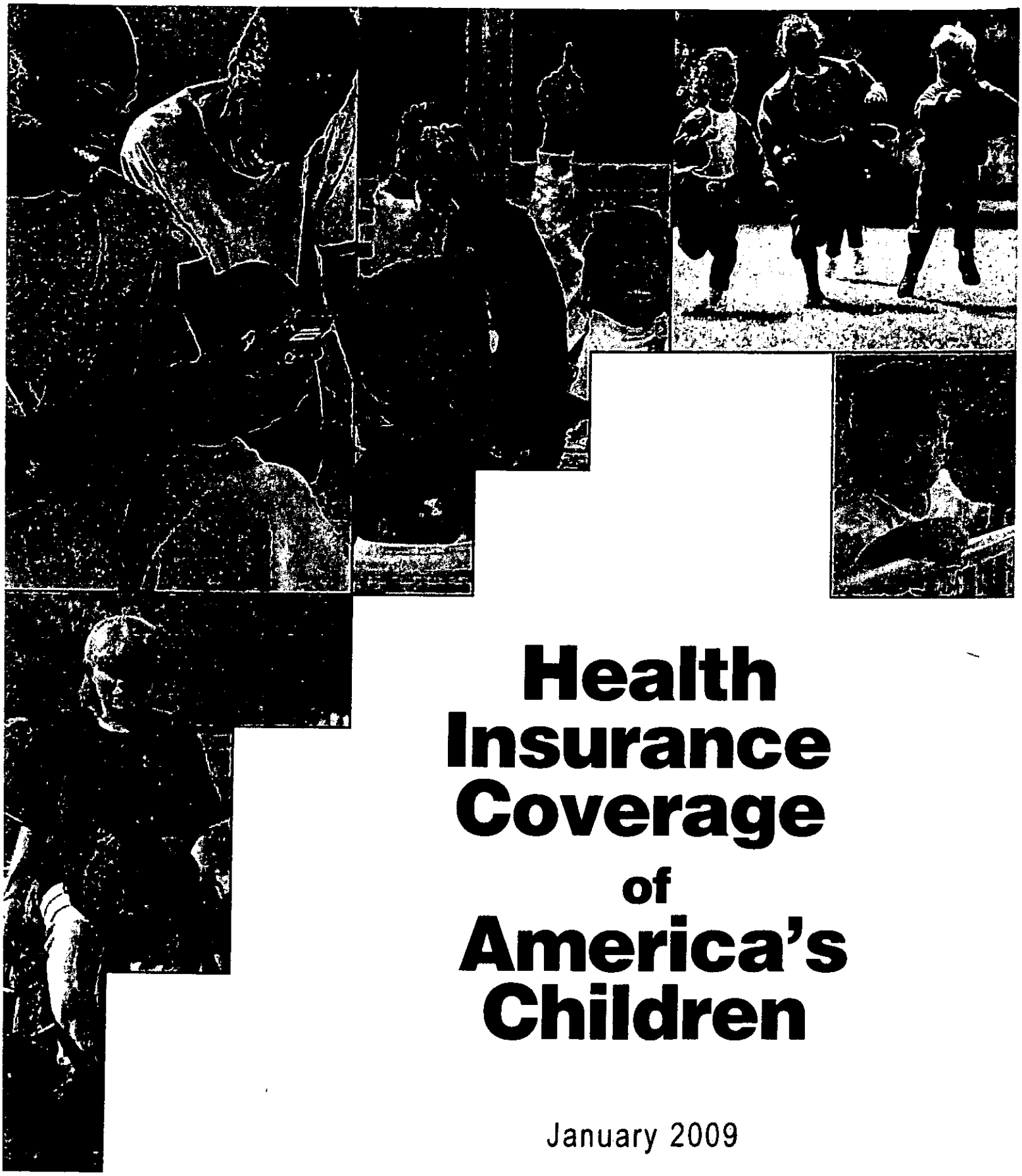
Federal Legislation May Provide Needed Help for States

Two major pieces of legislation are being considered in Congress as this report is being written. Both are critical to addressing the challenges states are facing as they report mounting deficits and also attempt to assist the growing demand for health coverage among families that are suffering the effects of the weakening economy. The first is reauthorization and extension of SCHIP legislation, which is currently operating with temporary funding through March 2009. This legislation would provide the additional funds to maintain coverage for children currently enrolled and cover additional uninsured children. It would also provide bonus payments designed to encourage states to enroll more eligible children under Medicaid.

The second piece of legislation is the economic recovery package. In this recession, with substantial state deficits, one form of assistance the federal government could provide is an increase in the federal share of financial assistance for the Medicaid program (FMAP). The amount of funding for the enhanced FMAP, the duration of the relief, the distribution of the funds across states, and the conditions or maintenance of effort requirements related to eligibility are critical issues in the design of a recovery package. In 2003, one of the conditions for states receiving an increased FMAP was that they were prohibited from reducing eligibility levels in order to qualify for this financial assistance. Congress could also consider requiring states to maintain enrollment procedures to qualify for federal assistance and additional provisions to extend temporary Medicaid coverage to individuals affected by the economic downturn.

The SCHIP reauthorization and economic recovery plan could provide an essential boost that would enable states to sustain the coverage gains they have achieved and give families hard-hit by the recession the confidence that assistance with health coverage will be available.

[1] Kaiser Commission on Medicaid and the Uninsured analysis of the National Health Interview Survey data.
[2] Donna Cohen Ross, Aleya Horn and Caryn Marks, "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles," Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.
[3] Letter from Dennis Smith, Director for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, to State Health Officials, August 17, 2007.
[4] Elizabeth McNichol and Iris Lav, *State Budget Troubles Worsen,* Center on Budget and Policy Priorities, Washington, DC, *Updated,* January 14, 2009.
[5] Donna Cohen Ross and Laura Cox, Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2004.
[6] *Ibid.*
[7] Nicholas Johnson, Phil Oliff and Jeremy Koulish, "Facing Deficits, Two-Thirds of States Are Imposing Cuts that Hurt Vulnerable Residents," Center on Budget and Policy Priorities, Washington, DC, Updated January 14, 2009.
[8] Michael Perry, Barbara Lyons, Robin Rudowitz and Julia Paradise, "Turning to Medicaid and SCHIP in an Economic Recession: Conversations with Recent Applicants and Enrollees," Kaiser Commission on Medicaid and the Uninsured, December 2009.
[9] Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent States Experiences," Kaiser Commission on Medicaid and the Uninsured, 2005.
[10] Conversation with Robert D. Beardsley, Deputy Director, Medical Assistance Division, New Mexico Department of Human Services, January 12, 2009.



Health Insurance Coverage of America's Children

January 2009

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

3243

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

Health Insurance Coverage of America's Children

Karyn Schwartz and Jhamirah Howard
Kaiser Commission on Medicaid and the Uninsured

With

Aimee Williams and Allison Cook
The Urban Institute

THE HENRY J. KAISER FAMILY FOUNDATION

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Medicaid and the Uninsured

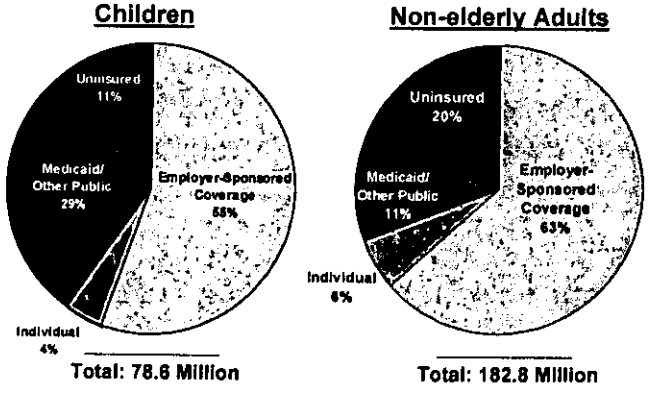
3245

Health Insurance Coverage of America's Children
2007

**Thirty-four million—over 40% of all children—are from poor or near-poor families.
Over twenty million rely on Medicaid and SCHIP for health insurance.
Nearly nine million children were uninsured in 2007.**

There are about 79 million children in the United States and their access to health care is determined in large part by whether or not they have health insurance coverage. Uninsured children are less likely to have a medical home compared to those with health insurance. Needed care is more likely to be postponed and uninsured children are also less likely to see a physician or dentist for standard preventive care. Unhealthy children miss school and their parents miss work to care for them – just some of the consequences the nearly 9 million uninsured children in the U.S. experience.

Health Insurance Coverage of Children And Adults, 2007



Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Children are at greater risk than adults of being uninsured because as a group they are more likely to be poor. While about a third of adults under age 65 come from low-income families (incomes less than twice the poverty level, which in 2007 was about $42,000 for a family of four) — more than 40% of children come from low-income families. However, children are much less likely than adults to be uninsured (11% vs. 20% in 2007) because of two public insurance programs: Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid and SCHIP cover all children whose family incomes are below levels set by individual states that are at or above federal minimum requirements.

Medicaid, SCHIP, and other state programs for children's coverage play an important role in providing health insurance for children. The programs cover more than 60% of all poor children (family incomes less than the poverty level) and about 40% of near-poor children (those with family incomes between one and two times the poverty level). Including higher income children with disabilities who qualify, these public programs insure more than a quarter of all children in the United States.

This chartbook provides essential facts about children's health insurance coverage today. Using the most recent Census Bureau data available (2007), it examines children's coverage by:

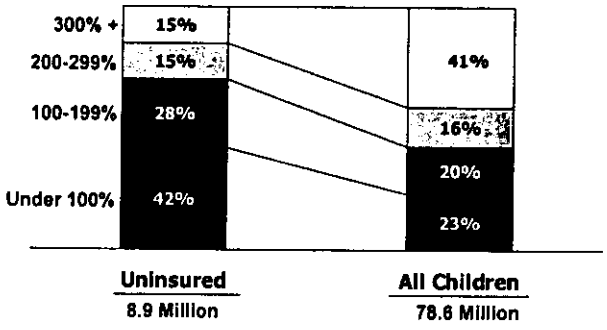
- family income
- family work status
- type of family or household
- age
- health status
- race and ethnicity
- citizenship status, and
- geographic region.

In addition to figures, each section also contains tables that provide more detailed information about family income and health insurance. For example, estimates of the share of uninsured children in families with full-time workers who are from poor, near-poor, middle-income or higher income families are included in the tables. Not all subgroups of children could be analyzed in this way however, because the survey sample size was not large enough to produce reliable estimates in all cases. Due to small sample sizes, two years of data, from 2006 and 2007, were used to analyze health coverage of children by race and ethnicity, citizenship and health status. Sample sizes were too small for Asian, American Indian, and multiracial children to analyze their health coverage by income groups. In addition, a set of state-level tables (for all children, low-income children, and uninsured rates by poverty level) can be found at the end of the chartbook.

Family Poverty Level and Health Coverage

While 43% of all children come from poor or near-poor families, more than two-thirds (70%) of uninsured children come from low-income families (less than 200% of the poverty level, e.g., about $42,000 for a family of four in 2007). The majority of low-income children do not have private health insurance.

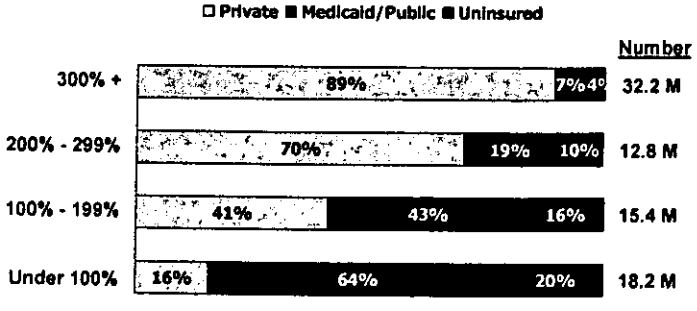
Uninsured Children vs. All Children, by Family Poverty Level, 2007



The Federal Poverty Level for a family of four in 2007 was $21,203 (according to the U.S. Census Bureau's poverty threshold). Family size and total family income are grouped by insurance eligibility. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Public insurance programs—Medicaid, SCHIP, and other state programs—are essential sources of coverage for children in this country, covering nearly two-thirds of all poor children and more than 40% of near-poor children. However, one in five poor children and 16% of near-poor children remain uninsured. Most of these low-income uninsured children are eligible for Medicaid or SCHIP, but confusion over who qualifies for these programs and an enrollment process that can be difficult to navigate have left many uninsured

Children's Health Insurance Coverage by Family Poverty Level, 2007

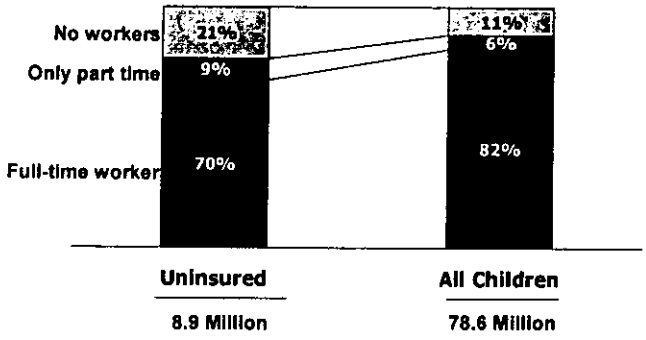


Data may not total 100% due to rounding. The Federal Poverty Level for a family of four in 2007 was $21,203 (according to the U.S. Census Bureau's poverty threshold). Family size and total family income are grouped by insurance eligibility. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Work Status and Health Coverage

Although job-based health insurance is declining, it still covers more than half of children in this country. However, not all working families have access to, or can afford, employer-sponsored insurance. Seventy percent of uninsured children live in families where there is at least one full-time worker.

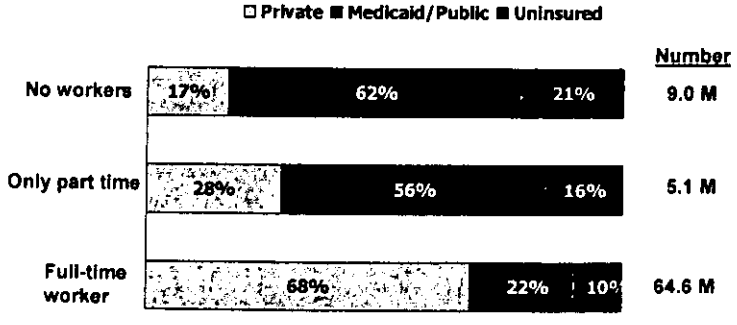
Uninsured Children vs. All Children, by Family Work Status, 2007



Data may not total 100% due to rounding. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Just over one fifth of children in families with a full-time worker are covered by Medicaid or other public insurance; leaving 10% of this large group of nearly 65 million children with no health insurance. Fewer than one-third of low-income children living in families with at least one full-time worker have employer-sponsored insurance.

Children's Health Insurance Coverage by Family Work Status, 2007



Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Distribution of Uninsured Children in Each Poverty Category by Family Work Status 2007

Poverty Level	Number	Distribution	1 or 2 Full-time Workers	Part-time Workers or No Workers	Total
<100%	3,718,880	41.9%	38.4%	61.6%	100.0%
100-199%	2,505,489	28.2%	90.9%	—	100.0%
200-299%	1,319,593	14.9%	94.5%	—	100.0%
300%+	1,328,125	15.0%	94.1%	—	100.0%
Total	8,872,087	100.0%	69.9%	30.1%	100.0%

Health Insurance Coverage of Children By Family Work Status and Family Income (Federal Poverty Levels, FPL) 2007

Children in Families with Full-Time Workers

	Children of FT Workers		Distribution by Coverage Type					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	6,965,231	10.8%	13.2%	2.5%	62.7%	1.1%	20.5%	100.0%
100-199%	13,724,645	21.2%	38.9%	3.4%	39.9%	1.2%	16.6%	100.0%
200-299%	12,269,354	19.0%	66.9%	4.5%	16.7%	1.8%	10.2%	100.0%
300%+	31,642,412	49.0%	84.6%	4.9%	5.2%	1.3%	3.9%	100.0%
Total	64,601,642	100.00%	63.8%	4.3%	21.0%	1.3%	9.6%	100.0%

Children in Families with Only Part-Time Workers or No Workers

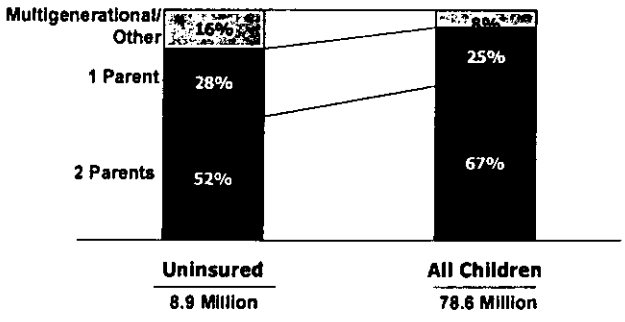
	Children of PT or No Workers		Distribution by Coverage Type					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	11,250,321	80.1%	12.3%	3.4%	62.3%	1.6%	20.4%	100.0%
100-199%	1,633,347	11.6%	—	—	53.4%	—	—	100.0%
200-299%	560,811	4.0%	—	—	—	—	—	100.0%
300%+	599,100	4.3%	—	—	—	—	—	100.0%
Total	14,043,579	100.0%	16.1%	5.1%	58.1%	1.7%	19.0%	100.0%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.
Estimates with relative standard errors greater than 30% are not provided.

Household Type and Health Coverage

Most children live in households with two parents (67%), as do over half of uninsured children. Uninsured children however, are more likely than others to live with just one parent and/or with grandparents, or other extended family members (referred to as multigenerational and other households here).

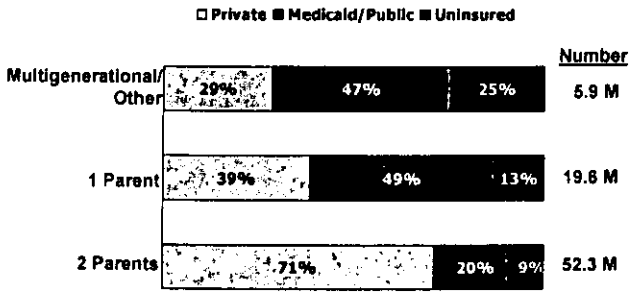
Uninsured Children vs. All Children, by Household Type, 2007



Children includes all individuals under age 19. Approximately 1% of children live in households with no adult, three-quarters of whom are 17-18 years old.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS

Children living with two parents are the most likely to have private health insurance (71%) because family incomes are generally higher and there are potentially two sources for employer-based insurance. Children living with one parent are more likely to qualify for Medicaid and SCHIP and, for them, these programs are the primary source of health insurance, covering nearly half of these children (49%). Children living with extended family are the least likely to have health coverage—25% are uninsured.

Children's Health Insurance Coverage by Household Type, 2007



Data may not total 100% due to rounding. Children includes all individuals under age 19
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS

Distribution of Uninsured Children in Each Poverty Category by Household Type 2007

Poverty Level	Number	Distribution	2 Parents with Children	1 Parent with Children	Multigenerational/ Other with Children*	Total**
<100%	3,718,880	41.9%	31.8%	32.7%	30.7%	95.1%
100-199%	2,505,489	28.2%	59.7%	30.9%	—	98.2%
200-299%	1,319,593	14.9%	70.0%	—	—	98.8%
300%+	1,328,125	15.0%	79.4%	—	—	99.1%
Total	8,872,087	100.0%	52.5%	28.3%	16.3%	97.2%

Health Insurance Coverage of Children By Household Type and Family Income (Federal Poverty Levels, FPL) 2007

Children in Households with Two Parents

Poverty Level	Children in Households with Two Parents: Number	Children in Households with Two Parents: Distribution	Distribution by Coverage Type: Private: Employer	Private: Individual	Public: Medicaid	Public: Other	Uninsured	Total
<100%	5,245,365	10.0%	12.4%	3.1%	60.0%	2.0%	22.5%	100.0%
100-199%	8,988,262	17.2%	39.0%	3.8%	38.9%	1.6%	16.7%	100.0%
200-299%	9,431,282	18.0%	68.4%	4.2%	15.8%	1.9%	9.8%	100.0%
300%+	28,682,866	54.8%	85.5%	4.7%	4.8%	1.3%	3.7%	100.0%
Total	52,347,775	100.0%	67.1%	4.3%	18.2%	1.5%	8.9%	100.0%

Children in Households with One Parent

Poverty Level	Children in Households with One Parent: Number	Children in Households with One Parent: Distribution	Distribution by Coverage Type: Private: Employer	Private: Individual	Public: Medicaid	Public: Other	Uninsured	Total
<100%	8,218,291	41.9%	10.8%	2.2%	70.9%	1.2%	14.8%	100.0%
100-199%	5,409,126	27.6%	34.4%	3.7%	46.6%	0.9%	14.3%	100.0%
200-299%	2,868,233	14.7%	58.2%	7.2%	22.9%	—	10.3%	98.5%
300%+	3,114,507	15.9%	72.4%	9.5%	9.8%	1.1%	7.3%	100.0%
Total	19,630,157	100.0%	34.1%	4.5%	47.5%	1.2%	12.8%	100.0%

* Multigenerational/other households with children include families with at least three generations in a household, plus families in which adults are caring for children other than their own (e.g. a niece living with her aunt).

** Totals do not equal 100% because approximately 3% of uninsured children live in households with no adult.

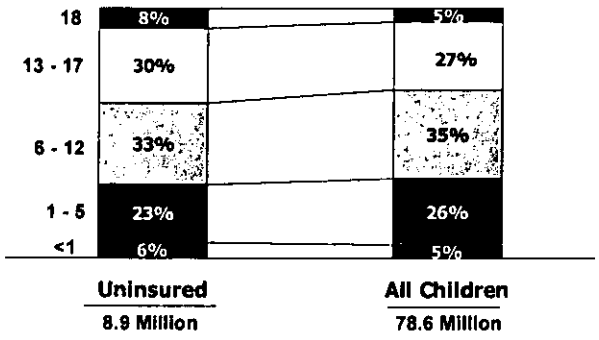
( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.

Estimates with relative standard errors greater than 30% are not provided.

Age and Health Coverage

Uninsured children span the age spectrum, but 18 year-olds are at the greatest risk of being uninsured, in part because some of them are no longer living at home and may no longer be dependents. Infants compose 6% of the uninsured, and they are particularly vulnerable to the negative effects of being uninsured given their high health care needs.

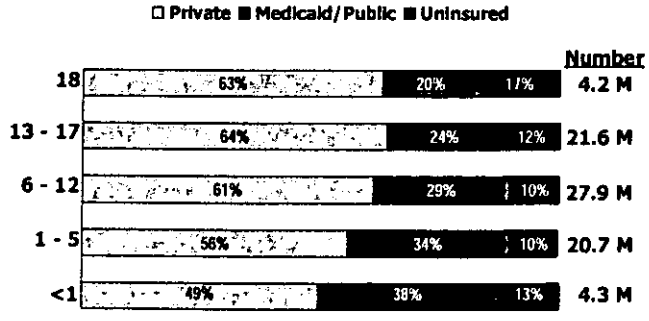
Children
Uninsured vs. Population, by Age Group, 2007



Data may not total 100% due to rounding. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Younger children are more likely to be insured by Medicaid or other public coverage. Were it not for Medicaid and SCHIP, the chances of being uninsured among children would be much higher, particularly among pre-schoolers and infants.

Children's Health Insurance Coverage by Age Group, 2007



Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Distribution of Uninsured Children in Each Poverty Category by Age 2007

Poverty Level	Number	Distribution	0-5 Years Old	6-12 Years Old	13-18 Years Old	Total
<100%	3,718,880	41.9%	31.4%	29.9%	38.7%	100.0%
100-199%	2,505,489	28.2%	29.3%	35.8%	34.9%	100.0%
200-299%	1,319,593	14.9%	---	---	---	100.0%
300%+	1,328,125	15.0%	---	---	---	100.0%
Total	8,872,087	100.0%	29.5%	32.7%	37.8%	100.0%

Health Insurance Coverage of Children By Age and Family Income (Federal Poverty Levels, FPL) 2007

Children 0-5 Years Old

Poverty Level	Children 0-5 Years Old		Distribution by Coverage Type					
			Private		Public		Uninsured	
	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	6,756,102	27.1%	9.9%	1.2%	69.9%	1.8%	17.3%	100.0%
100-199%	5,039,908	20.2%	34.9%	2.2%	46.8%	1.5%	14.5%	100.0%
200-299%	3,846,182	15.4%	65.4%	3.1%	19.7%	2.2%	9.6%	100.0%
300%+	9,301,704	37.3%	85.2%	4.4%	5.8%	0.9%	3.7%	100.0%
Total	24,943,896	100.0%	51.6%	2.9%	33.6%	1.5%	10.5%	100.0%

Children 6-12 Years Old

Poverty Level	Children 6-12 Years Old		Distribution by Coverage Type					
			Private		Public		Uninsured	
	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	5,994,682	21.5%	13.6%	1.9%	64.8%	1.1%	18.6%	100.0%
100-199%	5,727,292	20.6%	39.1%	3.0%	41.0%	1.2%	15.7%	100.0%
200-299%	4,748,092	17.0%	68.7%	3.7%	16.7%	1.4%	9.5%	100.0%
300%+	11,385,104	40.9%	85.0%	4.6%	5.3%	1.3%	3.9%	100.0%
Total	27,855,170	100.0%	57.4%	3.5%	27.4%	1.2%	10.4%	100.0%

Children 13-18 Years Old

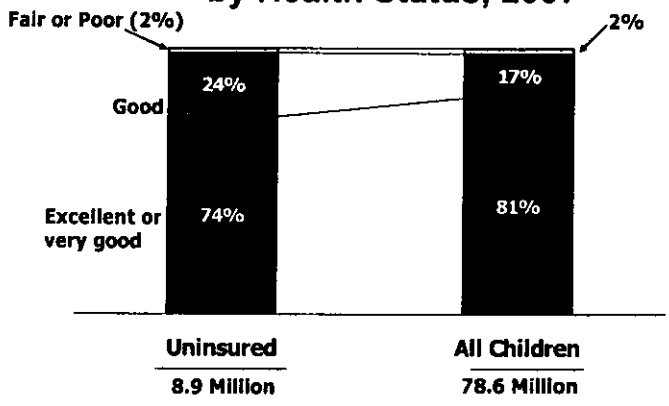
Poverty Level	Children 13-18 Years Old		Distribution by Coverage Type					
			Private		Public		Uninsured	
	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	5,464,768	21.1%	15.0%	6.7%	50.7%	1.2%	26.3%	100.0%
100-199%	4,590,791	17.8%	37.2%	6.9%	35.7%	1.2%	19.0%	100.0%
200-299%	4,235,891	16.4%	62.3%	7.7%	16.5%	1.7%	11.8%	100.0%
300%+	11,554,704	44.7%	82.0%	6.5%	5.2%	1.7%	4.7%	100.0%
Total	25,846,154	100.0%	56.7%	6.8%	22.1%	1.5%	13.0%	100.0%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.
Estimates with relative standard errors greater than 30% are not provided.

Health Status and Health Coverage

Uninsured children are somewhat less likely to be in the best health compared to all children. While 81% of all children are reported to be in excellent or very good health, only 74% of uninsured children are in such good health.

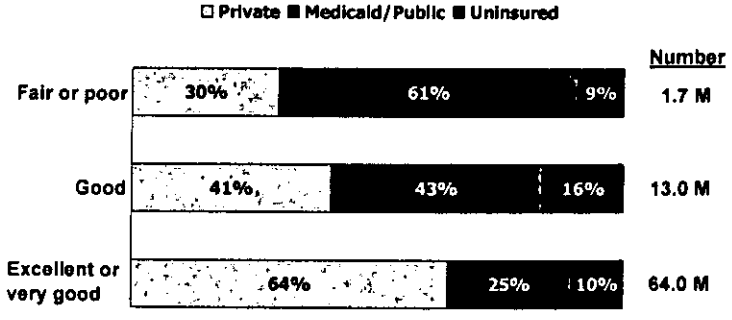
Uninsured Children vs. All Children, by Health Status, 2007



Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Among children in the worst health (reported as fair or poor), the majority are covered by Medicaid and other public insurance, and just 30% are enrolled in private insurance. In contrast, nearly two-thirds of children in the best of health are insured privately, and a quarter are covered by public programs.

Children's Health Insurance Coverage by Health Status, 2007



Data may not total 100% due to rounding. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Distribution of Uninsured Children in Each Poverty Category by Health Status 2006-2007

Poverty Level	Number	Distribution	Excellent/ Very Good Health	Good Health	Fair/Poor Health	Total
<100%	3,790,701	41.4%	71.6%	25.7%	2.6%	100.0%
100-199%	2,570,213	28.1%	73.6%	24.3%	2.1%	100.0%
200-299%	1,368,470	14.9%	79.6%	19.0%	—	100.0%
300%+	1,427,696	15.6%	81.7%	17.3%	—	100.0%
Total	9,157,079	100.0%	74.9%	23.0%	2.0%	100.0%

Health Insurance Coverage of Children By Health Status and Family Income (Federal Poverty Levels, FPL) 2006-2007

Children in Excellent or Very Good Health

	Children in Excellent or Very Good Health		Distribution by Coverage					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	12,791,998	20.0%	14.8%	3.7%	58.8%	1.5%	21.2%	100.0%
100-199%	11,834,852	18.5%	39.6%	4.1%	38.8%	1.5%	16.0%	100.0%
200-299%	10,788,851	16.9%	67.2%	5.1%	15.9%	1.8%	10.1%	100.0%
300%+	28,572,119	44.7%	85.1%	5.2%	4.4%	1.1%	4.1%	100.0%
Total	63,987,820	100.0%	59.6%	4.7%	23.6%	1.4%	10.7%	100.0%

Children in Good Health

	Children in Good Health		Distribution by Coverage					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	4,394,215	34.5%	9.2%	2.2%	65.5%	1.0%	22.2%	100.0%
100-199%	3,215,836	25.2%	28.7%	3.1%	47.6%	1.3%	19.4%	100.0%
200-299%	2,036,539	16.0%	57.7%	4.1%	23.3%	2.1%	12.8%	100.0%
300%+	3,090,649	24.3%	75.4%	4.3%	11.1%	1.2%	8.0%	100.0%
Total	12,737,239	100.0%	37.9%	3.2%	41.0%	1.3%	16.5%	100.0%

Children in Fair or Poor Health

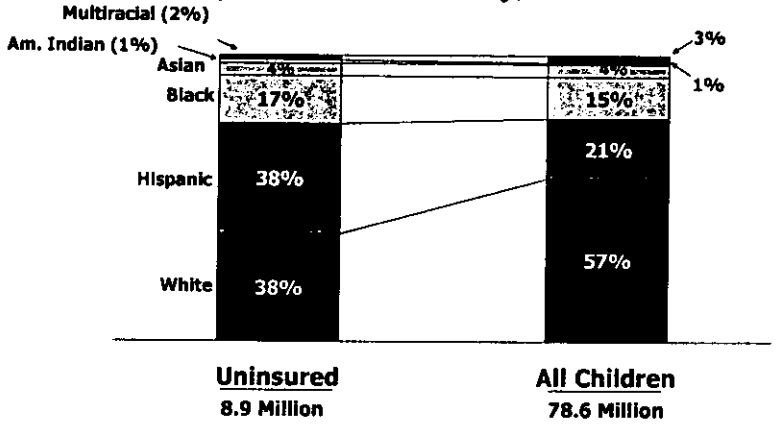
	Children in Fair or Poor Health		Distribution by Coverage					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	660,784	38.9%	5.3%	—	(75.8%)	—	15.1%	100.0%
100-199%	441,960	26.0%	19.4%	—	(64.4%)	—	12.5%	100.0%
200%+	597,197	35.1%	(61.7%)	4.0%	27.4%	—	5.4%	100.0%
Total	1,699,941	100.0%	28.8%	3.1%	55.8%	1.3%	11.0%	100.0%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.
Estimates with relative standard errors greater than 30% are not provided.

Race and Health Coverage

Almost 60% of all children are white in this country, but they compose only 38% of uninsured children. As a group, white children come from higher income families, which explains part of the racial and ethnic differences in health coverage. Hispanic children make up just 21% of all children, but 38% of uninsured children.

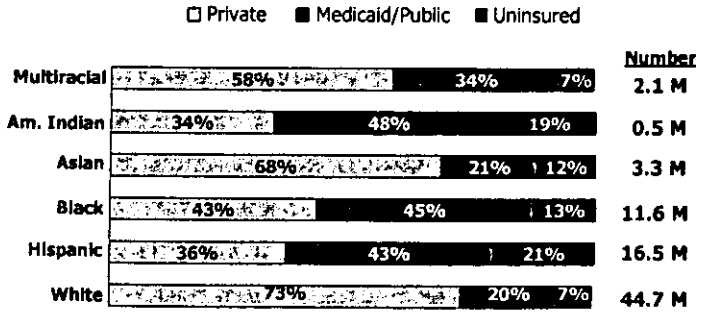
Uninsured Children vs. All Children, by Race and Ethnicity, 2007



Children includes all individuals under age 19. American Indian category includes Aleutian Eskimos. Asian includes South Pacific Islander. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

The majority of white, Asian, and multiracial children have private health insurance, compared to about 40% of Black, Hispanic, and American Indian children combined. Medicaid plays a larger role for low-income groups; still, among all American Indians and Hispanics, about 20% of children are uninsured.

Children's Health Insurance Coverage by Race and Ethnicity, 2007



Children includes all individuals under age 19. American Indian category includes Aleutian Eskimos. Asian includes South Pacific Islander. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Distribution of Uninsured Children in Each Poverty Category by Race 2006-2007

Poverty Level	Number	Distribution	White, Non-Hispanic	Hispanic	Black, Non-Hispanic	Asian	American Indian	Two or More Races	Total
<100%	3,790,701	41.4%	28.6%	40.7%	23.5%	3.4%	1.6%	2.1%	100.0%
100-199%	2,570,213	28.1%	31.6%	47.3%	14.0%	4.7%	1.1%	1.4%	100.0%
200-299%	1,368,470	14.9%	45.5%	34.6%	12.6%	4.2%	1.6%	1.6%	100.0%
300%+	1,427,696	15.6%	60.7%	20.3%	10.6%	5.7%	—	2.1%	100.0%
Total	9,157,079	100.0%	37.0%	38.5%	17.2%	4.3%	1.3%	1.8%	100.0%

Health Insurance Coverage of Children By Race/Ethnicity and Family Income (Federal Poverty Levels, FPL) 2006-2007

White, Non-Hispanic Children

Poverty Level	White, Non-Hispanic Children		Distribution by Coverage					
			Private		Public		Uninsured	
	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	6,169,827	13.8%	17.3%	5.5%	58.2%	1.5%	17.5%	100.0%
100-199%	6,921,195	15.4%	42.7%	5.8%	38.1%	1.8%	11.7%	100.0%
200-299%	7,896,296	17.6%	70.3%	5.9%	14.3%	1.6%	7.9%	100.0%
300%+	23,827,066	53.2%	85.3%	5.7%	4.3%	1.0%	3.6%	100.0%
Total	44,814,384	100.0%	66.7%	5.7%	18.7%	1.3%	7.6%	100.0%

Hispanic Children

Poverty Level	Hispanic Children		Distribution by Coverage					
			Private		Public		Uninsured	
	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	5,573,450	34.4%	9.1%	1.4%	60.6%	1.2%	27.7%	100.0%
100-199%	4,899,464	30.2%	25.7%	2.1%	46.6%	0.9%	24.8%	100.0%
200-299%	2,584,916	15.9%	52.8%	3.0%	23.9%	1.9%	18.3%	100.0%
300%+	3,148,811	19.4%	75.9%	3.6%	10.2%	1.0%	9.2%	100.0%
Total	16,206,641	100.0%	34.0%	2.3%	40.7%	1.2%	21.7%	100.0%

Black, Non-Hispanic Children

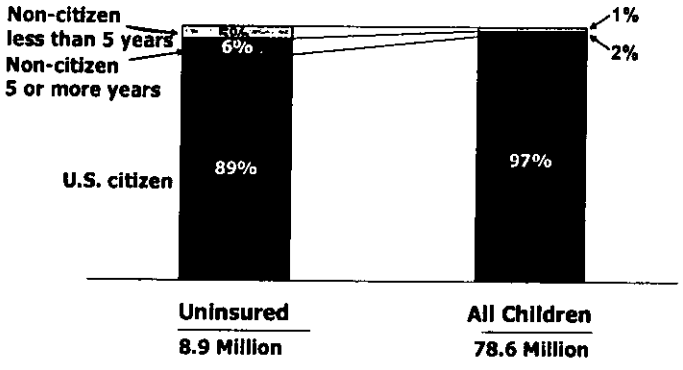
Poverty Level	Black, Non-Hispanic Children		Distribution by Coverage					
			Private		Public		Uninsured	
	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	4,819,168	41.7%	12.1%	2.3%	65.7%	1.3%	18.5%	100.0%
100-199%	2,626,679	22.8%	41.5%	2.6%	40.9%	1.4%	13.7%	100.0%
200-299%	1,677,833	14.5%	63.4%	3.0%	21.3%	2.0%	10.3%	100.0%
300%+	2,420,846	21.0%	81.4%	2.4%	7.5%	2.4%	6.3%	100.0%
Total	11,544,526	100.0%	40.8%	2.5%	41.4%	1.6%	13.7%	100.0%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.
Estimates with relative standard errors greater than 30% are not provided. The sample size was too small to produce reliable estimates of health coverage by income for Asian, American Indians and multiracial children.

Citizenship and Health Coverage

Almost 90% of uninsured children are U.S. citizens. However, non-citizen children are disproportionately represented among the uninsured (11% vs. 3% of all children) in part because they are more likely to be from low-income families and many do not qualify for public coverage. The chances of being uninsured are substantially greater for non-citizen children, who are almost four times as likely to go without coverage as citizen children.

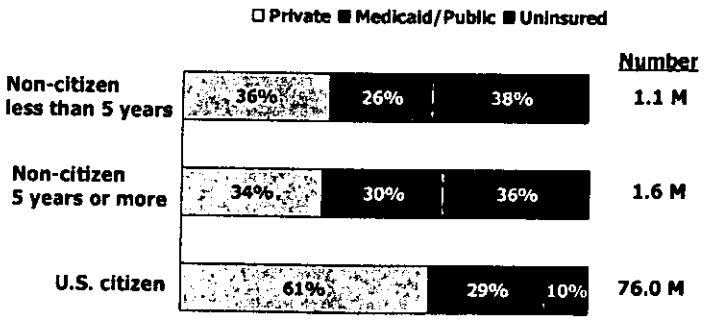
Uninsured Children vs. All Children, by Citizenship Status, 2007



Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Legal immigrants entering the country are only eligible for the full benefits of Medicaid after they have lived here five years unless their state chooses to provide separate coverage for legal non-citizens. Some 38% of non-citizen children who have lived in the U.S. less than five years have no health insurance.

Children's Health Insurance Coverage by Citizenship Status, 2007



Children includes all individuals under age 19. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Distribution of Uninsured Children in Each Poverty Category by Citizenship Status 2006-2007

Poverty Level	Number	Distribution	U.S. Citizen	Non-citizen, Resident 5+ yrs	Non-citizen, Resident <5 yrs	Total
<100%	3,790,701	41.4%	86.1%	7.7%	6.2%	100.0%
100-199%	2,570,213	28.1%	88.0%	7.9%	4.1%	100.0%
200-299%	1,368,470	14.9%	90.6%	5.3%	4.1%	100.0%
300%+	1,427,696	15.6%	95.4%	2.7%	1.9%	100.0%
Total	9,157,079	100.0%	88.8%	6.6%	4.6%	100.0%

Health Insurance Coverage of Children By Citizenship and Family Income (Federal Poverty Levels, FPL) 2006-2007

U.S. Citizen Children

	U.S. Citizen Children		Distribution by Coverage					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	16,809,560	22.2%	13.2%	3.3%	62.6%	1.4%	19.4%	100.0%
100-199%	14,760,010	19.5%	37.4%	4.0%	41.8%	1.5%	15.3%	100.0%
200-299%	12,667,733	16.7%	66.0%	4.9%	17.3%	1.9%	9.8%	100.0%
300%+	31,437,928	41.5%	84.2%	5.1%	5.2%	1.2%	4.3%	100.0%
Total	75,675,231	100.0%	56.3%	4.5%	27.1%	1.4%	10.7%	100.0%

Non-U.S. Citizen Children

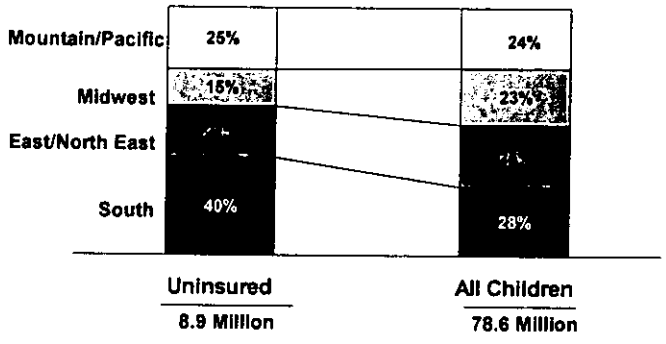
	Non-U.S. Citizen Children		Distribution by Coverage					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	1,037,436	37.7%	10.2%	3.1%	35.7%	--	50.6%	100.0%
100-199%	732,637	26.6%	22.5%	--	32.8%	--	42.2%	100.0%
200-299%	384,222	14.0%	(42.5%)	--	(19.9%)	--	(33.5%)	100.0%
300%+	595,471	21.7%	74.3%	5.2%	8.8%	--	11.0%	100.0%
Total	2,749,766	100.0%	31.9%	3.3%	26.9%	--	37.4%	100.0%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.
Estimates with relative standard errors greater than 30% are not provided.

Region and Health Coverage

Health insurance coverage varies by region, and even by state, depending on the share of families with low incomes, the nature of employment in the area, and the inclusiveness of state Medicaid and SCHIP programs. While fewer than 30% of all children live in ten southern states, about 40% of uninsured children live there.

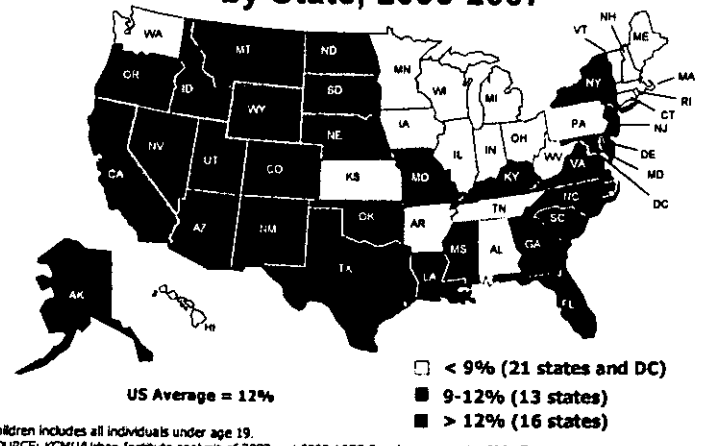
Children
Uninsured vs. Population, by Region, 2007



Children includes all individuals under age 19. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

More than one in ten children nationally are uninsured, but the chances of being uninsured range widely across the states—from a low of 5% (MA, WI) to a high of 22% in Texas. Among the states in which children's uninsured rates exceed the national average, all but one is in the southern and western regions.

Uninsured Rates for Children under 19, by State, 2006-2007



Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2007 and 2008 ASEC Supplements to the CPS. Two-year pooled estimates for states and the US (2006-2007).

Distribution of Uninsured Children in Each Poverty Category by Region 2007

Poverty Level	Number	Distribution	South	East/ North East	Midwest	Mountain/ Pacific	Total
<100%	3,718,880	41.9%	40.7%	21.7%	--	23.1%	100.0%
100-199%	2,505,489	28.2%	39.0%	18.9%	15.6%	26.5%	100.0%
200-299%	1,319,593	14.9%	--	--	--	--	100.0%
300%+	1,328,125	15.0%	--	--	--	--	100.0%
Total	8,872,087	100.0%	39.6%	20.8%	15.1%	24.5%	100.0%

Health Insurance Coverage of Children By Region and Family Income (Federal Poverty Levels, FPL) 2007

Children in Southern States

	Children in Southern States		Distribution by Coverage					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	8,045,890	37.9%	11.5%	2.5%	58.8%	2.2%	25.0%	100.0%
100-199%	4,402,674	20.3%	35.2%	3.0%	38.2%	1.5%	22.2%	100.0%
200-299%	3,405,479	15.7%	57.8%	5.0%	18.0%	2.5%	16.8%	100.0%
300%+	7,786,172	36.0%	80.8%	4.8%	6.8%	1.8%	5.8%	100.0%
Total	21,640,215	100.0%	48.5%	3.8%	29.5%	1.9%	16.3%	100.0%

Children in East/North East States

	Children in East/North East States		Distribution by Coverage					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	4,189,983	21.2%	13.2%	--	63.5%	--	19.3%	100.0%
100-199%	3,518,820	17.8%	38.9%	3.8%	42.7%	1.2%	13.4%	100.0%
200-299%	3,156,662	15.9%	68.5%	3.9%	18.2%	1.9%	7.5%	100.0%
300%+	8,932,565	45.1%	86.1%	4.2%	4.7%	1.4%	3.6%	100.0%
Total	19,798,030	100.0%	59.5%	3.9%	26.1%	1.3%	9.3%	100.0%

Children in Midwestern States

	Children in Midwestern States		Distribution by Coverage					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	3,812,341	20.9%	--	--	69.8%	--	--	100.0%
100-199%	3,419,703	18.7%	40.3%	4.6%	42.6%	1.1%	11.4%	100.0%
200-299%	3,178,191	17.4%	74.4%	5.4%	14.2%	0.6%	5.4%	100.0%
300%+	7,829,977	42.9%	86.9%	4.7%	4.6%	0.7%	3.0%	100.0%
Total	18,240,212	100.0%	60.4%	4.4%	27.0%	0.8%	7.3%	100.0%

Children in Mountain/Pacific States

	Children in Mountain/ Pacific States		Distribution by Coverage					
			Private		Public		Uninsured	
Poverty Level	Number	Distribution	Employer	Individual	Medicaid	Other		Total
<100%	4,167,338	22.0%	13.7%	--	60.0%	--	20.6%	100.0%
100-199%	4,016,795	21.2%	35.1%	4.4%	42.5%	1.5%	16.6%	100.0%
200-299%	3,089,833	16.3%	62.2%	5.2%	19.7%	1.9%	11.1%	100.0%
300%+	7,692,799	40.6%	81.9%	7.1%	5.6%	1.3%	4.0%	100.0%
Total	18,966,765	100.0%	53.8%	5.6%	27.7%	1.4%	11.5%	100.0%

U.S. Regions were defined as:
South: AL, AR, FL, GA, LA, MS, OK, SC, TN, TX
East/ North East: CT, DE, DC, ME, MD, MA, NH, NJ, NY, NC, PA, RI, VT, VA, WV
Midwest: IL, IN, IA, KS, KY, MI, MN, MO, NE, ND, OH, SD, WI
Mountain/ Pacific States: AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY
( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

STATE TABLES

Table 1: Health Insurance Coverage of Children by State, 2006-2007

Table 2: Health Insurance Coverage of Low-Income Children by State, 2006-2007

Table 3: Uninsured Rates Among Children by Poverty Level and State, 2006-2007

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Table 1
Health Insurance Coverage of Children by State, 2006-2007

	Children (thousands)[a]	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
United States	**78,425**	**55.4%**	**4.4%**	**27.1%**	**1.4%**	**11.7%**
Alabama	1,187	60.5%	2.5%	28.0%	---	7.7%
Alaska	192	54.1%	3.5%	23.6%	7.6%	11.2%
Arizona	1,769	48.9%	3.3%	31.1%	---	15.9%
Arkansas	742	42.6%	4.2%	43.8%	---	8.4%
California	10,036	49.7%	6.1%	30.7%	1.2%	12.3%
Colorado	1,260	61.5%	6.7%	15.5%	2.5%	13.8%
Connecticut	872	66.8%	3.2%	23.0%	---	6.3%
Delaware	220	63.7%	2.7%	22.0%	---	10.0%
District of Columbia	119	45.6%	---	44.0%	---	7.6%
Florida	4,332	50.7%	5.2%	23.3%	1.3%	19.5%
Georgia	2,604	52.6%	2.7%	29.3%	2.9%	12.5%
Hawaii	307	62.5%	2.6%	23.3%	5.7%	5.8%
Idaho	433	56.4%	6.2%	23.7%	1.6%	12.2%
Illinois	3,362	61.8%	3.6%	25.5%	0.7%	8.3%
Indiana	1,686	64.0%	3.5%	25.5%	---	6.7%
Iowa	750	62.1%	5.9%	26.0%	---	5.5%
Kansas	742	55.9%	6.3%	28.0%	2.0%	7.7%
Kentucky	1,068	53.6%	4.4%	31.3%	---	9.4%
Louisiana	1,149	45.2%	5.1%	34.8%	---	14.5%
Maine	301	57.2%	4.4%	31.4%	---	5.6%
Maryland	1,457	65.4%	4.1%	19.0%	---	10.4%
Massachusetts	1,549	67.3%	3.3%	24.1%	---	5.1%
Michigan	2,579	61.6%	4.2%	27.7%	---	5.9%
Minnesota	1,327	67.2%	5.2%	20.0%	---	7.2%
Mississippi	823	41.2%	4.5%	36.7%	---	16.2%
Missouri	1,491	53.8%	6.0%	29.7%	---	9.8%
Montana	231	49.5%	7.2%	28.1%	---	13.8%
Nebraska	472	62.6%	5.9%	19.3%	1.9%	10.4%
Nevada	689	63.3%	4.7%	14.5%	---	16.8%
New Hampshire	317	71.5%	4.2%	16.6%	---	7.1%
New Jersey	2,209	66.4%	3.5%	16.4%	---	13.3%
New Mexico	539	40.6%	3.7%	36.7%	2.3%	16.6%
New York	4,744	55.9%	2.7%	32.3%	---	9.0%
North Carolina	2,340	49.6%	5.0%	29.7%	2.4%	13.3%
North Dakota	156	60.1%	8.0%	20.7%	2.1%	9.1%
Ohio	2,948	60.3%	3.8%	27.9%	---	7.5%
Oklahoma	971	46.5%	4.2%	32.4%	3.6%	13.3%
Oregon	916	55.4%	7.6%	23.3%	---	12.8%
Pennsylvania	2,917	62.4%	4.4%	25.3%	---	7.7%
Rhode Island	252	60.1%	2.9%	29.1%	---	6.6%
South Carolina	1,108	52.7%	3.9%	28.9%	---	13.1%
South Dakota	207	57.2%	7.4%	24.2%	2.5%	8.8%
Tennessee	1,553	51.8%	5.0%	31.7%	3.4%	8.1%
Texas	6,989	45.1%	3.8%	27.3%	2.0%	21.8%
Utah	861	61.2%	7.1%	18.0%	---	13.1%
Vermont	138	51.6%	2.9%	36.0%	---	8.5%
Virginia	1,939	61.1%	3.6%	19.1%	5.5%	10.7%
Washington	1,623	60.9%	4.4%	24.8%	2.7%	7.1%
West Virginia	422	52.7%	---	38.2%	---	6.6%
Wisconsin	1,393	64.6%	4.1%	25.3%	---	5.2%
Wyoming	132	59.0%	6.7%	22.3%	2.8%	9.2%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table 2
Health Insurance Coverage of Low-Income Children (Less than 200% of Poverty) by State, 2006-2007

	Low-Income Children (thousands)[a]	% of Children with Low Incomes[c]	Percent Distribution by Coverage Type				
			Private		Public		Uninsured
			Employer	Individual	Medicaid	Other[b]	
United States	**33,340**	**42.5%**	**24.1%**	**3.6%**	**51.9%**	**1.4%**	**19.1%**
Alabama	539	45.4%	(29.2%)	---	(52.9%)	---	13.2%
Alaska	63	32.7%	(21.2%)	---	(52.6%)	7.3%	(17.3%)
Arizona	899	50.8%	23.3%	---	51.1%	---	23.2%
Arkansas	416	56.0%	18.9%	3.0%	65.3%	---	11.5%
California	4,587	45.7%	20.0%	4.7%	54.7%	1.4%	19.2%
Colorado	441	35.0%	(29.1%)	---	(34.8%)	---	(29.9%)
Connecticut	269	30.9%	(26.3%)	---	(56.3%)	---	12.9%
Delaware	86	39.0%	(34.1%)	---	(44.2%)	---	17.5%
District of Columbia	69	57.8%	(19.9%)	---	(68.0%)	---	9.5%
Florida	1,890	43.6%	24.3%	4.6%	39.0%	---	31.1%
Georgia	1,140	43.8%	21.9%	---	52.3%	3.0%	21.8%
Hawaii	122	39.6%	(38.7%)	---	(45.9%)	---	10.5%
Idaho	186	43.1%	(31.0%)	3.9%	(46.0%)	---	17.3%
Illinois	1,290	38.4%	26.9%	3.0%	54.0%	---	14.9%
Indiana	655	38.9%	29.2%	3.7%	(56.8%)	---	10.2%
Iowa	270	36.0%	(26.7%)	---	(58.6%)	---	8.8%
Kansas	310	41.7%	(23.0%)	4.4%	(57.5%)	---	12.9%
Kentucky	508	47.6%	22.7%	3.8%	(57.9%)	---	14.1%
Louisiana	554	48.3%	15.3%	---	(60.3%)	---	21.1%
Maine	110	36.5%	(20.3%)	---	(65.8%)	---	8.3%
Maryland	457	31.3%	(28.1%)	---	(45.4%)	---	(23.0%)
Massachusetts	514	33.2%	(26.3%)	5.2%	(58.2%)	---	9.7%
Michigan	1,022	39.6%	28.9%	4.1%	56.5%	---	9.3%
Minnesota	413	31.1%	(30.5%)	---	(48.6%)	---	16.5%
Mississippi	466	56.6%	14.9%	4.7%	54.7%	---	24.8%
Missouri	673	45.1%	24.3%	4.5%	(54.8%)	---	15.6%
Montana	98	42.3%	(20.4%)	---	(53.3%)	---	(20.7%)
Nebraska	161	34.2%	(27.1%)	5.9%	(46.4%)	---	(19.1%)
Nevada	298	43.3%	(38.4%)	---	(29.0%)	---	(29.2%)
New Hampshire	70	22.0%	---	---	---	---	(15.3%)
New Jersey	686	31.0%	27.9%	2.7%	(40.5%)	---	27.7%
New Mexico	252	46.7%	13.2%	---	(60.0%)	---	(23.0%)
New York	2,059	43.4%	25.6%	2.9%	58.1%	---	13.2%
North Carolina	1,090	46.6%	22.1%	3.5%	54.0%	---	19.3%
North Dakota	61	39.0%	(28.6%)	7.5%	(42.7%)	---	(18.2%)
Ohio	1,208	41.0%	26.6%	2.6%	58.2%	---	12.2%
Oklahoma	500	51.5%	22.4%	3.9%	(53.9%)	---	16.9%
Oregon	377	41.1%	(26.8%)	5.8%	(46.2%)	---	(20.4%)
Pennsylvania	1,129	38.7%	27.8%	4.3%	53.2%	---	14.1%
Rhode Island	90	35.5%	(24.9%)	---	(61.9%)	---	10.9%
South Carolina	527	47.5%	24.6%	---	(52.6%)	---	18.1%
South Dakota	76	36.9%	(22.1%)	7.6%	(54.0%)	---	13.7%
Tennessee	753	48.5%	26.4%	3.5%	56.8%	3.3%	10.0%
Texas	3,547	50.8%	18.0%	2.5%	45.7%	2.2%	31.5%
Utah	333	38.7%	(37.5%)	4.5%	35.9%	---	21.6%
Vermont	44	32.1%	(16.4%)	---	(67.3%)	---	(13.4%)
Virginia	739	38.1%	29.4%	3.1%	42.9%	4.7%	20.0%
Washington	551	34.0%	(28.0%)	---	(54.9%)	---	10.2%
West Virginia	207	49.1%	23.1%	---	(65.9%)	---	7.5%
Wisconsin	490	35.2%	(27.6%)	4.2%	(57.9%)	---	9.1%
Wyoming	47	35.6%	(30.7%)	7.1%	(45.8%)	---	13.0%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table 3
Uninsured Rates Among Children by Poverty Level and State, 2006-2007

	Children (thousands)[a]	Percent Uninsured Within Poverty Levels			
		All Levels[c]	<200% FPL	200-399% FPL	400%+ FPL
United States	**78,425**	**11.7%**	**19.1%**	**8.7%**	**3.6%**
Alabama	1,187	7.7%	13.2%	---	---
Alaska	192	11.2%	(17.3%)	9.0%	7.4%
Arizona	1,769	15.9%	23.2%	12.9%	---
Arkansas	742	8.4%	11.5%	---	---
California	10,036	12.3%	19.2%	9.0%	4.1%
Colorado	1,260	13.8%	(29.9%)	7.0%	---
Connecticut	872	6.3%	12.9%	---	---
Delaware	220	10.0%	17.5%	7.5%	---
District of Columbia	119	7.6%	9.5%	---	---
Florida	4,332	19.5%	31.1%	14.9%	5.4%
Georgia	2,604	12.5%	21.8%	6.8%	4.0%
Hawaii	307	5.8%	10.5%	---	---
Idaho	433	12.2%	17.3%	11.2%	---
Illinois	3,362	8.3%	14.9%	5.8%	2.7%
Indiana	1,686	6.7%	10.2%	5.2%	---
Iowa	750	5.5%	8.8%	---	---
Kansas	742	7.7%	12.9%	6.1%	---
Kentucky	1,068	9.4%	14.1%	7.5%	---
Louisiana	1,149	14.5%	21.1%	7.1%	9.5%
Maine	301	5.6%	8.3%	---	---
Maryland	1,457	10.4%	(23.0%)	7.7%	---
Massachusetts	1,549	5.1%	9.7%	---	---
Michigan	2,579	5.9%	9.3%	4.9%	---
Minnesota	1,327	7.2%	16.5%	4.9%	---
Mississippi	823	16.2%	24.8%	---	---
Missouri	1,491	9.8%	15.6%	6.1%	---
Montana	231	13.8%	(20.7%)	8.8%	---
Nebraska	472	10.4%	(19.1%)	7.4%	---
Nevada	689	16.8%	(29.2%)	9.8%	---
New Hampshire	317	7.1%	(15.3%)	7.4%	---
New Jersey	2,209	13.3%	27.7%	11.5%	4.0%
New Mexico	539	16.6%	(23.0%)	(15.1%)	---
New York	4,744	9.0%	13.2%	8.0%	3.4%
North Carolina	2,340	13.3%	19.3%	10.7%	4.6%
North Dakota	156	9.1%	(18.2%)	---	---
Ohio	2,948	7.5%	12.2%	5.9%	---
Oklahoma	971	13.3%	16.9%	11.6%	---
Oregon	916	12.8%	(20.4%)	8.6%	---
Pennsylvania	2,917	7.7%	14.1%	5.3%	---
Rhode Island	252	6.6%	10.9%	---	---
South Carolina	1,108	13.1%	18.1%	10.2%	---
South Dakota	207	8.8%	13.7%	7.2%	---
Tennessee	1,553	8.1%	10.0%	8.1%	---
Texas	6,989	21.8%	31.5%	17.5%	5.2%
Utah	861	13.1%	21.6%	10.9%	---
Vermont	138	8.5%	(13.4%)	7.3%	---
Virginia	1,939	10.7%	20.0%	6.4%	4.0%
Washington	1,623	7.1%	10.2%	6.7%	4.5%
West Virginia	422	6.6%	7.5%	6.0%	---
Wisconsin	1,393	5.2%	9.1%	4.4%	---
Wyoming	132	9.2%	13.0%	9.4%	---

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table Endnotes

The term family as used in family income, family poverty levels, and family work status, is defined as a health insurance unit (those who are eligible as a group for "family" coverage in a health plan) throughout this report.

[a] Children includes all individuals under age 19.

[b] Other includes other public insurance (mostly Medicare and military-related, e.g., Veterans Administrati and TRICARE). SCHIP is included in Medicaid.

[c] The 2007 federal poverty level for a family of four was $21,203.

THE KAISER COMMISSION ON

Medicaid and the Uninsured

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This report (#7609-02) is available on the Kaiser Family Foundation's website at www.kff.org.

Lynda Zaugg

From: Jennifer Saunders [jennifer.saunders@ncsl.org]
Sent: Wednesday, February 11, 2009 9:27 AM
To: Lynda Zaugg; Thomas Obermeyer; Sen. Bettye Davis
Cc: Jennifer Breshears
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)
Attachments: SCHIP Cost Sharing Rules 2-10-09.doc

Senator Davis,

We enjoyed listening to your Health and Social Services committee meeting on Monday regarding Senate Bill 13 and Senate Bill 87.
The attached memo is intended to answer the question posed about the SCHIP cost-sharing rules.

Please let me know if you have additional questions or need additional information.

Best regards,
Jennifer

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National Conference of State Legislatures
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> ----- Original Message -----
> **From:** Jennifer Saunders
> **To:** Thomas Obermeyer
> **Cc:** Martha King ; Jennifer Breshears
> **Sent:** Monday, February 09, 2009 11:54 AM
> **Subject:** Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)
>
> Thomas,
>
> In addition, you may be interested to know that the legislation signed by President Obama to reauthorize SCHIP last week includes a provision that requires states who wish to cover low-income pregnant women under SCHIP must also cover children in families with incomes up to 200 percent of the federal poverty guidelines.
>
> Please see the link to the full text of this legislation (HR 2).
> http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/2009 schip reauth/chipra2009.pdf
>
> I have also copy and pasted this information below.
>
> Best regards,

Jennifer

Subtitle B—Focus on Low-Income Children
and Pregnant Women
SEC. 111. STATE OPTION TO COVER LOW-INCOME PREGNANT WOMEN
UNDER CHIP THROUGH A STATE PLAN AMENDMENT.
(a) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.), as
amended by section 112(a), is amended by adding at the end the
following new section:
"SEC. 2112. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN THROUGH A STATE PLAN AMENDMENT.
"(a) IN GENERAL.—Subject to the succeeding provisions of this section, a State may elect through an amendment to its State child health plan under section 2102 to provide pregnancy-related assistance under such plan for targeted low-income pregnant women.
"(b) CONDITIONS.—A State may only elect the option under subsection (a) if the following conditions are satisfied:
"(1) MINIMUM INCOME ELIGIBILITY LEVELS FOR PREGNANT WOMEN AND CHILDREN.—The State has established an income eligibility level—
"(A) for pregnant women under subsection
(a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (l)(1)(A) of section 1902
that is at least 185 percent (or such higher percent as
the State has in effect with regard to pregnant women
under this title) of the poverty line applicable to a family
of the size involved, but in no case lower than the percent
in effect under any such subsection as of July 1, 2008;
and
"(B) for children under 19 years of age under this title (or title XIX) that is at least 200 percent of the poverty line applicable to a family of the size involved.
"(2) NO CHIP INCOME ELIGIBILITY LEVEL FOR PREGNANT
WOMEN LOWER THAN THE STATE'S MEDICAID LEVEL.—The State
does not apply an effective income level for pregnant women
under the State plan amendment that is lower than the effective
income level (expressed as a percent of the poverty line and
considering applicable income disregards) specified under subsection
(a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (l)(1)(A) of section
1902, on the date of enactment of this paragraph to be eligible
for medical assistance as a pregnant woman.
"(3) NO COVERAGE FOR HIGHER INCOME PREGNANT WOMEN
WITHOUT COVERING LOWER INCOME PREGNANT WOMEN.—The
State does not provide coverage for pregnant women with
higher family income without covering pregnant women with
a lower family income.
"(4) APPLICATION OF REQUIREMENTS FOR COVERAGE OF TARGETED
LOW-INCOME CHILDREN.—The State provides pregnancyrelated
assistance for targeted low-income pregnant women
in the same manner, and subject to the same requirements,
as the State provides child health assistance for targeted lowincome
children under the State child health plan, and in
addition to providing child health assistance for such women.
"(5) NO PREEXISTING CONDITION EXCLUSION OR WAITING
PERIOD.—The State does not apply any exclusion of benefits
H. R. 2—20
for pregnancy-related assistance based on any preexisting condition
or any waiting period (including any waiting period
imposed to carry out section 2102(b)(3)(C)) for receipt of such
assistance.

"(6) APPLICATION OF COST-SHARING PROTECTION.—The State provides pregnancy-related assistance to a targeted low-income woman consistent with the cost-sharing protections under section 2103(e) and applies the limitation on total annual aggregate cost sharing imposed under paragraph (3)(B) of such section to the family of such a woman.
"(7) NO WAITING LIST FOR CHILDREN.—The State does not impose, with respect to the enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

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----- Original Message -----
From: Jennifer Saunders
To: Thomas Obermeyer
Cc: Martha King ; Jennifer Breshears
Sent: Monday, February 09, 2009 9:50 AM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Martha King and I will be on the call this afternoon to answer questions.

As we discussed on the phone on Friday, Alaska's SCHIP program is a Medicaid expansion program and therefore must comply with Medicaid's cost-sharing rules as specified under the Deficit Reducation Act of 2005.

The following document summarizes these requirements and I would refer you to the summary on page 1 under the heading "Options for Premiums and Cost-sharing" and the "Important Links" on the bottom of page 2. See the document here: http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf

Under provisions of the Deficit Reduction Act of 2005, states generally cannot impose cost sharing on children in families with income below 150 percent of the federal poverty guidelines except in certain circumstances. In addition, even at more moderate-income levels, federal rules exempt some special services from any cost sharing requirements.

To create cost sharing requirements that differ from the Medicaid requirements, states can do so by submitting a waiver to and obtaining approval from the Centers for Medicare and Medicaid (CMS) or by creating a stand-alone SCHIP program.

For more information about cost sharing and SCHIP, please see the following CMS website:
http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp
(Scroll down to see the information under the heading "Cost Sharing.")

Best regards,
Jennifer

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----- Original Message -----
From: Jennifer Saunders
To: Thomas Obermeyer ; Lynda_Zaugg@legis.state.ak.us
Cc: Martha King ; Jennifer Breshears
Sent: Thursday, February 05, 2009 12:02 PM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Yes, the following Kaiser report indicates that 7 states have SCHIP eligibility levels below 200 percent of the federal poverty guidelines (FPG):
Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009
http://www.kff.org/medicaid/7855.cfm
(See page 10, Figure 1.)

The 7 states are:

Alaska	175 percent FPG
Idaho	185 percent FPG
Montana	175 percent FPG
Nebraska	185 percent FPG
North Dakota	150 percent FPG
Oklahoma	185 percent FPG*
Oregon	185 percent FPG

* Oklahoma passed legislation to increase the income eligibility guideline to 300 percent of the federal poverty line under its current section 1115 waiver. However, the currently proposed expansion has been scaled back to 217 percent of the federal poverty line and the future expansion of 218 percent to 300 percent of the federal poverty line is pending further CMS guidance and SCHIP reauthorization.

Sources:
Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009
http://statehealthfacts.org/comparemaptable.jsp?ind=203&cat=4

Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009
http://statehealthfacts.org/comparemaptable.jsp?ind=204&cat=4

Would you still like for NCSL to participate by phone in the Senate HESS hearing concerning SB 13 on February 9, 2009?
If yes, what are you expecting from us (a presentation, or just being available to answer questions, etc.)?

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
Research Analyst
Health Program
National Conference of State Legislatures
7700 East First Place
Denver, CO 80230
303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org

----- Original Message -----
From: Thomas Obermeyer
To: Jennifer Saunders
Cc: Lynda Zaugg
Sent: Wednesday, February 04, 2009 9:26 PM
Subject: RE: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Jennifer,
In reviewing one of your recommended web sites, the Kaiser Commission on Medicaid and the Uninsured, January 2009 reported that only 7 states, apparently including Alaska, are below 200% FPL. Can you tell me which are the other 6 states?

Tom Obermeyer
Office of Senator Davis
907-465-3762

From: Jennifer Saunders [mailto:jennifer.saunders@ncsl.org]
Sent: Wednesday, February 04, 2009 8:31 AM
To: Thomas Obermeyer
Subject: Fw: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Hi Thomas,

I wanted to follow up with you to check that you received the information about SCHIP that I sent you last week.

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
Research Analyst
Health Program
National Conference of State Legislatures
7700 East First Place
Denver, CO 80230
303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org

----- Original Message -----
From: Jennifer Saunders
To: Thomas Obermeyer
Cc: jennifer breshears ; Martha King ; Senator_Bettye_Davis@legis.state.ak.us ; Lynda_Zaugg@legis.state.ak.us ; Don_Burrell@legis.state.ak.us
Sent: Friday, January 30, 2009 2:05 PM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

In the attached document, I have compiled some information regarding your questions about the State Children's Health Insurance Program and have included additional resources. At the end of the document, you will find summaries of enacted state legislation that you may find helpful. Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
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Health Program
National Conference of State Legislatures
7700 East First Place
Denver, CO 80230
303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org

----- Original Message -----
From: Martha King
To: Thomas Obermeyer
Cc: jennifer saunders ; jennifer breshears
Sent: Tuesday, January 27, 2009 9:41 AM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Greetings Thomas!

We're happy to provide the information you've requested in your email and to participate by phone on February 9th, if you continue to think we could be helpful. I am asking the two NCSL staff named in the cc line to work on the specifics you've asked for and we will be getting back to you as soon as possible.
In the meantime, please give our regards to Senator Davis & stay warm up there! martha

----- Original Message -----
From: Thomas Obermeyer
To: martha.king@ncsl.org
Cc: Sen. Bettye Davis ; Lynda Zaugg ; Don Burrell
Sent: Monday, January 26, 2009 2:48 PM
Subject: RE: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

January 26, 2009

Martha King, Group Director,
Health Programs, NCSL - Denver
303-364-7700 main line
303-364-7800 fax
303-856-1448 – direct line
E-mail: Martha.king@ncsl.org

RE: Request for:
A) review and comments concerning Alaska Senate Bill 13 (attached), and
B) request for NCSL staff to testify at Senate HESS hearing concerning SB 13, Denali KidCare, Alaska SCHIP program February 9, 2009 at 1:30-3:00 pm (3:30-5:00 pm Mountain/Denver time). **Call in number is 888-295-4546**

Dear Ms. King,

Please read the attached **Alaska Senate Bill No. 13,** 26th Legislature, sponsored by Senator Bettye Davis, regarding **increasing income eligibility** under the Denali KidCare -State Children's Health Insurance Program (SCHIP) **to 200% Federal Poverty Guidelines (FPG)**. It was raised to 175% last year under SB 27, 25th Legislature.

Senator Davis, Chair, Senate HESS Committee (and Vice-Chair NCSL Health Committee) is considering an amendment at hearing to extend optional coverage to applicants over 200% FPG not to exceed 250% FPG with provisions of premiums or co-payments . You will note that there is no asset test in the bill.

Your comments in return e-mail to me as soon as possible before the hearing would be particularly helpful in the following areas:

1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review, and
2. if asset tests, payments, and co-payments are common, and if other matters of eligibility other than income and household size under federal poverty guidelines are codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits.
3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.
4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines.

Please have NCSL staff call in to the hearing teleconference line on February 9, 2009 noted above at 888-295-4546 to testify and/or field questions.

Sincerely,

Thomas S. Obermeyer
Legislative Assistant
Office of Senator Bettye Davis
907-465-3822 office
907-465-3762 direct line
907-465-3756 fax
Thomas_Obermeyer@legis.state.ak.us

Thomas Obermeyer

From: Jennifer Saunders [jennifer.saunders@ncsl.org]

Sent: Monday, February 09, 2009 9:54 AM

To: Thomas Obermeyer

Cc: Martha King; Jennifer Breshears

Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

In addition, you may be interested to know that the legislation signed by President Obama to reauthorize SCHIP last week includes a provision that requires states who wish to cover low-income pregnant women under SCHIP must also cover children in families with incomes up to 200 percent of the federal poverty guidelines.

Please see the link to the full text of this legislation (HR 2).
http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/2009_schip_reauth/chipra2009.pdf

I have also copy and pasted this information below.

Best regards,
Jennifer

Subtitle B—Focus on Low-Income Children
and Pregnant Women
SEC. 111. STATE OPTION TO COVER LOW-INCOME PREGNANT WOMEN
UNDER CHIP THROUGH A STATE PLAN AMENDMENT.
(a) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.), as
amended by section 112(a), is amended by adding at the end the
following new section:
"SEC. 2112. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN THROUGH A STATE PLAN AMENDMENT.
"(a) IN GENERAL.—Subject to the succeeding provisions of this section, a State may elect through an amendment to its State child health plan under section 2102 to provide pregnancy-related assistance under such plan for targeted low-income pregnant women.
"(b) CONDITIONS.—A State may only elect the option under subsection (a) if the following conditions are satisfied:
"(1) MINIMUM INCOME ELIGIBILITY LEVELS FOR PREGNANT WOMEN AND CHILDREN.—The State has established an income eligibility level—
"(A) for pregnant women under subsection
(a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (l)(1)(A) of section 1902
that is at least 185 percent (or such higher percent as
the State has in effect with regard to pregnant women
under this title) of the poverty line applicable to a family
of the size involved, but in no case lower than the percent
in effect under any such subsection as of July 1, 2008;
and
"(B) for children under 19 years of age under this title (or title XIX) that is at least 200 percent of the poverty line applicable to a family of the size involved.
"(2) NO CHIP INCOME ELIGIBILITY LEVEL FOR PREGNANT
WOMEN LOWER THAN THE STATE'S MEDICAID LEVEL.—The State
does not apply an effective income level for pregnant women

under the State plan amendment that is lower than the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) specified under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (l)(1)(A) of section 1902, on the date of enactment of this paragraph to be eligible for medical assistance as a pregnant woman.
"(3) NO COVERAGE FOR HIGHER INCOME PREGNANT WOMEN WITHOUT COVERING LOWER INCOME PREGNANT WOMEN.—The State does not provide coverage for pregnant women with higher family income without covering pregnant women with a lower family income.
"(4) APPLICATION OF REQUIREMENTS FOR COVERAGE OF TARGETED LOW-INCOME CHILDREN.—The State provides pregnancyrelated assistance for targeted low-income pregnant women in the same manner, and subject to the same requirements, as the State provides child health assistance for targeted lowincome children under the State child health plan, and in addition to providing child health assistance for such women.
"(5) NO PREEXISTING CONDITION EXCLUSION OR WAITING PERIOD.—The State does not apply any exclusion of benefits
H. R. 2—20
for pregnancy-related assistance based on any preexisting condition or any waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) for receipt of such assistance.
"(6) APPLICATION OF COST-SHARING PROTECTION.—The State provides pregnancy-related assistance to a targeted low-income woman consistent with the cost-sharing protections under section 2103(e) and applies the limitation on total annual aggregate cost sharing imposed under paragraph (3)(B) of such section to the family of such a woman.
"(7) NO WAITING LIST FOR CHILDREN.—The State does not impose, with respect to the enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

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----- Original Message -----
From: Jennifer Saunders
To: Thomas Obermeyer
Cc: Martha King ; Jennifer Breshears
Sent: Monday, February 09, 2009 9:50 AM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

last year under SB 27, 25th Legislature.

Senator Davis, Chair, Senate HESS Committee (and Vice-Chair NCSL Health Committee) is considering an amendment at hearing to extend optional coverage to applicants over 200% FPG not to exceed 250% FPG with provisions of premiums or co-payments . You will note that there is no asset test in the bill.

Your comments in return e-mail to me as soon as possible before the hearing would be particularly helpful in the following areas:

1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review, and
2. if asset tests, payments, and co-payments are common, and if other matters of eligibility other than income and household size under federal poverty guidelines are codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits.
3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.
4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines.

Please have NCSL staff call in to the hearing teleconference line on February 9, 2009 noted above at 888-295-4546 to testify and/or field questions.

Sincerely,

Thomas S. Obermeyer
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907-465-3822 office
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907-465-3756 fax
Thomas_Obermeyer@legis.state.ak.us

Sponsor Statement

Senate Bill 13: "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date"

SB 13 increases and restores the qualifying income eligibility standard for the Denali KidCare Program to 200% of the Federal Poverty Line (FPL) to its original levels 12 years ago. As you know, Alaska is one of the nation's wealthiest states yet Alaska is only one of 5 states that still funds our SCHIP program below 200% FPL. SB 13 makes health insurance accessible to approximately 1,277 uninsured children and 225 pregnant women in Alaska.

Denali KidCare is an "enhanced" reimbursement program with Alaska currently receives about 66% under the federal government's State Children's Health Insurance Program (SCHIP), which was created in 1997. Congress reauthorized the SCHIP program and President Obama signed into law on February 4, 2009. This reauthorization expanded the coverage to 4 million additional children and is re-authorized through 2013.

Consider the following information from the Kaiser Commission on Medicaid and the Uninsured, January, 2009:

- 45 states, including D.C., cover children in families with incomes at 200% FPL or higher.
- 33 states cover children in families with income between 200% and 250% FPL.
- 19 states including D.C., cover children in families with income at 250% or higher. 10 of these states cover children in families with income at 300% FPL or higher.
- 35 states allow premiums or enrollment fees, and 24 states have co-payments for selected services in SCHIP programs on a sliding scale of FPL.
- 46 states do not require asset tests.

Denali KidCare serves an estimated 7,900 Alaska children and remains one of the least costly medical assistance programs in the state at about $1,700 per child with full coverage, including dental, which is about 20% of the cost of adult senior coverage.

It is estimated that uninsured children with a medical need are five times as likely not to have a regular doctor as insured children and four times more likely to use emergency rooms at a much higher cost. Early intervention and preventative care under SB 13 will greatly increase Alaska children's health and yield substantial savings to the state, public and private sector hospitals, emergency rooms which are required to admit indigent and uninsured patients for non-emergency treatment.

There are still an estimated 18,000 uninsured children in Alaska. This is about 9% of the children age 18 and under. Private health care coverage for children has declined over 30% in the last ten years, and the deepening recession is pulling more children and families into the uninsured ranks. Alaska should do its share and take advantage of available federal matching funds by insuring its low income children and pregnant women up to and including 200% FPL under SB 13.

Denver, CO 80230
303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org

----- Original Message -----
From: Jennifer Saunders
To: Thomas Obermeyer ; Lynda_Zaugg@legis.state.ak.us
Cc: Martha King ; Jennifer Breshears
Sent: Thursday, February 05, 2009 12:02 PM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

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(See page 10, Figure 1.)

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Would you still like for NCSL to participate by phone in the Senate HESS hearing concerning SB 13 on February 9, 2009?
If yes, what are you expecting from us (a presentation, or just being available to answer questions, etc.)?

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Alaska's Citizen Review Panel

Citizen Review Panel

Our focus areas today will be:

- To provide a brief overview of the Citizen Review Panel & to highlight our activities since last year
- To share with you what we hear about the Office of Children's Services
- To ask you to help improve the situation

Mandate for the Group

The Citizen Review Panel is mandated by state and federal law. The CRP was created through the federal Child Abuse Prevention & Treatment Act (CAPTA); Keeping Children & Families Safe Act of 2003 and through Alaska statute Sec. 47.14.205.

Citizen Review Panel

CRP Vision

To enable the Office of Children's Services to implement its policies and procedures in a culturally sensitive and consistent manner across the state.

Citizen Review Panel

Who are we?

The CRP is composed of volunteer members who are broadly representative of the state, including members who have expertise in the prevention and treatment of child abuse and neglect. The group chooses its own members.

Current members

- Fred VanWallinga, Willow (Chair)
- Carol Olson, Anchorage (Vice-Chair)
- Pamela Dupras, Kodiak
- Dana Hallett, Soldotna
- Art Hansen, Fairbanks
- Susan Heuer, Anchorage
- Kristin Hull, Wasilla
- Ralph Taylor, Anchorage (currently deployed with the Alaska National Guard)

CRP Duties

Evaluate Office of Children's Services (OCS) compliance with federal and state laws, examine the policies, procedures and practices of OCS, and, where appropriate, evaluate specific cases of child abuse or neglect.

CRP Duties (continued)

The CRP must also:

- Maintain confidentiality
- Conduct public outreach
- Produce an annual report
- Meet at least quarterly

Our focus for the past year

- Potential for additional 5th service region
- Improving situation in Copper River Basin

Citizen Review Panel

What we've been doing

- Holding monthly teleconferences
- Produced an annual report
- Attended the Alaska Native Indian Child Welfare Summit
- Attended national Citizen Review Panel conference in Minnesota
- Meeting in-person quarterly

What else we've been doing

- Meeting with OCS partner agencies
- Meeting with OCS staff from Director Sandoval to line workers
- Participated in the federal Child and Family Services Review
- Met with UA staff responsible for OCS training
- Meeting with the Commissioner and Legislators

A couple more things we did

- Attended the Family to Family Conference
- Attended the Community Care Conference
- Heard from concerned citizens
- Received training on safety assessment

Where some of us have been

- Aniak
- Bethel
- Copper Center
- Dillingham
- Fairbanks
- Glennallen
- Juneau
- King Salmon
- Naknek
- St. Mary's
- Unalaska

Citizen Review Panel

We've met with...

- Counseling center staff
- District attorneys
- Foster parents
- Health aides & public health nurses
- ICWA workers
- Local police departments
- OCS staff
- School principals, nurses & counselors
- State troopers
- Tribal representatives
- WIC workers

OCS is improving due to...

- Key personnel changes
- System changes—safety assessment, expanded training, ORCA programming improvements
- Increased collaboration with partnering state agencies (DJJ, Dept. of Law, etc.)

OCS is improving due to…

- Continued and increased financial support from Legislature during past couple fiscal years
- Responsive to outside recommendations (ACTION for Children, CRP, federal audit)

Issues of concern

- Hiring freeze
- Region 5
- Many solutions to problems are beyond the control of OCS, Director lacks discretion
- Standardization

Issues of concern

- Hiring freeze

  OCS is public safety like the Troopers in as much as they have a protective function

In rural areas, workers are already stretched, further unfillable vacancies with no end in sight will directly affect child safety

Increased risk of current workers leaving due to work overload

Issues of concern

- Region 5
  - Last year we strongly advocated for Region 5 based on Bethel community support
    - SCRO has 13 offices, next largest region has 7
  - OCS costed-out Region 5 for $1.5 million, but the region was not in the Governor's budget

Issues of concern

- Region 5
  - Bethel OCS and community partners continue to support this idea, but other communities have concerns
  - Over the next year, the CRP will intensively survey all Southwestern Alaska field offices and community partners
  - We continue to think that a smaller more culturally focused region is in the best interest of children

Issues of concern

- Many solutions to problems are beyond the control of OCS, Director lacks discretionary powers

Issues of concern

- Standardization of supports for employees varies between state agencies
  - Housing
  - Internet

We'd like your help to address these concerns

- Support the exemption of OCS from hiring freeze and issuance of immediate variances
- Investigate and resolve the lack of standardization between state agencies

Benefits of CRP

- Seven volunteer members all contributing a minimum of 250 active hours annually
- We're the eyes and ears of the public for the Legislature and OCS
- Unique function of identifying and advocating for ancillary services that OCS cannot request
- Jointly we can achieve a vastly improved child protection system for the children of Alaska

Alaska's Citizen Review Panel

For more information, please visit our website

www.crpalaska.org

Citizen Review Panel

SB 27

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: (Labor and Commerce) Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 4/7/09

Health and Social Services Committee considered SENATE BILL NO. 27

SB 27 FOSTER CARE AGE LIMIT/TUITION WAIVER

"An Act relating to tuition waivers for a child who was in foster care; relating to eligibility for foster care and subsidy payments for a hard-to-place child; and amending the definition of 'child' in certain statutes."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 27 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS/CSM	3/16	✓			1
DHS/FCBR	3/17	✓			2
DHS/FP	3/17	✓			3

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	✓			
	THOMAS	✓			
	DYSON			✓	
	PASKVAN	X			
CHAIR: Betty Davis	DAVIS	X			

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 27

"An Act relating to tuition waivers for a child who was in foster care; relating to eligibility for foster care and subsidy payments for a hard-to-place child; and amending the definition of 'child' in certain statutes."

Sponsor Statement

SB 27 provides waivers of tuition and fees combined with other assistance to help foster or out-of-home care children enjoy the opportunity and benefits of a higher education afforded to others. Recognizing the severe educational disadvantages of persons placed in foster care or out-of-home care, many states have initiated a variety of college tuition waiver and scholarship programs for these persons. The University of Alaska increased tuition waivers and additional assistance from five (5) to ten (10) students statewide who were in foster care on their 18th birthday, but the need is much greater. Data in 2006 indicated that there are over 2,000 children in foster care in Alaska at any one time. Over 5,000 live in out-of-home care with relatives who are in a subsidized guardianship program. The average length of stay in foster care in Alaska was 25 months but only 40% of children had 2 or fewer placements.

Education has been shown in studies to be a significant factor in determining the success of children and youth as they exit the foster care system. Research measuring educational, social, and vocational outcomes for children and youth in foster care indicates that the majority of children who enter the protection of child welfare agencies do poorly in school due to instability in placements and changes in schools. The small number who have successfully finished high school and are eligible and qualified to attend college need financial support and other assistance to continue in school. Too often they "age out" of the foster care system at age 18 and wind up on the streets and in shelters.

A Casey Family Program study of 1,000 foster care youth found that youth who had one or fewer home placements per year were twice as likely to graduate from high school before leaving care. Additionally, it was found that:

- Less than **70%** of youth in foster care finish high school before leaving care.
- Children and youth in out-of-home care experience **1 or 2** placement changes per year on average.
- Students in foster care score **16 to 20** percentile points below others in statewide standardized tests (Washington State study).
- Only about **3%** obtain a bachelor's degree within a few years of emancipation.

Nationwide the Casey Foundation reports that every year more than 25,000 youth attempt to make the transition from foster care to self-sufficiency as they reach age 18. Only half finish high school, and about 11 percent go on to college or vocational schools. Statistically, Alaska which regularly lags behind many other states in educational performance, provides far less assistance to persons in foster care to go to college. SB 27 should help many more deserving foster care and out-of-home care youth go to college and obtain undergraduate degrees.

3311

adopted 3/11 by committee
No changes

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
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Senator Bettye Davis

3/27 - hearing - No action

CSSB 27 ( ) "E" version, 26-LS0205\E

"An Act relating to tuition waivers for a child who was in out-of-home care; relating to out-of-home care for a child; amending the definition of 'child' in certain statutes; and relating to out-of-home care transition to independent living."

The CS SB 27 ( ) "E" version It changes the definition of "foster care" to "out-of-home" care because so many relatives who are not licensed take care of children who are in "out-of-home" care. The bill extends eligibility for tuition waivers for a person in the foster care from 19 to 21, if the person was in foster care at age 16 for not less than 6 consecutive months and is in out-of home care at time of application. The bill subjects waivers of tuition to availability of funds by appropriation.

Section 1. Adds a new section, AS 14.43.086, entitling a person who was placed by the state in out-of-home care to a waiver of undergraduate tuition and fees in a state-supported school.

Section 2. Adds a cross reference to a definition for out-of home care for purposes of the tuition waiver.

Section 3. Changes "foster care to "out-of-home care" for purposes of the procurement code.

Section 4. Adds a cross reference to a definition for out-of-home care form medical assistance provision.

Section 5. Extends court orders to age 21 for a child committed to the custody of the department if they are placed in out of home care.

Section 6. Changes definition of "child" under AS 47.10.990(3) (child in need of aid) to include a person under 21 years of age living in out-of-home care.

Section 7. Changes "foster care" to "out-of-home care" for purposes of the child in need of aid statutes.

Section 8. Changes "foster care" to "out-of-home care" for purposes of the transition program to independent living.

Section 9. Changes "foster care" to "out of home care" form purposes of the transition program for children who are not less than age 18 living in out-of-home care, as defined.

Section 10. Adds children who were placed in out –of-home care to provide transition program services for the purpose of achieving self-sufficiency.

Section 11. Changes "foster care" to "out-of-home" care for purposed of the transition program definition .

Section 12. Adds a monetary stipend for children in the transition program for a specified period of time.

Section 13. Adds a cross reference to a definition for out-of-home care for purposes of the transition program.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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MEMORANDUM March 10, 2009

SUBJECT: Sectional Summary (CSSB 27( )
(Work Order No. 26-LS0205\E))

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds a new section entitling a person who was placed by the state in out-of-home care to a waiver of undergraduate tuition and fees in a state-supported school.

Section 2. Adds a cross reference to a definition for out-of-home care for the tuition waiver.

Section 3. Changes "foster care" to "out-of-home care" for purposes of the procurement code.

Section 4. Adds a cross reference to a definition for out-of-home care for medical assistance provisions.

Section 5. Extends court orders to age 21 for a child committed to the custody of the department.

Section 6. Changes the definition of "child" under AS 47.10 (child in need of aid) to include a person under 21 years of age living in out-of-home care.

Section 7. Changes "foster care" to "out-of-home care" for purposes of the child in need of aid statutes.

Section 8. Changes "foster care" to "out-of-home care" for purposes of the transition program to independent living.

Section 9. Changes "foster care" to "out-of-home care" for purposes of the transition program for children who are not less than age 18 living in out-of-home care, as defined.

Section 10. Adds children who were placed in out-of-home care to provide transition program services for the purpose of achieving self-sufficiency.

Section 11. Changes "foster care" to "out-of-home care" for purposes of the transition program definition.

Section 12. Adds a monetary stipend for children in the transition program for a specified period of time.

Section 13. Adds a cross reference to a definition for out-of-home care for purposes of the transition program.

JMM:plm
09-149.plm

26-LS0205\E
Mischel
3/5/09

CS FOR SENATE BILL NO. 27( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, Ellis

adopted 3/11 by comm. No changes

A BILL

FOR AN ACT ENTITLED

"An Act relating to tuition waivers for a child who was in out-of-home care; relating to out-of-home care for a child; amending the definition of 'child' in certain statutes; and relating to out-of-home care transition to independent living."

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

*** Section 1.** AS 14.43 is amended by adding a new section to read:

Article 3A. Free Tuition for a Person Who Was in Out-of-home Care.

Sec. 14.43.086. Free tuition and fees for a person who was in out-of-home care. (a) A person who enrolls as a student in good standing in a state-supported educational institution in the state is entitled to a waiver of tuition, fees, and room and board expenses if the person provides adequate proof that the person

(1) was in the custody of the state under AS 47.10 or AS 47.14; and

(2) was placed in out-of-home care for a period of not less than six consecutive months on or after the person became 16 years of age.

(b) The amount of the waiver to which a person is entitled under this section is

the amount of unmet need for tuition, room, and board expenses, as determined by the commission after deducting all available funding for the school year from education loans, grants, or scholarships for a person eligible for a waiver.

(c) The proceeds of an education loan, grant, or scholarship received by a person eligible for a waiver under this section must be paid to the educational institution to offset the person's tuition, fees, and room and board expenses.

(d) A state-supported educational institution in the state is required to provide a waiver under (a) of this section only if the legislature appropriates funds for the purpose of offsetting waivers under this section. If an appropriation is not sufficient to fully offset waivers for each person entitled to a waiver under (a) of this section, the institution may offer full or partial waivers to eligible applicants as funding permits and at the discretion of the institution.

*** Sec. 2.** AS 14.43.160 is amended by adding a new paragraph to read:

(7) "out-of-home care" has the meaning given in AS 47.14.400.

*** Sec. 3.** AS 36.30.850(b)(42) is amended to read:

(42) grants and contracts with qualified entities for services under AS 47.18.330 for the **out-of-home** [FOSTER] care transition program;

*** Sec. 4.** AS 47.07.020 is amended by adding a new subsection to read:

(o) In this section, "out-of-home care" has the meaning given in AS 47.14.400.

*** Sec. 5.** AS 47.10.080(c) is amended to read:

(c) If the court finds that the child is a child in need of aid, the court shall

(1) order the child committed to the department for placement in an appropriate setting for a period of time not to exceed two years or in any event not to extend past the date the child becomes 19 years of age, except that the department or the child's guardian ad litem may petition for and the court may grant in a hearing

(A) one-year extensions of commitment that do not extend beyond the child's 19th birthday if the extension is in the best interests of the child; and

(B) **one-year extensions of commitment that do not extend beyond the child's 21st birthday** [AN ADDITIONAL ONE-YEAR PERIOD OF STATE CUSTODY PAST 19 YEARS OF AGE] if the continued state

custody is in the best interests of the person and the person consents to it;

(2) order the child released to a parent, adult family member, or guardian of the child or to another suitable person, and, in appropriate cases, order the parent, adult family member, guardian, or other person to provide medical or other care and treatment; if the court releases the child, it shall direct the department to supervise the care and treatment given to the child, but the court may dispense with the department's supervision if the court finds that the adult to whom the child is released will adequately care for the child without supervision; the department's supervision may not exceed two years or in any event extend past the date the child reaches 19 years of age, except that the department or the child's guardian ad litem may petition for and the court may grant in a hearing

(A) one-year extensions of supervision that do not extend beyond the child's 19th birthday if the extensions are in the best interests of the child; and

(B) an additional one-year period of supervision past 19 years of age if the continued supervision is in the best interests of the person and the person consents to it; or

(3) order, under the grounds specified in (o) of this section or AS 47.10.088, the termination of parental rights and responsibilities of one or both parents and commit the child to the custody of the department, and the department shall report quarterly to the court on efforts being made to find a permanent placement for the child.

*** Sec. 6.** AS 47.10.990(3) is amended to read:

(3) "child" means a person **who is**

(A) under 18 years of age**;**

(B) [AND A PERSON] 19 years of age if that person was under 18 years of age at the time that a proceeding under this chapter was commenced**; and**

(C) under 21 years of age if that person is living in out-of-home care;

*** Sec. 7.** AS 47.10.990 is amended by adding a new paragraph to read:

(33) "out-of-home care" has the meaning given in AS 47.14.400.

* **Sec. 8.** AS 47.18.300(a) is amended to read:

(a) The department, in coordination with local public and private agencies, shall design, develop, and implement **an out-of-home care** [A FOSTER CARE] transition program to provide support and services to individuals who

(1) reach or have reached the age of 16 or older while in state **custody and placed in out-of-home** [FOSTER] care and have not yet reached 23 years of age; and

(2) meet other eligibility criteria established by the department under (b) of this section.

* **Sec. 9.** AS 47.18.310 is amended to read:

Sec. 47.18.310. Program design. The department, in coordination with local public and private agencies, shall design the program as a continuation of the training efforts related to independent living skills that were initiated **for a child in state custody who was placed in out-of-home care and** [WHEN THE STATE FOSTER CARE RECIPIENTS WERE] identified as being likely to remain in **out-of-home** [STATE FOSTER] care until reaching **not less than** the age of 18. The program design must require that program participants are directly involved in identifying the program activities that will prepare them for independent living.

* **Sec. 10.** AS 47.18.320(a) is amended to read:

(a) Subject to the availability of an appropriation made for the purposes of AS 47.18.300 - 47.18.390, the program may provide

(1) education and vocational training;

(2) assistance in obtaining basic education and training;

(3) career and employment services;

(4) training in basic life skills;

(5) housing and utility assistance;

(6) mentoring and counseling; and

(7) other appropriate services to complement the efforts of former state foster care recipients **or a child who was in state custody and placed in out-of-home care** to achieve self-sufficiency.

* **Sec. 11.** AS 47.18.390(1) is amended to read:

(1) "program" means the **out-of-home** [FOSTER] care transition program authorized under AS 47.18.300 - 47.18.390;

* **Sec. 12.** AS 47.18 is amended by adding a new section to read:

Sec. 47.18.335. Monetary living expense stipend. The department shall provide to an individual eligible for services under the program who has left out-of-home care a monthly stipend in an amount set by the department that is not more than the daily rate provided to a licensed foster parent for necessary living expenses. The stipend shall continue for a period of not more than one year and shall end before the individual is 23 years of age. The department may adopt regulations to implement this section.

* **Sec. 13.** AS 47.18.390(3) is repealed and reenacted to read:

(3) "out-of-home care" has the meaning given in AS 47.14.400.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB027(HSS)
() Publish Date:

Identifier (file name): SB027CS(HSS)-DHSS-CSM-3-17-09
Title: Foster Care Age Limit/Tuition Waiver
Sponsor: Davis
Requester: Senate HSS

Dept. Affected: Health & Social Services
RDU: Children's Services
Component: Children's Services Management
Component Number: 2666

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual	204.2		0.0	0.0	0.0	0.0	0.0
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**204.2**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	73.5						
1003 GF Match	130.7						
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**204.2**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The intent of CS SB 027 is to address the educational, financial, and housing challenges that face youth as they transition out of foster care, and to support those care providers who are willing to help them during that period of transition.

The Office of Children's Services Online Resource for the Children of Alaska (ORCA) data base is mandated by the federal government and must be continuously updated to reflect changes in both state and federal law and policy. The following provides the estimated cost of ORCA updates that will be required to implement this bill.

(continued on next page)

Prepared by: Tammy Sandoval, Director
Division: Office of Children's Services
Phone: 465-3191
Date/Time: 3/16/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 3/17/2009

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. CSSB027(HSS)

ANALYSIS CONTINUATION

Requirement	Functional LOE (hours)	Development LOE (hours)	Total LOE (hours)	Cost
Update Services page for new services.	120	80	200	$22,000.00
Update Education page with post-secondary educational institutions.	80	60	140	$15,400.00
Update OHP for unlicensed independent living service categories and service types.	120	80	200	$22,000.00
Update OHP for licensed service categories and service types over 18.	120	100	220	$24,200.00
Update Ref Value for age change from 18 to 21	80	60	140	$15,400.00
Update Eligibility page calculations for new age requirement.	180	160	340	$37,400.00
Update Medicaid Eligibility page calculations for new page	180	160	340	$37,400.00
Visitation Report	40	36	76	$8,360.000
Batch updates for OHP and Eligibility	40	160	200	$22,000.00
Days:	960/8 = 120 days	896/8 = 112 days	1856/8 = 232 total days	Total Estimate $204,160.00

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB027(HSS)
() Publish Date:

Identifier (file name): SB027CS(HSS)-DHSS-FP 3-17-09
Dept. Affected: Health & Social Services
Title: Foster Care Age Limit/Tuition Waiver
RDU: Office of Children's Services
Component: Family Preservation
Sponsor: Davis
Requester: Senate HSS
Component Number: 1628

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	4,833.1		1,907.8	1,907.8	1,907.8	1,907.8	1,907.8
Miscellaneous							
TOTAL OPERATING	**4,833.1**	**0.0**	**1,907.8**	**1,907.8**	**1,907.8**	**1,907.8**	**1,907.8**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts			238.4	316.5	316.5	316.5	316.5
1003 GF Match			1,669.4	1,591.3	1,591.3	1,591.3	1,591.3
1004 GF	4,833.1						
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**4,833.1**	**0.0**	**1,907.8**	**1,907.8**	**1,907.8**	**1,907.8**	**1,907.8**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The intent of CSSB27 is to address the educational, financial and housing challenges that face youth as the transition out of foster care and to support foster care providers who are willing to help youth during that period of transition.

CSSB 27, as it relates to the Department of Health and Social Services Office of Children's Services, amends AS 47.10.080(c) to provide the court the authority to commit a child to placement to age 21 if in the best interest of the youth and the youth is in agreement; amends AS 47.10.990(3) by further defining a child to include youth under 21 years of age if that youth is living in out-of-home care; and expands the current Foster Care Transition Program (AS 47.18.300-390) to include children in state custody who were placed in out-of-home care and

(continued on next page)

Prepared by: Tammy Sandoval, Director
Division: Office of Children's Services
Phone: 465-3191
Date/Time: 3/16/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 3/17/2009

ANALYSIS CONTINUATION

identified as likely to remain in out-of-home care until age 18; and allows for a one-year monetary living expense stipend to eligible youth who have left out-of-home care up to age 23. This fiscal note addresses increased costs related to the one-year monetary living expense stipend to eligible youth up to age 23 who have left out-of-home care.

The OCS, lacking historical data or comparative program results, has made the following assumptions and applied them to this fiscal note:

1) The monetary stipend will be made available to youth age 18 to 23 who leave out-of-home care at any time during that age span.

2) The monetary stipend is not tied to post secondary education.

3) The number of youth who age out of foster care will remain somewhat stagnant at about 110 youth annually;

4) Assumes that 70% of youth ages 18 to 23 who are eligible to participate in the Independent Living Program (IL) will make use of the monetary stipends in FY2010. This equates to approximately 380 full time equivalents (FTEs) who will become eligible, resulting in higher program costs the first year the stipend is available. FTEs are used to account for the constant change in the population as more youth turn 18 to 23 and move on and off the program at varying rates.

5) The out years will lose children aging out of foster care and pick up new youth between ages 19 and 23 who have not yet utilized the program, still maintaining the assumption that 70% will eventually utilize the program. There is no available data or program results upon which to base these assumptions.

6) Calculations are based on 360 days at an average daily rate of $35.33; $35.33 x 30 = $1,060/month.

7) Currently, federal reimbursement for the extension of the IL program is not available. However, the Adoption and Guardianship Fostering Connections to Success and Increasing Adoptions Act of 2008 includes the option to enhance the program. This fiscal note assumes that option can be implemented when available, October 1, 2010, and therefore is available for the final three quarters of FY2011 forward, only.

8) The foster care penetration rate and the Medical Assistance Percentage Rate will remain somewhat stable over the time period of this fiscal note.

	FFP	IL FTE	MOS FC/FTE	TOTAL EXP	Federal	GF
SFY 2010	0.00%	380	$1,060	$4,833,144	$0	$4,833,144
SFY2011	12.50%	150	$1,060	$1,907,820	$238,414	$1,669,406
SFY2012	16.59%	150	$1,060	$1,907,820	$316,546	$1,591,274
SFY2013	16.59%	150	$1,060	$1,907,820	$316,546	$1,591,274
SFY2014	16.59%	150	$1,060	$1,907,820	$316,546	$1,591,274
SFY2015	16.59%	150	$1,060	$1,907,820	$316,546	$1,591,274

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB027(HSS)
() Publish Date:

Identifier (file name): SB027CS(HSS)-DHSS-FCBR 3-17-09
Dept. Affected: Health & Social Services
Title: Foster Care Age Limit/Tuition Waiver
RDU: Office of Children's Services
Component: Foster Care Base Rate
Sponsor: Davis
Requester: Senate HSS
Component Number: 2236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	725.0		445.2	445.2	445.2	445.2	445.2
Miscellaneous							
TOTAL OPERATING	**725.0**	**0.0**	**445.2**	**445.2**	**445.2**	**445.2**	**445.2**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts			55.6	73.9	73.9	73.9	73.9
1003 GF Match			389.6	371.3	371.3	371.3	371.3
1004 GF	725.0						
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**725.0**	**0.0**	**445.2**	**445.2**	**445.2**	**445.2**	**445.2**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

CSSB 27, as it relates to the Department of Health and Social Services Office of Children's Services, amends AS 47.10.080(c) to provide the court the authority to commit a child to placement to age 21 if in the best interest of the youth and the youth is in agreement; amends AS 47.10.990(3) by further defining a child to include youth under 21 years of age if that youth is living in out-of-home care; and expands the current Foster Care Transition Program (AS 47.18.300-390) to include children in state custody who were placed in out-of-home care and identified to likely remain in out-of-home care until age 18; and allows for a one-year monetary living expense stipend to eligible youth who have left out-of-home care up to age 23. This fiscal note addresses increased foster care base rate reimbursements to providers for youth who remain in out-of-home care as defined by CSSB 27.

(continued on next page)

Prepared by: Tammy Sandoval, Director
Division: Office of Children's Services
Phone: 465-3191
Date/Time: 3/16/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 3/17/2009

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. CSSB027(HSS)

ANALYSIS CONTINUATION

The OCS, lacking historical data or comparative program results, has made the following assumptions and applied them to this fiscal note:

1) Foster care reimbursement payments will be made available to foster parents who provide care for youth who remain in the custody of the state beyond age 18 to age 21;

2) The choice made by youth in custody to remain in custody after age 18 is not tied to post secondary education;

3) Youth who are between the ages of 18 and 21 and were in state custody will not re-enter foster care;

4) The number of youth who age out of foster care will remain somewhat stagnant at about 110 youth annually;

5) It is assumed that many of the youth who decide to stay in foster care will be interested in post secondary education.

6) It is assumed that the percent of youth who choose to stay in foster care will decline as they age; at which point the youth will instead chose the option for a monetary stipend.

7) Calculations are based on 360 days per year, at an average daily rate of $35.33, using full time equivalents (FTEs) to account for the constant change in the population as youth turn 18, 19, and 20 and move on and off the program at varying rates. $35.33/day x 30 = $1,060/mo x 12 months = $12,720/year.

8) FTEs were estimated based on assuming that 15% of the youth in foster care will decide to remain in their foster homes when they reach 18 (17 individuals); 10% when they reach 19 (11 individuals); and 5% when they reach 20 (5 individuals); for a total of 33 youths in FY2010.

9) In addition to the 33 youth who choose to remain in foster care in FY2010, the OCS estimates that 24 additional children with special needs will want to remain in foster care in FY2010. Approximately 18 special needs children age out of foster care annually. Currently about 6 of the 18 are placed annually in extended care by the courts. While there is no statistical data to support the assumption that youth with special needs will chose to remain in foster care, the OCS believes that during FY2010, the ability for these youth currently age 17, 18, and 19 to agree to stay in care will be encouraged by foster parents, guardians ad litem, and the courts. The OCS projects that 12 of those youth will remain in foster care when they turn 18; 6 will remain when they turn 19; and 6 will remain when they turn 20; for a total of 24 youths with special needs in FY2010.

10) In FY2010, 33 youth will decided to stay in foster care, many of whom will seek post secondary education and 24 children with special needs will be encouraged to remain in foster care in order to receive the services they require, bringing the total number of youth to 57.

(continued on next page)

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. CSSB027(HSS)

ANALYSIS CONTINUATION

11) The OCS believes that after the first year of implementation when those youth currently age 17, 18, and 19 are brought into the program, out years will stabilize at 35 as the OCS, the courts, guardians ad litem, foster families and youth better prepare to take advantage of free tuition and costs as well as the monetary stipend. There is no data or comparative program information available to support this assumption.

12) Currently, federal reimbursement for the extension of the foster program is not available. However, the Adoption and Guardianship Fostering Connections to Success and Increasing Adoptions Act of 2008 includes the option to extend the assistance age through 20. This fiscal note assumes that option will be implemented when available, October 1, 2010, and therefore is available for the final three quarters of FY2011 forward, only.

13) The foster care penetration rate and the Medical Assistance Percentage Rate will remain somewhat stable over the time period of this fiscal note.

Fiscal Year	FTEs	AGES	Annual Cost per/FTE	Est. FFP	Total Annual Est. Cost	Federal Funds	General Funds
2010	57	18,19	$12,720	0.00%	$725,029	$0	$725,029
2011	35	18,19,20	$12,720	12.50%	$445,193	$55,635	$389,558
2012	35	18,19,20	$12,720	16.59%	$445,193	$73,868	$371,325
2013	35	18,19,20	$12,720	16.59%	$445,193	$73,868	$371,325
2014	35	18,19,20	$12,720	16.59%	$445,193	$73,868	$371,325
2015	35	18,19,20	$12,720	16.59%	$445,193	$73,868	$371,325

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 10, 2009

SUBJECT: Sectional Summary (CSSB 27( )
(Work Order No. 26-LS0205\E))

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds a new section entitling a person who was placed by the state in out-of-home care to a waiver of undergraduate tuition and fees in a state-supported school.

Section 2. Adds a cross reference to a definition for out-of-home care for the tuition waiver.

Section 3. Changes "foster care" to "out-of-home care" for purposes of the procurement code.

Section 4. Adds a cross reference to a definition for out-of-home care for medical assistance provisions.

Section 5. Extends court orders to age 21 for a child committed to the custody of the department.

Section 6. Changes the definition of "child" under AS 47.10 (child in need of aid) to include a person under 21 years of age living in out-of-home care.

Section 7. Changes "foster care" to "out-of-home care" for purposes of the child in need of aid statutes.

Section 8. Changes "foster care" to "out-of-home care" for purposes of the transition program to independent living.

Section 9. Changes "foster care" to "out-of-home care" for purposes of the transition program for children who are not less than age 18 living in out-of-home care, as defined.

Section 10. Adds children who were placed in out-of-home care to provide transition program services for the purpose of achieving self-sufficiency.

Section 11. Changes "foster care" to "out-of-home care" for purposes of the transition program definition.

Section 12. Adds a monetary stipend for children in the transition program for a specified period of time.

Section 13. Adds a cross reference to a definition for out-of-home care for purposes of the transition program.

JMM:plm
09-149.plm

CS SB 27
Needs fiscal
notes
3/11
Report 2/19

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 995(
Phone: (907) 269-01
Fax: (907) 269-0148

Session: (Jan. - May)
tate Capitol, Suite 30
eau, AK 99801-1182
one: (907) 465-3822
Fax: (907) 465-3756
free: (800) 770-3822

CS for Senate Bill 27( ) 26-LS0205\R

"An Act relating to tuition waivers for a child who was in out-of-home care; relating to eligibility for out-of-home care payments for a child; and amending the definition of 'child' in certain statutes."

Explanation of Committee Substitute

The Committee Substitute for Senate Bill 27 **narrowed the scope of the original bill** to include a) only those persons living under state custody in foster care or out-of-home care; b) who are under age 23; and c) who are presently enrolled as students in good standing. **It did not**, as the former bill indicated, **extend subsidies** to all foster care or out-of-home care persons ages 18-23 who may have aged out of the foster care system and are no longer under custody of the department or full-time students.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
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Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

CS for Senate Bill 27( ) 26-LS0205\R

"An Act relating to tuition waivers for a child who was in out-of-home care; relating to eligibility for out-of-home care payments for a child; and amending the definition of 'child' in certain statutes."

Sponsor Statement

The Committee Substitute (CS) for Senate Bill 27( ) adds a new section entitling a person who was placed by the state in foster or out-of-home care to a waiver of undergraduate tuition and fees in a state-supported school if the person is under 23 years of age, is living in out-of-home care, and enrolls as a student in good standing. The CS also changes the definition of "child," or child in need of aid or delinquent minor under AS 47.10 and 47.12 respectively, to include a person under 23 years of age living in out-of-home care. The hope is that the waiver of tuition and fees provided by CS SB 27 combined with other assistance in scholarships, mentoring, and in life skills without parental support will help level the playing field for out-of-home care children who deserve the opportunity and benefits of a higher education afforded to others.

Recognizing the severe educational disadvantages of persons placed in foster care or out-of-home care, many states have initiated a variety of college tuition waiver and scholarship programs for these persons. **Only recently the University of Alaska increased tuition waivers and additional assistance from five (5) to ten (10) students statewide who were in foster care in the state of Alaska on their 18th birthday.** The need is much greater. Data in 2006 indicated that there are over 2,000 children in foster care in Alaska at any one time. Over 5,000 live with relative care givers who are in a subsidized guardianship program. The average length of state in foster care in Alaska was 25 months but only 40% of children had 2 or fewer placements.

Education has been shown in studies to be a significant factor in determining the success of children and youth as they exit the foster care system. Research measuring educational, social, and vocational outcomes for children and youth in foster care indicate that the majority of children who enter the protection of child welfare agencies do poorly in school due to instability in placements and changes in schools. The small number who have successfully finished high school and are eligible and qualified to attend college need financial support and other assistance to continue in school. Too often they "age out" of the foster care system at age 18 and wind up on the streets and in shelters.

A Casey Family Program study of 1,000 foster care youth found that youth who had one or fewer home placements per year were twice as likely to graduate from high school before leaving care. Additionally, it was found that:

- Less than **70%** of youth in foster care finish high school before leaving care.
- Children and youth in out-of-home care experience **1 or 2** placement changes per year on average.
- Students in foster care score **16 to 20** percentile points below others in statewide standardized tests (Washington State study).
- Only about **3%** obtain a bachelor's degree within a few years of emancipation.

Nationwide the Casey Foundation reports that every year more than 25,000 youth attempt to make the transition from foster care to self-sufficiency as they reach age 18. Only half finish high school, and about 11 percent go on to college or vocational schools. Statistically, Alaska which regularly lags behind many other states in educational performance, provides foster care persons far less assistance in going to college. The CS SB 27 should help many more deserving and qualified foster care or out-of-home care youth obtain undergraduate degrees.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
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Fax: (907) 269-0148

Session: (Jan. - May)
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http://www.akdemocrats.org

Senator Bettye Davis

CS for Senate Bill 27( ) 26-LS0205\R

"An Act relating to tuition waivers for a child who was in out-of-home care; relating to eligibility for out-of-home care payments for a child; and amending the definition of 'child' in certain statutes."

Explanation of Committee Substitute

The Committee Substitute for Senate Bill 27 **narrowed the scope of the original bill** to include a) only those persons living under state custody in foster care or out-of-home care; b) who are under age 23; and c) who are presently enrolled as students in good standing. **It did not**, as the former bill indicated, **extend subsidies** to all foster care or out-of-home care persons ages 18-23 who may have aged out of the foster care system and are no longer under custody of the department or full-time students.

26-LS0205\R
Mischel
1/29/09

CS FOR SENATE BILL NO. 27( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, Ellis

A BILL

FOR AN ACT ENTITLED

"An Act relating to tuition waivers for a child who was in out-of-home care; relating to eligibility for out-of-home care payments for a child; and amending the definition of 'child' in certain statutes."

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

*** Section 1.** AS 14.43 is amended by adding a new section to read:

Article 3A. Free Tuition for a Person Who Was in Out-of-home Care.

Sec. 14.43.086. Free tuition and fees for a person who was in out-of-home care. A person who was in the custody of the state under AS 47.10 or AS 47.14 and placed in out-of-home care is entitled to a waiver of undergraduate tuition and fees if the person enrolls as a student in good standing in a state-supported educational institution in this state.

*** Sec. 2.** AS 47.10.990(3) is amended to read:

(3) "child" means a person **who is**

(A) under 18 years of age;

New Text Underlined [DELETED TEXT BRACKETED]

3334

(B) [AND A PERSON] 19 years of age if that person was under 18 years of age at the time that a proceeding under this chapter was commenced**; and**

(C) under 23 years of age if that person is

(i) in the custody of the department;

(ii) currently placed in out-of-home care; and

(iii) a full-time student.

*** Sec. 3.** AS 47.14.990 is amended by adding a new paragraph to read:

(13) "child" means a person under

(A) 18 years of age; and

(B) 23 years of age if the person is

(i) in the custody of the department;

(ii) currently placed in out-of-home care; and

(iii) a full-time student.

LEGAL SERVICES

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Juneau, Alaska 99801-1182
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MEMORANDUM January 30, 2009

SUBJECT: Sectional Summary (CSSB 27( ); Work Order No. 26-LS0205\R)

TO: Senator Bettye Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds a new section entitling a person who was placed by the state in out-of-home care to a waiver of undergraduate tuition and fees in a state-supported school.

Section 2. Changes the definition of "child" under AS 47.10 (child in need of aid) to include a person under 23 years of age living in out-of-home care.

Section 3. Changes the definition of "child" under AS 47.12 (delinquent minors) to include a person under 23 years of age living in out-of-home care.

JMM:ljw
09-051.ljw

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Friday, March 27, 2009 12:52 PM
To: Lynda Zaugg; Jake Hamburg
Subject: SB 133

Just wanted to let you know that Bill Streur, Deputy Commissioner for Medicaid and Health Care Policy, will be testifying for HSS on SB 133 in Senate HSS today.

Wilda Laughlin, DHSS Legislative Liaison
Juneau: 907-465-1613
Cell: 907-723-3802

Will be calling in

Dyson - No
Ellis - yes
Paskvan
Thomas - has fin -

Note:
Both Ellis & Thomas have bills up
in fin @ 2:30

Lynda Zaugg

From: Thomas Obermeyer
Sent: Monday, January 26, 2009 3:09 PM
To: mike.lesmann@alaska.gov; Don Burrell; Sen. Bettye Davis; Lynda Zaugg
Subject: FW: Request by OCS staff for appointment this week with Sen Davis regarding SB 27, Tuition Waiver, Foster Care

January 26, 2009

Mr. Lesman,

I would be happy to meet with you and Ms. Sandoval on short notice at almost any time for a few minutes, but if you have specific concerns about the wording of SB 27 or any other issues related to this bill or others, please first forward them in writing and/or by e-mail, so I can incorporate them in my work product, files, and discussions with you as legislation progresses.

Tom Obermeyer
465-3762
Thomas_Obermeyer@legis.state.ak.us

From: Don Burrell
Sent: Monday, January 26, 2009 2:41 PM
To: Thomas Obermeyer
Subject: RE: Request by OCS staff for appointment this week with Sen Davis regarding SB 27, Tuition Waiver, Foster Care

I have already spoke with Mike and informed him that he could coordinate with you to meet with you individually this week sometime because the Senator cannot except anymore appointments on Wednesday or Thursday of this week. You can meet with them on your own, but I cannot schedule them to meet with the Senator this week.

Don Burrell Jr.
Legislative Aide
Office of Senator Bettye Davis
State Capitol Building, Rm. 30
Juneau, Alaska 99801
P 907-465-3822
F 907-465-3756
don_burrell@legis.state.ak.us

From: Thomas Obermeyer
Sent: Monday, January 26, 2009 2:39 PM
To: Don Burrell; Sen. Bettye Davis; Lynda Zaugg
Cc: mike.lesmann@alaska.gov
Subject: Request by OCS staff for appointment this week with Sen Davis regarding SB 27, Tuition Waiver, Foster Care

Don Burrell, 465-3822 -

Mike Lesmann, Program Coordinator and legislative liaison for OCS left me a voice-mail message today requesting an appointment with Senator Davis on Wednesday or Thursday this week including him, his

supervisor Tammy Sandoval, and perhaps me, concerning SB 27, Foster care Tuition Waiver.

I noted Senator Davis has a very busy schedule this week, but since you are the gate-keeper of her appointments, **could you please see what time may be arranged with Mr. Lesmann and Ms. Sandoval and give Mr. Lesmann a call? Mr. Lesmann's phone is 465-3548. Please advise of an agreed time.**

Tom Obermeyer
465-3762

adn.com
Anchorage Daily News

Rally spotlights foster kid needs

IDEAS: Braces, tuition waivers, longer health benefits advocated.

By LISA DEMER
ldemer@adn.com

(09/30/08 23:31:47)

Alaska foster kids and former foster kids rallied Tuesday to put attention on their agenda for improved college opportunities, better health benefits and help with housing as they leave foster care.

The event took place across the street from the state Office of Children's Services downtown, and some state workers stood alongside the kids, said Amanda Metivier, president of the advocacy group Facing Foster Care in Alaska. About 20 people, including state Rep. Les Gara, who grew up in foster care, took part, she said.

"We're rallying around our policy agenda," said Metivier, a former foster child who will graduate in December with a social work degree from the University of Alaska Anchorage.

The group's efforts are powerful and could make a difference, said Tammy Sandoval, director of the state Office of Children's Services.

"I am thrilled that they have come together and have found their voice to help OCS and legislators and other policy makers to help get their needs known and out," Sandoval said.

The group wants tuition waivers for all former foster children at the University of Alaska instead of a limited number a year, which just increased from five to 10 statewide, Metivier said. Studies show that only about 1 percent of former foster kids now graduate with a four-year college degree or vocational certificate, the group says.

The foster care group also wants more help for kids as they reach adulthood. For one, the group says Alaska kids should be able to receive state support until age 21, even if they live on their own. Some states allow that, the group says, and Alaska needs to be more creative. Too many former foster kids end up on the streets and in shelters, Metivier said.

"This summer has been terrible. We've had so many homeless youth," Metivier said.

The foster care group would also like to see Medicaid coverage extend to former foster children until age 21. And they want Medicaid to pay for braces for foster youth, which is currently not the case.

In coming up with their agenda, the foster youth and former foster kids "brainstormed all these ideas. But the braces were No. 1. It's a self-esteem thing," Metivier said.

The foster care group did its homework, Sandoval said. Now it's up to OCS, legislators and others to study the proposals and see what could work here, she said. Some things already are improving. Sandoval mentioned a bill that passed last year allows churches, private groups, businesses and individuals to create college savings accounts for foster kids.

CLASP

Child Welfare In Alaska

September 2006

Alaska's Children [1]

Child Population	183,355
Children Living in Poverty	26,623
Child Poverty Rate	14.5%

Child Abuse and Neglect [2]

Child Victims — Data Unavailable

Type of Abuse and Neglect	Percent*
Neglect and Medical Neglect	Data Unavailable
Physical Abuse	Data Unavailable
Sexual Abuse	Data Unavailable
Psychological and Other Maltreatment	Data Unavailable

*Percentages may not total 100% because abuse or neglect can be reported in one or more categories.

Foster Care [3]

Number of Children in Foster Care*	2,040	Average Length of Stay in Foster Care	25.1 mos.
Children with 2 or Fewer Placements	40%	Abused and Neglected While in Care	Data Unavailable

*Foster care includes family foster care, group care and institutional care

Permanency [4]

Number of Exits from Foster Care — 781

Type of Exit	Percent
Adoption	22.5%
Reunification	66.7%
Legal Guardianship	4.1%
Other	3.5%
Missing Data	3.2%

Percent of Children Reunified		Percent of Children Adopted	
Within 0-11 months	58.7%	Within 0-11 months	6.8%
Within 12-23 months	29.8%	Within 12-23 months	17.0%
After 24 months	11.1%	After 24 months	76.1%

Number of Children Waiting for Adoption — 639

Relative Caregivers [5]

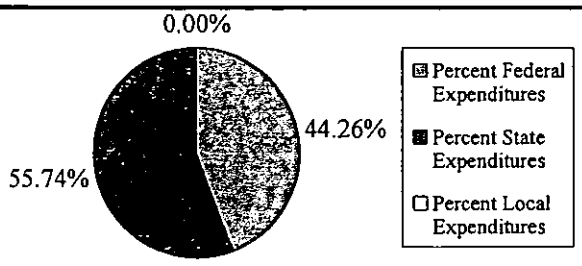
Number of Children Living with Relatives Without Either Parent Present (not necessarily in foster care) — 5,110

Subsidized Guardianship Program? — Yes

Subsidized guardianship programs make it possible for eligible children to live permanently in the care of a legal guardian who has agreed to provide a safe and loving home for them and who receives ongoing payments to help provide for the needs of the child. In many cases, the child's guardian is a relative or a close family friend.

Sources of Child Welfare Spending [6]

FY 2004	Amount
Federal Expenditures	$37,786,604
State Expenditures	$47,581,700
Local Expenditures	$0
Total	$85,368,304



Major Federal Child Welfare Spending [6]

FY 2004	Amount	Percent of Total Federal Spending
Title IV-B	$1,081,499	2.86%
Title IV-E	$20,441,777	54.1%
Social Services Block Grant (SSBG)	$7,042,600	18.64%
TANF (Temporary Assistance for Needy Families)	$0	0%
Medicaid (Excludes Medicaid expenditures for routine health care services provided to children in foster care.)	$7,008,813	18.55%

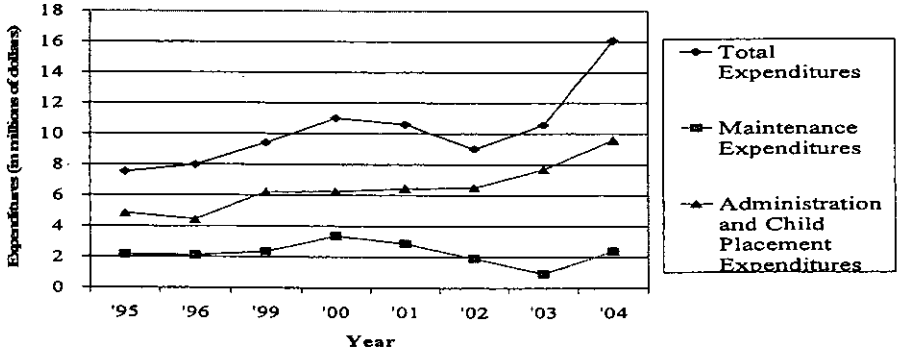
Percentages may not total 100% because some states could not categorize all federal spending by source.
The previous version of this fact sheet contained information on spending from SSI. The Urban Institute did not collect that data in the most recent survey.

Federal Title IV-E Spending [7]

Foster Care Expenditures FY 2004			Adoption Assistance Expenditures FY 2004		
Type	Amount	Percent	Type	Amount	Percent
Maintenance Payments	$2,389,921	14.87%	Adoption Assistance Payments	$6,365,459	91.27%
Administration and Child Placement Services	$9,586,594	59.64%	Administration	$596,641	8.55%
SACWIS	$3,314,715	20.62%	Training	$12,411	0.18%
Training	$781,653	4.86%	Total	$6,974,511	
Total	$16,072,883				

- In 2003, 190 (9.31%)* Children in Foster Care Received Title IV-E Funded Foster Care Payments
- In 2002, 995 (85.63%)** Children Adopted from Foster Care Received IV-E Funded Adoption Assistance Payments

Federal Title IV-E Foster Care Spending 1995-2004



*Average monthly number of children receiving federal foster care divided by the number of children in foster care on the last day of the year.
**Average monthly number of children receiving federal adoption assistance divided by the total number of children receiving adoption assistance at a point in time.

Sources and Notes

*All data provided are most current available as of September 2006.

1) United States Census Bureau, 2005 American Community Survey, Summary Table S1701. Poverty Status in the Past 12 Months Calculations by CDF, August 2006
2) U.S. Department of Health and Human Services (DHHS), Children's Bureau, *Child Maltreatment 2004* (Washington, D.C.; Government Printing Office, 2006) Tables 3-2 and 3-5
3) The number of children in foster care is the number in foster care on Sept. 30, 2003: U.S. DHHS, Administration on Children, Youth and Families, *Child Welfare Outcomes 2003: Annual Report* (Washington D.C.; Government Printing Office, September 2006), Context Data Chart C; Length of stay and placement data (2001): U.S. Congress, House of Representatives, Committee on Ways and Means, 2004 Greenbook (Washington, D.C.; Government Printing Office, 2004) Charts 11-38 & 11-36; and abuse and neglect data (2003): U.S. DHHS, Administration on Children, Youth and Families, *Child Welfare Outcomes 2003: Annual Report* (Washington D.C.; Government Printing Office, September 2006), Table 2.1
4) *Child Welfare Outcomes 2003: Annual Report*, Tables 3.1, 4.1, 5.1, and Context Data Chart D
5) U.S. Department of Commerce, Bureau of the Census, *2000 Census American Fact Finder Advanced Query.* Calculations by CDF of the number of children living in relative-headed households without either parent present; and CDF *States' Subsidized Guardianship Laws At A Glance* (Washington, D.C.; CDF, 2006).
6) Cynthia Andrews Scarcella, Roseana Bess, Erica Hecht Zieleweski, and Rob Geen. *The Cost of Protecting Vulnerable Children V: Understanding State Variation in Child Welfare Financing* (Washington, D.C.; The Urban Institute, 2006).
7) U.S. Department of Health and Human Services Expenditure Data for FYs 2000-2004; U.S. Congress, House of Representatives, Committee on Ways and Means, Greenbook: 1996, 1998, 2000, and 2004; and Ursula Gilmore and Elizabeth Oppenheim, Interstate Movement of Children Receiving Adoption Assistance (Wash, D.C.; American Public Human Services Association, 2003).

For more information please contact tconway@clasp.org (202-906-8031) or jchang@childrensdefense.org (202-662-3629)

Why Focus on Foster Care and Education?

For the over **800,000** children and youth served in foster care each year in the United States, education is a potential positive counterweight to abuse, neglect, separation, impermanence and instability.

Positive school experiences enhance their well-being, help them make more successful transitions to adulthood, and increase their chances for personal fulfillment and economic self-sufficiency, as well as their ability to contribute to society.

Education should be approached as an integral part of permanency rather than as a choice between permanency and education.

Studies have shown that education is a significant factor in determining the success of youth as they exit the foster care system and beyond.

When the focus is on education, the results are improved educational performance, fewer behavior problems, lower drop-out rates, and more successful transitions to employment and higher education.

Facts and Figures*

- Less than **70%** of youth in foster care finish high school before leaving care.
- Children and youth in out-of-home care experience **1 or 2** placement changes per year on average.
- Students in foster care score **16 to 20** percentile points below others in statewide standardized tests (Washington State study).
- Only about **3%** obtain a bachelor's degree within a few years of emancipation.

***Visit www.casey.org/friendsandfamilies /partners for fact sheet citations.**

The National Working Group on Foster Care and Education

The mission of the National Working Group on Foster Care and Education is to ensure successful educational outcomes for children and youth in foster care across the country.

This partnership has grown out of the recognition that only through collaboration can practice, policy, and cultural changes take place that will support educational stability and achievement as priorities in the lives of children and youth in care.

The Working Group is committed to heightening awareness of the educational needs of children and youth in care and to promoting best and promising practices and reforms across the education, child welfare, and court systems.

The Working Group's goals are to promote:

- Educational stability for children and youth in foster care
- Seamless educational transitions for children and youth when education changes do occur
- High quality educational experiences, expectations and aspirations for young people in foster care
- Greater national attention to the disparate educational outcomes for young people in foster care, particularly youth of color

American Bar Association Center for Children and the Law/National Child Welfare Resource Center on Legal and Judicial Issues
American Public Human Services Association
Casey Family Programs
Child Welfare League of America
Education Law Center—PA
Juvenile Law Center
National CASA Association
National Council of Juvenile and Family Court Judges
National Foster Parent Association

Come See What's New! Visit the all new Family Forums, Parenting Forums and Pregnancy Forums Today.

College Tuition Waiver and Scholarship Programs

A significant post adoptive service offered by states is the waiver or payment of college tuition on behalf of adopted children who were once in foster care.

States with College Tuition Waiver Programs

Florida
Children who are in foster care, receiving independent living services, or who are adopted from the Department of Children and Families after December 31, 1997 are exempt from all undergraduate fees, including registration, matriculation, and laboratory fees associated with enrollment in college preparatory instruction and completion of the college level communication and computation skills testing program in the State Community College System, the State University System, and other adult general education programs.

Kentucky
Tuition and mandatory fees for any public postsecondary institution, including all four year universities and colleges and institutions of the Kentucky Community and Technical College System, shall be waived for a Kentucky foster or adopted child who is a full-time student. [KRS 194B.050(1), 164:2847]

Maine
Funding is available for children up to age 21 using Title IV-B dollars. The program is limited to children whose families received adoption assistance.

Maryland
Available for youths who were adopted after their 14th birthday.

Massachusetts
Legislation passed July 1, 2000

Oregon
Children who were a ward of the court and in the legal custody of the state between age 16 and 21 are able to apply for the Former Foster Children Scholarship. More information is available from 800-452-8807 x 7395

Texas
Available for youth in state conservatorship at 14 years or older, if the youth is eligible for adoption

Virginia
Children must have been in foster care. For special needs children. Legislation passed in the 2000 session. Go to: www.vccs.cc.va.us/vccsasr/tuitiongrant/tuitiongrant.html

States With Other College Tuition Programs

Delaware
Offers a scholarship program for former foster children. Adopted children can apply but family income is considered. The DE Legislature budgeted $50,000 in 2001.

District of Columbia
Offers a scholarship program for children adopted from the District's foster care system after Oct. 1, 2000. Covers vocational training, as well as college funding.

Hawaii
Continues to pay board rate for former foster children (not adopted) up to the 22nd birthday if in vocational school/college. See www.hcf-hawaii.org or 888-731-3863.

Illinois
DFS has statutory authority to award up to 48 scholarships per year to children who are in substitute care, who have been adopted and prior to their adoption were under the Department's legal responsibility, or who are in subsidized guardianship living arrangements.

Minnesota
The Minnesota State College and University System offers free tuition to children committed to state guardianship (i.e., foster children) but are not adopted.

West Virginia
The department has tuition waivers for foster children only.

States That Are Exploring a Tuition Waiver Programs

Arkansas

Missouri

Montana

Casey Family Programs and Orphan Foundation of America

Each year, more than 25,000 youth attempt to make the transition from foster care to self-sufficiency as they reach age 18. Only half finish high school, and about 11 percent go on to college or vocational education much lower rates than the national averages. Through a new post-secondary education scholarship program, The Casey Family Programs will provide up to $10,000 per year to youth under the age of 25 who have spent at least 12 months in foster care and were not subsequently adopted.

The awards will be renewable each year, based on satisfactory progress and financial need. The Orphan Foundation of America (OFA) will administer the program, and the recipients will also receive ongoing support through OFA's E-Mentor Program. OFA scholarship coordinators will match each student with a trained, screened adult who will interact with the student via e-mail, letters, and phone calls on a weekly basis to address specific issues faced by young people without parental support, including money management and life skills.

For more information on this and other OFA scholarship programs, visit www.orphan.org/casey.html or call 800-950-4673.

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College Tuition Waiver and Scholarship Programs

A significant post adoptive service offered by states is the waiver or payment of college tuition on behalf of adopted children who were once in foster care.

States with College Tuition Waiver Programs

Adoption Subsidy

United States
- State Profiles
- Fact Sheets
- Definitions
- National Summary

Canada
- Provincial Profiles

News & Resources

FAQs

Florida	Children who are in foster care, receiving independent living services, or who are adopted from the Department of Children and Families after December 31, 1997 are exempt from all undergraduate fees, including registration, matriculation, and laboratory fees associated with enrollment in college preparatory instruction and completion of the college level communication and computation skills testing program in the State Community College System, the State University System, and other adult general education programs.
Kentucky	Tuition and mandatory fees for any public postsecondary institution, including all four year universities and colleges and institutions of the Kentucky Community and Technical College System, shall be waived for a Kentucky foster or adopted child who is a full-time student. [KRS 164:2847]
Maine	Funding is available for children up to age 21 using Title IV-B dollars. The program is limited to children whose families received adoption assistance.
Maryland	Maryland offers the Maryland Waiver, which allows children who meet certain criteria to attend college in Maryland. To be eligible for the waiver you must meet the following criteria: 1. Be a Maryland resident 2. Be in a foster care placement at the time you are graduating high school, or successfully completed your GED or adopted after your 14th birthday. 3. Attend a college in Maryland, the waiver does not pay for a training program, nor does it cover the cost of books and or transportation. 4. Applicant must complete the Free Application for Federal Student Aid

	(FAFSA). 5. Waiver is good for 5 years after first year enrolling.
Massachusetts	Legislation passed July 1, 2000
New Jersey	New Jersey offers a College Tuition Waiver or College Scholarship program for foster and adopted youth. Adopted children over the age of 12 are eligible. The program is managed by Foster and Adoptive Family Services (FAFS), 800-222-0047 (ask for the scholarship department), email at scholarship@FAFSonline.org, or on the web at www.fafsonline.org/Scholarship.html
Oregon	Children who were a ward of the court and in the legal custody of the state between age 16 and 21 are able to apply for the Former Foster Children Scholarship. More information is available from 800-452-8807 x 7395
Texas	As of September 1, 2003, a student is exempt from the payment of college tuition and fees at state supported colleges and universities if the student was adopted AND was the subject of an adoption assistance agreement between the adoptive parents and DFPS (under Subchapter D, Chapter 162, of the Texas Family Code) Please note that any child adopted and who was the subject of an adoption assistance agreement between the adoptive parents and DFPS before September 1, 2003 is eligible, as well as any person in the future meeting this requirement.
Virginia	Children must have been in foster care. For special needs children. Legislation passed in the 2000 session. Go to: http://www.dss.state.va.us/family/tuitiongrant.html

States With Other College Tuition Programs

Delaware	Offers a scholarship program for former foster children. Adopted children can apply but family income is considered. The DE Legislature budgeted $50,000 in 2001.
District of Columbia	Offers a scholarship program for children adopted from the District's foster care system after Oct. 1, 2000. Covers vocational training, as well as college funding.
Hawaii	Continues to pay board rate for former foster children (not adopted) up to the 22nd birthday if in vocational school/college. See www.hcf-hawaii.org or 888-731-

	3863.
Illinois	DFS has statutory authority to award up to 48 scholarships per year to children who are in substitute care, who have been adopted and prior to their adoption were under the Department's legal responsibility, or who are in subsidized guardianship living arrangements.
Minnesota	The Minnesota State College and University System offers free tuition to children committed to state guardianship (i.e., foster children) but are not adopted.
West Virginia	West Virginia has a tuition waiver program available. It is limited to children residing in a foster care setting when they graduate from high school, starting with the graduating class of 2000. It is available in state-supported colleges only. The application can be obtained from the college of choice. (Effective October 2002) Children adopted from the DHHR foster care system during the month they turn 16 are eligible to receive the Chafee Education Voucher to assist with post-secondary education costs.

States That Are Exploring a Tuition Waiver Programs

Arkansas

Missouri

Montana

Casey Family Programs and Orphan Foundation of America

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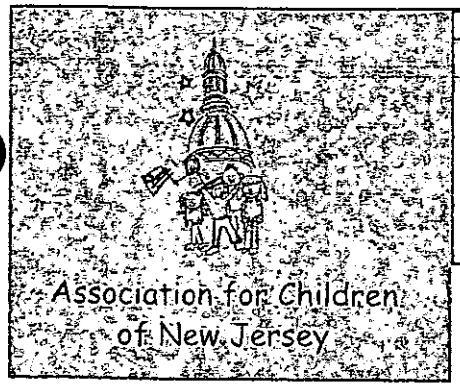

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Getting Foster Youth to and through College

Successes and Challenges of the New Jersey Foster Care Scholars Program

This report was made possible by grants from the Annie E. Casey Foundation and the Delisi Family Foundation. It was written and researched by ACNJ Communications Director Maia Davis and ACNJ legal intern Elizabeth Losey.

Introduction

In 2003, New Jersey took advantage of federal funding to start a scholarship program for foster youth to attend college. State officials anticipated that a few dozen youth would apply. But New Jersey Foster Care Scholars drew 90 young people its first year. By the 2007-08 academic year, the number enrolled in the program had grown six-fold to 556. Of those, 443 went on to register for classes and receive grants.

The popularity of the scholarship program is a testament to its importance. Many young people flocking to apply for scholarships see an opportunity for higher education that they thought they would never have.

> *"I always thought, 'College costs too much. I don't have money to pay for it.'" —Kassim, 22, in the scholarship program three years and starting his senior year of college.*

Young people know a college degree is increasingly essential to success in today's competitive economy. Without it, they risk spending their lives stuck in low-wage work.

Youth aging out of foster care are particularly vulnerable. Many come from families unable to provide the stability or support children need to succeed in school. After being removed from their homes because of abuse or neglect, the children may endure repeated moves, further disrupting their schooling. The results of such childhood trauma, deprivation and dislocation can show up in their academic records. Among a 2005 sample of Midwestern foster youth, more than a third had not achieved either a high school diploma or GED by age 19. That is more than three times the percentage of their peers without this basic level of educational attainment.[1]

The New Jersey Foster Care Scholars program (NJFC Scholars) requires scholarship recipients to have either a high school diploma or GED. But some begin college with an educational deficit they have to make up through non-credit remedial courses. In addition to academic challenges, former foster youth are more likely than their peers to lack either the financial or emotional support of parents. On average in the United States, young people ages 18 to 34 receive an estimated $38,000 from parents to pay for college, supplement wages, assist with down payments on a house and other types of financial help.[2] This gives an idea of what former foster youth lose when they lack parents' financial support during college and after.

Typical college students also rely on parents for non-material assistance, including emotional support; advice on possible career paths and how to adapt to college life; and a place to live during college breaks. Studies show the lack of family involvement experienced by many foster youth creates a need for supplemental, non-financial supports, such as mentoring or counseling. For some students, such supports could make the difference of whether they stay in college or drop out.

The Association for Children of New Jersey has taken a look at the scholarship program through interviews with staff at the state Department of Children and Families (DCF) and the private agency that administers the program for the state; older foster youth and their counselors; and officials in other states that run similar scholarship programs. This report is the second in a series of ACNJ briefs on youth aging out of foster care.

To address the needs of foster youth, a comprehensive scholarship program should have:

- **Stable funding** sufficient to cover students' room and board costs as well as tuition and fees.
- **Non-material assistance** for students, including mentoring or counseling and access to academic tutoring.
- **Expansive eligibility rules** that offer scholarships to youth who left foster care as teenagers through adoption or guardianship in addition to those still in care or who have aged out.

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- **Practices based on the principles of "positive youth development,"** an approach designed to help youth become independent, self-supporting adults. This approach helps young people strengthen their abilities to make good decisions, reach out to community resources for help, and connect to the larger society.
- **Extensive data collection to track the progress of students,** including on how many graduate and what conditions are conducive to success in college. For example, data should be collected on whether students live on or off campus; are in state custody or enrolled in some state-funded service for aging out youth; whether they work full- or part-time; and whether they have student loans.

Our findings show New Jersey has most of these elements at least partially in place. But some are missing:

- New Jersey's scholarship program lacks a sufficient, stable source of funding because the Legislature never appropriated funds to implement a 2003 law guaranteeing former foster youth free tuition to state public colleges. Notably, the program lacks enough funding to cover room and board costs for all students. The lack of a legislative appropriation is of particular concern because of a cut this year in New Jersey's share of federal funds for foster youth scholarships. The federal funding cut is a result of a reduction in the number of New Jersey children in foster care.
- New Jersey offers mentoring to NJFC scholarship recipients but not all students have availed themselves of the service. Students may also receive counseling or case management from other sources, including a Division of Youth and Family Services (DYFS) caseworker, if they are still in state care. The challenge for New Jersey is that scholarship recipients have varied situations. Some may be receiving the counseling and emotional support they need; others may not. Academic tutoring is not offered through NJ Scholars. Students who need academic support are expected to seek it at their college.
- New Jersey's scholarship program has more expansive eligibility guidelines than scholarship initiatives in many other states. The state has intentionally, for example, opened enrollment to youth who are homeless, in Kinship Legal Guardianship, or who were adopted from foster care between 12 and 15 years old. Still, data suggest the program reaches only a fraction of the approximately 1,900 young people who may be eligible.
- DCF embraces the positive youth development approach to older youth and has this year conducted trainings in it for caseworkers and contracted service providers. The state is also incorporating some principles of positive youth development directly into the scholarship program, such as through a new requirement for scholarship recipients to sign an agreement that sets out their obligations in the program.
- New Jersey has insufficient data on youth who have received scholarships. DCF and Foster and Adoptive Family Services (FAFS), the private agency that administers NJFC Scholars for the state, are concerned that too many students are dropping out. They need data to confirm this and to track what might be contributing to the problem. FAFS will this year begin a significant expansion of its data collection, including on the number of students who return each year and the number who withdraw.

I. How It Began: A State Law With No Funding

Former Governor James McGreevey and the New Jersey Legislature in 2003 passed a law establishing the Statewide Tuition Waiver Program.[3] Despite its name, the law does not waive the college tuition of foster youth. Rather, it mandates that the state cover whatever tuition costs remain for eligible foster youth at state public colleges and vocational schools after all other grants, such as from Pell and the Tuition Aid Grant (TAG), are applied. In addition to these restrictions, the law was never funded by the Legislature, which has undercut its potential benefit to foster youth.

Federal Funding to the Rescue But it is Not Enough

New Jersey has been able to avoid appropriating money for the tuition-waiver law by relying largely on federal money. Around the same time the state law was passed, federal scholarship funds became available through Chafee Independent Living Education and Training Vouchers (ETV) for foster youth. The ETV program allows states to give up to $5,000 per year to current and former foster youth for higher education tuition, room, board and other expenses.

DCF has supplemented the ETV funds with significant additional financing from other state and federal grants to its department. It has used this mix of funding to fulfill the tuition-waiver law's mandate and go beyond it by providing scholarships to both public and private colleges, in and out of state. The funding is insufficient, however, to cover room and board for all students; housing costs are a big source of anxiety for many scholarship recipients. The funding crunch has been exacerbated this year by a cut in the state's share of federal ETV funding from $1,066,000 to $926,000.

II. How it Works: Some Quick Facts on the New Jersey Foster Care Scholars Program

- The scholarship program is run through a partnership of three agencies—DCF, FAFS and the Project Myself program at Rutgers University School of Social Work. FAFS, formerly called the Foster Parents Association, was a driving force behind the state's establishment of a foster youth scholarship initiative.
- DCF contracts with FAFS to administer the program, which includes processing applications; determining the size of grants based on students' eligibility and need; liaising with college financial aid offices; and disbursing grants for tuition and living expenses as varied as a computer, child care, or a bus pass.

- FAFS' responsibilities also include outreach to potential scholarship recipients. Its contract this year calls for less mass outreach, such as through advertising, and more targeted outreach to organizations and individuals who work with older and former foster youth, which DCF thinks will be more effective.
- DCF also contracts with the Rutgers School of Social Work to run Project Myself, which provides mentoring and arranges volunteer community service work for scholarship recipients.
- Students can qualify for scholarships through meeting the eligibility rules of either the state tuition waiver or federal ETV programs. Scholarships are also available to youth who have been homeless or left foster care through adoption or Kinship Legal Guardianship, an important benefit to families who provide permanent homes to older foster youth.
- Although there are several ways to qualify, scholarships all essentially come out of the same pot of money, which is a combination of federal and state funds.
- The maximum ETV grants are $5,000 per academic year. Grants may be higher for students who qualify under the tuition-waiver program and whose remaining tuition costs, after other federal and state grants are applied, exceed $5,000. FAFS works to develop a scholarship package for each student that maximizes the availability of funds.
- Most scholarships provided are for college; approximately 10 percent of the youth in 2007-08 applied for scholarships to private technical schools.
- FAFS encourages students to choose a college, public or private, that best meets their needs. Many foster youth begin their studies at state community colleges, which offer vocational-type courses such as in nursing or technology that may be in line with students' career goals. Courses at two-year colleges are also less costly than at four-year schools, which is particularly important when students must take non-credit remedial classes.

III. How NJFC Scholarship Participants Fare

How They Fare Financially: The Anxiety Over Living Expenses

College is an expensive proposition. Many NJFC scholarship recipients attend with no financial support from family.

As shown by examples on the chart below, the "cost of attendance" at New Jersey public and private colleges varies greatly. The chart does not include the costs at private technical schools, which can approach or exceed that of private colleges.

Students attending community colleges typically get nearly all their tuition covered by federal and state grants. They are more likely to get NJFC scholarship aid for room and board. But those at the more costly four-year schools, particularly schools that are private or out of state, are less likely to have anything but tuition covered. These students are more likely to have to pay some or all of their room and board and other living expenses on their own.

continued on page 6

Sample of One Year of Higher Education Costs in NJ vs. Grants Available for Youth in NJ Foster Care Scholars Program[1]

Cost of Attendance	Felician College (Private)	Montclair State University (Public)	Rutgers University (Public)	Brookdale Community College (Public)
Tuition and Fees	$23,500	$9,781	$10,614	$1,772
Room and Board	$9,350	$10,304	$9,482	$9,239
Books	$1,000	$1,000	$1,000	$600
Transportation	$800	$1,152	$900	$1,136
Miscellaneous	$1,800	$3,637	$1,500	$849
Total Cost	**$36,450**	**$25,874**	**$23,496**	**$13,596**
Maximum Entitlement Grant Eligibility				
Federal Pell Grant	$4,731	$4,731	$4,731	$4,310
Federal Supplemental Educational Opportunity Grant (SEOG)	$1,000	$1,800	unknown	$400
State Tuition Aid Grant	$10,136	$6,036	$7,922	$2,646
NJ Educational Opportunity Fund (EOF)[3]	$2,500	$1,400	$1,400	$1,050
From NJ Foster Care Scholars, either:				
State Tuition Waiver or	0	Covers remainder of tuition and fees only, after other grants are applied		
Maximum Chafee ETV	$5,000	$5,000	$5,000	$5,000
Total Grants (excluding tuition waiver)	**$23,367**	**$18,967**	**$19,053**	**$13,406**
Deficit	**$13,083**	**$6,907**	**$4,443**	**$190**

[1] All costs calculated based on full-time, in-state student living on campus. In the case of Brookdale Community College, estimated costs are for a student living independently.
[2] Cost of Attendance is the amount calculated by the college and used in the calculation of financial aid, including for NJFC Scholars.
[3] The New Jersey EOF serves students who are capable and motivated to attend college but who are economically disadvantaged and had poor high school preparation. It is primarily available to students from lower socioeconomic school districts. EOF is offered by nearly all private and public colleges and is administered separately at each college.

Comparison of State Scholarship Programs for Foster Youth

Numbers are for 2007–08 year unless otherwise noted.

Eligibility	Number of potentially eligible youth[1]	Number scholarships	Tuition coverage to state public colleges	Tuition coverage to private colleges	Tuition coverage to out-of-state colleges
NEW JERSEY 1. Eligible for tuition waiver: Youth who have been homeless or in foster care for at least 9 months at age 16 or older and youth who have lived in DYFS-funded transitional housing. Also homeless youth. Must apply by 23rd birthday and attend college full-time. 2. Eligible for ETV: Youth 16 to 21 who were in care or adopted from care after 16th birthday. 3. Youth who left care between ages of 12 to 16 through adoption or Kinship Legal Guardianship.	1903 total for state	443 total for state	Yes	Yes, except for students who qualify only for tuition waiver	Yes, except for students who qualify only for tuition waiver
CONNECTICUT Youth must voluntarily remain in state care to get scholarships. Eligibility for vocational school is up to age 21, for college it is up to age 23.	1,581	562	Yes	Yes	Yes
MARYLAND 1. Eligible for tuition waiver: Youth in care upon receipt of h.s. diploma or receipt of GED, or adopted from care after 14. 2. Eligible for ETV: Youth in care or who have aged out of care, and those adopted from care after age 16.	3,038	128 tuition waivers; 256 ETV recipients, 2006–07	Yes	No on tuition waiver, yes on ETV	No on tuition waiver, yes on ETV
NEW YORK ETV program only: Youth in care or who have been in care from age 18 up to 23, and those adopted from care after age 16.	8,680	810	Yes	Yes	Yes
NORTH CAROLINA 1. Eligible for ETV program: In state care on or after 17th birthday or adopted from care after 16th birthday. Eligible up to age 23. 2. Eligible for NC REACH, a new program starting in 2008-09: Youth who aged out of care at age 18 or were adopted from care after age 12.	1,583	263 ETV recipients. No number available for NC REACH as it is new program.	Yes	Yes on ETV; no on NC REACH	Yes on ETV; no on NC REACH

[1] *Based on the number of youth ages 16 to 21 who are or were in foster care, 2004 data from the federal Adoption and Foster Care Analysis Reporting System (AFCARS).*

Room and board coverage	Other Supports	Federal ETV Funding	Other federal money	State contribution	Total amount spent
Amount available is generally what is left after tuition. Maximum grant for tuition, room and board is $5,000.	Mentoring and community service work through Project Myself. Some students also receive counseling or case management from DYFS caseworkers or through DYFS-funded programs.	$1,066,000.	$947,327 (from Temporary Assistance to Needy Families (TANF) and Chafee Independent Living funds).	$905,396 (from state grants to DCF and DCF purchase of services).	$2,918,618.
Youth receive up to $1,813 per month from state housing program.	Funding from ETV also used for tutoring, computers and other supports.	$668,612.	Unknown.	$7,336,157 on tuition, housing and other supports.	$8,004,769.
dependent living supports (rent, utilities, etc.) available on case-by-case basis.	Mentoring, tutoring, and other supports provided by Orphan Foundation.	$962,000.	None.	$307,200 to tuition waiver program. $86,580 to ETV program.	$1,355,780.
Generally, amount available for room, board and other expenses is what is left after tuition and fees are paid.	Mentoring, tutoring, and other supports provided by Orphan Foundation.	$2,603,191.	None.	$234,287.	$2,837,478.
1. ETV: Amount available is generally what is left after tuition. Maximum grant for tuition, room and board is $5,000. 2. NC REACH: fully covers room, board, transportation and school supplies.	In both the ETV and NC REACH programs, mentoring, tutoring, and other supports are provided by Orphan Foundation.	$947,000.	None.	1. ETV: State contribution is equal to at least 20 percent of federal grant, or $189,400. 2. NC REACH: not available.	1. ETV program: At least $1,136,400. 2. NC REACH: unknown.

Housing in particular can be a big source of anxiety for scholarship recipients. Unlike other college students, many youth in the scholarship program have no stable family home where they might live while attending classes or during college breaks.

One student, whose name is being withheld, said housing and money are constant sources of worry: "Where am I going to go over the winter break? What do I do for housing junior and senior year? How can I work full-time and maintain the GPA I need?....Money is a huge thing."

Even some who may have a family or foster family they could live with choose to stay away. One student told ACNJ he avoided spending time at his foster home because it is in a crime-ridden neighborhood. He does not want to subject himself to that environment.

The Difficulty Students Face with Housing is Fueled in Part by Limitations of the State Tuition Waiver Law.

The law restricts waiver money to be used only for tuition, not housing. It also covers only what remains of tuition after other grants are applied. That can amount to very little aid for students whose tuition is covered nearly in full by Pell, TAG and other grants. Students at private or out-of-state colleges with higher tuition costs who could benefit most from the waiver are ineligible because it can be used only for state public colleges.

The damaging effect of these restrictions is perhaps most evident for students who qualify only for tuition waiver and not ETV. This includes homeless youth who were never in state care, youth who first apply for scholarships after their 21st birthday, and those who continue their studies after their 23rd birthday.

Among students ineligible for ETV, the fortunate ones live in a DYFS-funded transitional or independent living program or with their family or foster family. DCF last year began to extend foster care payments to families of college students so that more foster families may continue providing a home for young people pursuing a higher education.

But some youth are left to cover room and board through working full-time or student loans. The potential loan burden is a concern. There is growing alarm nationally that the increasing loan burden on U.S. undergraduates is excessive and harmful to their future prospects. This is a greater worry for former foster youth who are more likely to lack financial support from parents after college when loans become due.

"The scholarship was central to my academic success," says James Taylor, 25, profiled in a Star-Ledger newspaper article[4] when he graduated from Kean University in June 2008. James told ACNJ that while his tuition was covered by the tuition waiver, he paid for living expenses through working and student loans that amount to more than $30,000 for his five years in college. He feels lucky the total isn't higher. But he added that students need affordable, safe housing. "No one expects to get a free ride. But the environments we have to move to, you have to deal with drugs and vandalism and theft. Areas near college campuses are too expensive."

How Scholarship Recipients Fare Academically and Emotionally

Living expenses aren't the only source of stress for some foster youth in college. Some begin college with educational deficits and find themselves placed by their colleges in non-credit remedial courses. It can be frustrating to earn no credits while struggling to balance work and school.

"The first year was all non-credit classes. It seemed kind of pointless," said Delanne, 20, a community college student. But she said that after her DYFS case was closed when she was 18, she benefited from counseling in a DYFS-funded aftercare program for former foster youth. "I had somebody to really guide me and help me."

Students who do not need remedial courses can also feel overwhelmed by the demands of course work, jobs and personal responsibilities.

Jasmine, 23, found it a struggle a couple of years ago to balance caring for her baby daughter, working part-time, and carrying a full course load at a four-year college. She transferred to a community college where, "It seemed like the professors were more willing to sit down and talk if you needed to." She completed her associate's degree and is transferring to another four-year college this fall.

College students need emotional support and guidance to steer their way to a degree. Delanne has gotten that from a counselor in a state-funded program. Jasmine said she has benefitted from mentoring from Project Myself. The situations of NJFC scholarship recipients are varied, with some in DYFS-funded programs or state care and others living on their own without counseling or case management. DCF needs to ensure that all students have someone to offer guidance and encouragement.

IV. How Project Myself Works

Project Myself was founded in 1999 to offer supports to the then small number of former foster youth receiving DYFS scholarships. The program now serves NJFC scholarship recipients. It also runs the Transitions for Youth web site, www.transitionsforyouth.org, for aging out youth and operates a small summer program in which scholarship recipients live on the Rutgers campus, receive living stipends and participate in summer internships.

Project Myself's services to scholarship recipients have evolved over the years. In the past, it gave them several options for participating, including mentoring a younger NJFC scholarship student or doing community service. For the 2008-09 academic year, the plan is for graduate interns in social work to provide all of the mentoring, which promises a higher quality of service. In addition, all NJFC scholarship recipients will be required to do volunteer community work for 20 hours per semester. The purpose is to help them connect to their communities, gain experience that can guide career choices, and have something to put on their resumes.

All NJFC scholarship recipients are supposed to participate in Project Myself. But in 2007-08, only about a third were active, according to the Project Myself program director. One problem is that some students, after receiving their grants, don't keep in touch with either Project Myself or FAFS and fail to apprise them of changes in contact information. When Project Myself staff reach out by phone or email to students who have not contacted the program on their own, they often cannot get through or their messages aren't returned.

That should change this year. NJFC scholarship recipients are being required to sign a participation agreement in which they pledge among other things to keep in regular contact with FAFS and to participate in Project Myself. This means more students could potentially benefit from Project Myself. But it raises the question of how the program's small staff of two employees plus four social work interns could handle a potential tripling of their caseload. DCF may need to examine whether more funding is necessary for Project Myself to serve all scholarship recipients effectively.

V. How NJFC Scholars is Changing in the 2008–09 Academic Year

Despite the enormous growth in the scholarship program over the past few years, it is facing a federal funding cut. Chafee ETV funds are distributed to states based on their overall number of children in foster care. A significant drop in children in out-of-home placement in New Jersey has led to a 13 percent cut in ETV funds to about $926,000.

DCF has responded to both the funding squeeze and concerns about student retention by making certain changes to program management and the requirements upon scholarship recipients. The goal is to stretch available funds without turning away eligible students.

- Students will now have an October deadline to apply for scholarships for fall semester and March to apply for spring, in contrast to the past practice of rolling admissions throughout the year.
- The program will operate on an academic year. Previously, it ran on the federal fiscal year. That allowed some first-year students to receive up to $10,000 in ETV grants instead of $5,000 because they received one full installment early in the calendar year and the second after the start of the new fiscal year in October. The maximum ETV grant will now be up to $2,500 per semester, consistent with federal guidelines.
- Students will have to sign a participation agreement.
- Youth whose semester GPA falls below the required 2.0 will be put on academic probation and will have to demonstrate they have sought academic tutoring. They will have one semester to bring their GPA up or they will lose their scholarship.

DCF and NJFC program staff hope these changes will encourage students serious about higher education to pursue scholarships. They believe some foster youth may have pursued college scholarships because they lacked a sense of direction and were drawn by ETV funding for living expenses. But since the scholarship program began, there are more options for older foster youth in New Jersey. DYFS now allows young people to stay in foster care until age 21. The state also has significantly increased the amount of subsidized housing for aging out youth. These changes should help DCF reserve the scholarship program for those who really want higher education.

VI. What Other States Are Doing

The critical need to provide educational supports to former foster youth has been widely recognized by the federal government and states. It is useful to compare New Jersey's program to scholarship initiatives elsewhere to see what our state is doing well and where it might improve.

All 50 states plus the District of Columbia and Puerto Rico receive federal Chafee ETV funds for educational supports to older foster youth. Some, unlike New Jersey, fail to fully utilize these funds and return some portion to the federal government.

Eighteen states and the District of Columbia also give some type of tuition support for foster youth. The most common approach is like New Jersey's, a tuition waiver to state-funded colleges and vocational schools. Unlike New Jersey, however, at least some of these states have made a direct appropriation from their state budgets to fund the waiver.

Most states offering tuition waivers or other educational supports also cover at least some of the cost of housing and other expenses. Connecticut stands out. It spent $7.3 million of state funds last year in addition to $668,612 in ETV funds to cover full room and board, tuition and other expenses for foster youth attending any accredited college, public or private, in or out of state. Participants have no need for student loans. Unlike New Jersey and most other states, Connecticut requires youth to remain in state care to receive the tuition and housing aid.

Connecticut officials aren't satisfied with their program's graduation rate, 52 percent in 2005. Similar to New Jersey, they believe some students not ready for college may have enrolled because they or their social workers felt the young people weren't ready to live independently. To combat this, the state is now offering alternative paths to independence, including a new employment program that helps youth sustain gainful employment for 12 months while giving them limited support for living expenses.

New Jersey also offers housing to older and former foster youth through transitional living and independent living programs. The cost of these programs is not included in the $2.9 million spent on the scholarship initiative. Although some college students live in such housing, there are no spots reserved for them.

A glance at other states' programs suggests the New Jersey program might have an untapped potential for raising private money. Private fundraising could not substitute for stable and adequate state funding to the New Jersey program. But it might allow the scholarship program to offer more supports, such as through expanding mentoring or other services to scholarship recipients.

A model for this may be the national Orphan Foundation of America, which administers foster youth scholarship programs for nine states and raises private money to supplement its services. OFA's executive director says the program focuses strongly on both student retention and positive youth development.

OFA's practices include requiring that every ETV scholarship recipient be enrolled in a student support group and get matched with one of the trained volunteers in OFA's national virtual mentoring program. OFA matches mentors based on students' stated needs, including professional and career interests, according to the foundation's web site. Each student also receives three personalized care packages a year and phone calls and text messages on birthdays and during holidays and exam periods. Both the mentoring and care packages are funded at least in part through private donations to OFA.

For students identified as at a high risk of dropping out, OFA staff try to help students pinpoint obstacles to their achievement. The efforts appear to pay off in some states. In North Carolina, 85 percent of the students who began college in 2004-05 remained in school three years later. In New York state, the retention rate is lower: 65 percent of ETV recipients in 2007-08 were returning students. OFA is obligated under its contract with New York to improve retention.

New Jersey has recognized some OFA activities as "best practices" and is consciously adopting some. The participation agreement that students in the New Jersey program will have to sign this year is an example of positive youth development, as is the emphasis on community service at Project Myself.

VII. Conclusion

The fast growth of the NJ Foster Care Scholars program since it began five years ago shows its importance: The program touched a need. Its growth also testifies to the program's inclusiveness. New Jersey has gone beyond the requirements of the state tuition waiver law to meet the needs of vulnerable youth who have been in foster care or homeless. In addition, the state is taking important steps this year to strengthen the program, including requiring youth to get tutoring if their grades begin to slip and collecting data to track the progress of students.

But the lack of a legislative appropriation for the tuition waiver law or, for that matter, for any part of the NJFC Scholars program, has forced DCF to scramble for funding each year. The cut in federal ETV money this year exacerbates the funding crunch.

One solution could be for New Jersey to make the tuition waiver a true waiver by not charging tuition to eligible foster youth attending state public colleges and vocational schools. That would allow the scholarship program to use more of its funds for students' living expenses. Another option is for the Legislature to appropriate money for the tuition waiver law. Either way, the scholarship program would end up with more funds for strengthening its supports to foster youth in college. Those supports could make a difference, helping more foster youth achieve a college degree and become successful adults contributing to the future of New Jersey.

Notes

[1] Courtney, M., Dworsky A., Ruth G., Keller T., Havlicek J., Bost N. (2005) *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19.* Chapin Hall Center for Children at The University of Chicago, *p. 20.*

[2] Fernandes, A. (2007) *Vulnerable Youth: Background and Policies.* Congressional Research Service Report to Congress, p. 2

[3] Statewide Tuition Waiver Program: N.J.S.A. 40 (C.30:4C-101 to 30.4C-105)

[4] Livio, S. "Hard-Fought Success: One Man's Experience Shows the Challenges Facing Former Foster Children." (June 29, 2008) *The Star-Ledger* (Newark, New Jersey), p. 21.

Acknowledgements

Thank you to the many people who generously contributed their time and shared information and insights for this policy brief. They include:

The young people quoted in this brief for generously sharing their stories; and

At DCF:
Nancy Caplan
Mary Helen Cervantes
John Morino
Janet Murray
Erin O'Leary
Bob Sabreen

At other agencies in New Jersey:
Foster and Adoptive Family Services: Leslie Barda and Fran Gervasi
Project Myself: Treena Shivers
Robin's Nest: Jackie Watkins and Laurie DiBella Spears
Felician College financial aid office
New Jersey Commission on Higher Education, Educational Opportunity Fund

These agencies outside New Jersey:
Connecticut Department of Children and Families, Bureau of Adolescent and Transitional Services
Maryland Department of Human Services
New York State Office of Children and Family Services, Office of Strategic Planning and Policy Development
North Carolina Department of Social Services
Orphan Foundation of America

The Association for Children of New Jersey
35 Halsey Street, Newark, NJ 07102
(973) 643-3876 ■ Fax (973) 643-9153 www.acnj.org ■ www.kidlaw.org ■ www.MakeKidsCountNJ.org

Alaska Native Health Board

1840 Bragaw Street, Suite 220
Anchorage, Alaska 99508

Phone: (907) 562-6006
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April 3, 2009

Senator Donny Olson
State Capital Building, Room 514
Juneau, Alaska 99801-1182

Dear Senator Olson,

We write to express our support for SB 139, an act establishing a health professions loan repayment program and employment incentive program. **Alaska is one of only six states without a state-sponsored health professions support-for-service program such as a loan repayment and incentive program.** This, in combination with national health profession shortage dynamics, has given rise to an alarming vacancy rate among health professions in Alaska, particularly for Alaska Tribal providers, many of whom are located in remote rural areas of Alaska, and many of whom are the only health providers in their regions.

The competition for recruitment of providers is very difficult. Nationally, only 2% of medical students are choosing the primary care field. In Alaska, there are more than 90 pharmacist vacancies, many in rural areas. Many communities, particularly in rural areas, have well-documented shortages of dentists, physician assistants, nurse practitioners, nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists.

SB 139 provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

Because of the severe impact of the health workforce shortage on healthcare access for Alaska's residents, particularly among Alaska Natives and others served by Alaska Tribal health providers, the Alaska Native Health Board strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete in recruitment of health professionals from a shrinking national labor pool.

Respectfully,

Evangelyn Dotomain
President/CEO

SB 32

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/25/09

Health and Social Services Committee considered SENATE BILL NO. 32

SB 32 MEDICAID:HOME/COMMUNITY BASED SERVICES

"An Act relating to medical assistance payments for home and community-based services."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [✓] **CS** SB 32(HSS) _____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** CS _____)
Forthcoming

[ ] attached amendment(s)

[ ] adopt _____

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS	2/2/09	✓			1
DHS	1/29/09	✓			2

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	X			
	Thomas	✓			
	PASKVAN	X			
	Dyson			✓	
CHAIR:	DAVIS	X			

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 032
() Publish Date:

Identifier (file name): SB032-DHSS-RR-02-02-09
Dept. Affected: Health & Social Services
Title: Medicaid: Home/Community Based Services
RDU: Department Support Services
Component: Rate Review
Sponsor: Ellis
Requester: Senate HSS
Component Number: 2696

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	124.9		249.8	416.4	416.4	416.4	416.4
Travel	7.5		15.0	25.0	25.0	25.0	25.0
Contractual	19.2		3,598.4	2,244.0	2,244.0	2,244.0	2,244.0
Supplies	0.9		1.8	3.0	3.0	3.0	3.0
Equipment	45.0			30.0			
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**197.5**	**0.0**	**3,865.0**	**2,718.4**	**2,688.4**	**2,688.4**	**2,688.4**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	98.8		1,932.5	1,359.2	1,344.2	1,344.2	1,344.2
1003 GF Match	98.8		1,932.5	1,359.2	1,344.2	1,344.2	1,344.2
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**197.5**	**0.0**	**3,865.0**	**2,718.4**	**2,688.4**	**2,688.4**	**2,688.4**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	**3.0**		3.0	5.0	5.0	5.0	5.0
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation would require the Department to set rates for Medicaid home and community-based services providers as it currently sets rates for facilities such as hospitals and nursing homes. This rate-setting process involves providers developing detailed cost reports that the Department would then audit and use the findings to develop cost-based rates. Additional resources in staffing and contracting would be needed by the Department to fulfill its rate-setting functions for this new group of providers.

(Continued on next page)

Prepared by: William J. Streur, Deputy Commissioner
Phone 334-2520
Division: Health Care Services
Date/Time 2/2/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/2/2009
Dept. Health and Social Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB 032

ANALYSIS CONTINUATION

Under this legislation, the Department would receive and audit cost reports from approximately 350 home and community-based service providers. The Department would contract with auditors to perform the audits. Additional staff positions would be necessary to oversee the work and conduct rate setting operations. The contract would begin in FY2011 to audit all providers; in subsequent years, half of the providers would be audited on a biennial schedule.

In addition, the Department anticipates that, beginning in FY2012, its volume of rate setting appeals would increase as a result of auditing these new providers and that additional funds would be needed to the existing rate-setting process. Additional funds would be needed to support rate-setting appeal work in the Department of Law.

Assumption:

Annual Personal Services:
3 Internal Auditor III positions in the Office of Rate Review for cost reporting - $249.8 (half year in FY2010)
2 Internal Auditor positions in the Office of Rate Review for appeals - $166.6 (beginning in FY2012)

Annual Travel for audit staff to provide technical assistance and training to providers and receive training required by Government Auditing Standards - $5.0 per FTE

Annual Contractual:
Contract to hire auditors for biennial audit of cost reports
FY20 11 - $3,560.0
Subsequent years - $1,780
RSA with Dept. of Law for appeals - $400.0 (beginning in FY2012)
Office space, phones, etc. - $12.8 per FTE

Annual Supplies - $0.6 per FTE

One-Time Equipment - $15.0 per FTE , year of initial hire

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 032
() Publish Date:

Identifier (file name): SB032-DHSS-SDMS-01-29-09
Dept. Affected: Health & Social Services
Title: Medicaid: Home/Community Based Services
RDU: Senior & Disabilities Services
Component: Senior & Disabilities Medicaid Services
Sponsor: Ellis
Requester: Unknown
Component Number: 2662

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	8,680.7	0.0	12,390.5	17,405.2	21,833.6	26,385.9	31,065.8
Miscellaneous							
TOTAL OPERATING	**8,680.7**	**0.0**	**12,390.5**	**17,405.2**	**21,833.6**	**26,385.9**	**31,065.8**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	4,340.4		6,198.3	8,702.6	10,916.8	13,193.0	15,532.9
1003 GF Match	4,340.3		6,195.2	8,702.6	10,916.8	13,192.9	15,532.9
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**8,680.7**	**0.0**	**12,393.5**	**17,405.2**	**21,833.6**	**26,385.9**	**31,065.8**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The proposed legislation would add home and community-based service providers to the Medicaid health facility rate setting statute, AS 47.07.070. This legislation would require the Department to use a similar rate methodology for establishing rates for home and community-based service providers.

Passage of this bill would likely require additional Medicaid benefits appropriations in the division of Senior and Disabilties of $8,680.7 in 2010 and a 2.8% annual increase to home and community based provider payments in the basic cost of services each subsequent year. Costs would increase to a projected $31,065.8 by 2015.

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 907-269-7827
Division: Health Care Services
Date/Time 1/29/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 1/29/2009
Dept. Health & Social Services

FISCAL NOTE

STATE OF ALASKA BILL NO. SB032

2009 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

BACKGROUND

This statute would affect an estimated 356 businesses who are providers of home and community based services, including residential living services. These services are delivered under four Medicaid waivers: Adults with Disabilities, Children with Complex Medical Conditions, Mental Retardation/Developmental Disabilities, and Older Alaskans. The total expenditure for these waivers in 2008 was $141.5 million. Costs are projected to increase by $4.1 million in 2009 to $145.6 million, which is the baseline projection used for this fiscal note. By assuming the status quo, without changes in population or utilization, costs associated with rate increases can be isolated.

HCBS providers currently have their rates or rate methodologies established in regulation. Since 2004 all of those rates have been frozen (some longer), except for 2009, when the legislature approved a 4-6% increase. This statute will apply the current Medicaid law requiring that the Department use a rigorous, cost-based rate setting process for establishing Medicaid payment rates for health facilities to HCBS providers. There would be two types of additional costs incurred: costs for the rate adjustment and costs providers would incur to comply with new financial reporting requirements.

ESTIMATED RATE ADJUSTMENT

For the purpose of this fiscal note, it is assumed home and community based providers receive an annual inflation adjustment as facilities currently do under AS 47.07.070. The 2.8% is the inflation for Home Health Agencies as this is the closest provider category to the waiver service providers. The department does not have the detailed cost reports required to fully implement section 070 until 2012; however, the department has assumed it will make interim rate increases averaging 2.8% prior to that time. The 2.8% increase has been applied to the 2009 baseline starting in 2010 for an increase of $26,235.0 by 2015. Other impacts to the amount of additional reimbursement rates to providers are not possible to determine at this point in time.

ESTIMATED COSTS TO COMPLY WITH NEW FINANCIAL REQUIREMENTS

Many home and community based providers do not have the financial infrastructure to comply with the rigorous financial requirements of AS 47.07.070. Home and community based providers would have to invest substantial sums in accounting and report processes which in turn are passed on to the state through higher Medicaid payment rates. These costs are in addition to the costs for the rate adjustments. One-time costs include accounting system upgrades ($142.5) and purchase of specialized cost reporting software ($338.2). Ongoing annual costs include recordkeeper/accountant/contractor to obtain assistance with accounting efforts ($1,425.0); professional assistance in preparing cost reports and completing forms ($855.0); and annual independent audit ($1,543.8). Legal fees to challenge rate setting regulations ($300.0) would occur in 2010 & 2011 while legal fees for providers who appeal their rates ($1,007.0) would begin in 2012 once those rates are established. Total additional costs to comply with new financial requirements would be $4,604.5 in 2010, $4,123.8 in 2011, and $4,830.8 each year thereafter.

FUND SOURCE

Costs are eligible for the federal medical assistance percentage which is projected to be 50%.

26-LS0218\C
~~Mischel~~
2/20/09

CS FOR SENATE BILL NO. 32( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS ELLIS, Davis, Paskvan

↑ long term care tomorrow
need fiscal note
in CS —
Dept - drop CS would
have a fiscal note

A BILL

FOR AN ACT ENTITLED

"An Act relating to medical assistance payments for home and community-based services, provision of personal care services in a recipient's home, and assisted living homes; and providing for an effective date."

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

*** Section 1.** AS 47.07 is amended by adding a new section to read:

Sec. 47.07.069. Payment rates for provision of personal care services in a recipient's home, home and community-based services, and assisted living homes. (a) The department shall, by regulation, set rates of payment for provision of personal care services in a recipient's home under AS 47.07.030, home and community-based services under AS 47.07.045, and assisted living homes under AS 47.24.017 and AS 47.25.195(e) in accordance with 42 U.S.C. 1396 (Title XIX, Social Security Act, Medical Assistance) and this section. A rate established under this section takes effect under AS 44.62 (Administrative Procedure Act) but not until approved in writing by the commissioner. The commissioner may delegate the performance of these

functions.

(b) The department shall review the rates of payment established under of (a) of this section for a fiscal year. In reviewing the rates, the department shall, within the limit of appropriations made by the legislature for the department's programs under this chapter and under AS 47.25.120 - 47.25.300 for that fiscal year, including anticipated available federal revenue for that fiscal year, set rates that are based on

(1) reasonable costs related to patient care;

(2) audit and inspection results and reports, when the audit or inspection is conducted under AS 47.07.074; and

(3) the rate of inflation contained in the home health agency market basket data of the Centers for Medicare and Medicaid Services, United States Department of Health and Human Services.

(c) As a condition of obtaining payment under this section, a provider of personal care services in a recipient's home, a provider of home and community-based services, and an assisted living home shall allow

(1) the department reasonable access to the records of medical assistance recipients and providers; and

(2) audit and inspection of the records by state and federal agencies.

*** Sec. 2.** AS 47.24.017(d) is amended to read:

(d) If the protective services under this section include the placement of a vulnerable adult in an assisted living home at the state's expense, the minimum daily reimbursement rate to the assisted living home for the vulnerable adult is **the amount set under AS 47.07.069 for assisted living homes plus eligible room and board expenses** [$70]. The department may, under its regulations, provide for a daily rate higher than **the amount set under this section** [$70] if the additional care provided to the vulnerable adult in the assisted living home justifies the additional reimbursement. In this subsection, "assisted living home" means an assisted living home licensed under AS 47.32.

*** Sec. 3.** AS 47.25.195(e) is amended to read:

(e) Notwithstanding other provisions of this section and the provisions of AS 47.07, if the assistance provided to a needy person under AS 47.25.120 -

2/23

Dr Ellis -

Rate-adj - what kind?

Social Security -

General Relief - & S.S. Disability

Request Sherwood rd ##

for rate increase

for this yr -

47.25.300 includes the initiation or continuation of placement of the person in an assisted living home at the state's expense, the department's minimum daily reimbursement rate to the assisted living home for the person is **the amount set under AS 47.07.069 plus eligible room and board expenses** [$70. THIS MINIMUM RATE IS NOT SUBJECT TO REDUCTION UNDER (c) OF THIS SECTION]. The department may, under its regulations and under the procedures of AS 47.07.070 - 47.07.075, provide for a daily rate higher than **the amount set under this section** [$70] if the care provided to the needy person in the assisted living home justifies the higher reimbursement. [A DAILY RATE HIGHER THAN $70 FOR ASSISTED LIVING HOMES MAY BE REDUCED UNDER (c) OF THIS SECTION, BUT NOT BELOW $70.]

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REPORT ON MEDICAL ASSISTANCE PAYMENT RATES. (a) The Department of Health and Social Services shall prepare and submit an annual report on medical assistance payment rates established under AS 47.07.069 to the governor that

(1) identifies trends in established rates of payment;

(2) explains how the department has complied with AS 47.07.069(b) in establishing the rates; and

(3) includes a cross reference to regulations adopted under AS 47.07.069 and the availability of the regulations.

(b) The department shall notify all legislators of the availability of the report prepared under (a) of this section and provide a copy of the report to the

(1) presiding officers of each house of the legislature;

(2) chairs of the senate and house finance committees; and

(3) chairs of the senate and house health and social service committees.

*** Sec. 5.** Section 4 of this Act is repealed June 30, 2014.

*** Sec. 6.** This Act takes effect July 1, 2011.

Senate Labor and Commerce Committee, Chair
•
Legislative Budget and Audit Committee
•
Senate Rules Committee
•
Committee on Committees

ALASKA STATE LEGISLATURE

While in Session
State Capitol, Rm. 9
Juneau, AK 99801
(907) 465-3704
Fax: (907) 465-2529

While in Anchorage
716 W. 4th Ave, Ste. 440
Anchorage, AK 99501
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SENATOR JOHNNY ELLIS
SENATE MAJORITY LEADER

MEMORANDUM

DATE: **January 26, 2009**

TO: **Senator Bettye Davis**
Senate Health & Social Services Committee

FROM: **Senator Johnny Ellis**

RE: **Hearing Request for SB 32 – Medicaid: Home/Community Based Services**

I am requesting that Senate Bill 32 be scheduled for a hearing in the Senate Health and Social Services Committee at your earliest convenience.

This bill includes the providers of home- and community-based services to Alaska's senior and developmentally disabled populations in the regular rate review process afforded to providers of institutional care. Alaska has made great strides in reforming our network of support for seniors as well as for children and adults with developmental disabilities. Allowing people who live with developmental disabilities the opportunity to live a full life as a member of their community took a great leap forward with the closing of Harborview ten years ago. However, our statutes provide for an annual Medicaid rate review for our institutions without providing that same treatment to home and community based service providers, a situation which may force people back into the institutions we have worked to avoid.

Included in this packet:

- A current version of SB 32 – 26-LS0218\R
- Sponsor Statement
- Background Information
- Letter of Support

Other backup will be forthcoming as required. Thank you.

Senate Finance Committee
•
Health & Social Services Committee
•
Legislative Council
•
Committee on Committees

ALASKA STATE LEGISLATURE

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•
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SENATOR JOHNNY ELLIS
SENATE MAJORITY LEADER

SPONSOR STATEMENT – SENATE BILL 32

AN ACT RELATING TO MEDICAL ASSISTANCE PAYMENTS FOR HOME- AND COMMUNITY-BASED SERVICES

Senate Bill 32 creates a mechanism for regular Medicaid rate review for providers of home- and community-based services to Alaska's elderly and developmentally disabled citizens. Institutional service providers receive regular reviews in order to bring rates in line with costs. Over the last few years, however, rates for home- and community-based services have been frozen. During that time, not only have costs increased, the medical environment – including regulations, technology, and client expectations – has shifted dramatically. Home and community based services are the key to helping our seniors and those living with developmental disabilities live their lives as productive members of our communities, and without this regular review process, many providers will be forced out of business.

Senate Finance Committee
•
Health & Social Services Committee
•
Legislative Council
•
Committee on Committees

ALASKA STATE LEGISLATURE

While in Session
State Capitol, Rm. 103
Juneau, AK 99801
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SENATOR JOHNNY ELLIS
SENATE MAJORITY LEADER

MEMORANDUM

To: Senator Donny Olson,
Chair, Senate Finance Subcommittee on the Department of Health and Social Services

From: Senator Johnny Ellis JE

Date: February 23, 2009

Subject: Home and Community Based Services Increment

Home- and community-based services are a crucial element in the array of services provided to seniors and persons experiencing developmental disabilities in our state. They are a less-intrusive and more cost-effective way of dealing with long-term care, and play a crucial role in containing the overall growth of Medicaid spending.

While institutional care providers receive a statutorily mandated annual rate review, providers of home- and community-based services depend on regulatory action for increased rates. Except for an across-the-board increase last year, most providers have not received rate reviews or increases since 2004, and many have waited over a decade. While I have introduced legislation to remedy this situation (Senate Bill 32 is currently in front of the H&SS Committee, and goes next to the full Finance Committee), this long-term fix does nothing to solve this years problem.

I would ask for your subcommittee's support for a $3.9 million increment in the FY2010 budget in the Senior and Disability Services Medicaid funding. This amount would support a 2.8% increase for the providers of Medicaid waiver services, equivalent to the Home Health Agency inflation factor. Thank you for your consideration, and feel free to contact my office at any time with questions or concerns you may have.

Cc: Sen. Bettye Davis
Sen. Lesil McGuire
Sen. Kevin Meyer
Sen. Bill Wielechowski
Commissioner Bill Hogan, DHSS

Lynda Zaugg

From: Max Hensley
Sent: Monday, February 23, 2009 2:19 PM
To: Lynda Zaugg; Sherwood, Jon (HSS)
Cc: Sen. Johnny Ellis
Subject: SDS increment

If I may suggest an appropriate number, the original fiscal note for SB32 from SDS Medicaid Services contains the cost estimates for the amount of the Home Health Agency inflation rate (2.8%) for the 4 Medicaid waivers – a cost of approximately $3.9 million.

Max Hensley
Office of Sen. Johnny Ellis
State Capitol, Room 103
Juneau, AK 99801
(907) 465-3704; (888) 330-3704
http://ellis.aksenate.org

Lynda Zaugg

From: Sherwood, Jon (HSS) [jon.sherwood@alaska.gov]
Sent: Monday, February 23, 2009 11:01 AM
To: Max Hensley
Cc: Lynda Zaugg; Hefley, Patrick B (HSS); Hilgendorf, Rebecca J (HSS); Kesterson, Linda L (LAW); Laughlin, Wilda J (HSS); Hogan, William H (HSS)
Subject: RE: SB 32 draft language
Attachments: GR rates.pdf

Max,

Sorry for the delay, but I wanted to make sure I got it right. Medicaid pays for assisted living services out of the Senior and Disabilities Medicaid Services component. Room and board charges for Medicaid recipients are paid for out of their own funds (including any state or federal cash assistance such as APA or SSI), or if insufficient, the General Relief Assisted Living (AS 47.25.195(e)). Medicaid rates for assisted living are either pay under a formula established in regulation, which adjust for type of facility, regional differences, and client use of adult day care outside the assisted living home, or the rates can be individual provider rates that were originally based on budgeted costs prior to the rate freeze in 2004.

Payments for assisted living under Adult Protective Services (AS 47.24.017) and General Relief Assisted Living (AS 47.25.195(e)) would be paid out of Protection and Community Services under Senior and Disabilities Services after any required client contribution was paid. The GR/APS base rate is $70, which is the rate in Anchorage and Southeast. The base rates are higher in other parts of the state, with the highest being $93.10 for the Southwest Region. I have attached the rate document and a copy of the applicable regulations. The SDS/APS rates can be augmented up to $22 per day, per 7 AAC 47.471. The Behavioral Health folks, who are also in the GR program, have higher augmented rates, per 7 AAC 47.472

From: Max Hensley [mailto:Max_Hensley@legis.state.ak.us]
Sent: Thursday, February 19, 2009 3:06 PM
To: Sherwood, Jon (HSS)
Cc: Zaugg, Lynda (LAA)
Subject: RE: SB 32 draft language

Thanks again for the prompt reply. I do have one question, and am working with the drafters to make these changes. How does the Department currently pay the rates for the assisted living homes we are addressing in this bill (what is the fund source, if Medicaid dollars are disallowed), and what is the rate (if it's not the $70 minimum that is in statute)?

I look forward to hearing your response.

Max Hensley
Office of Sen. Johnny Ellis
State Capitol, Room 103
Juneau, AK 99801
(907) 465-3704; (888) 330-3704
http://ellis.aksenate.org

From: Sherwood, Jon (HSS) [mailto:jon.sherwood@alaska.gov]
Sent: Wednesday, February 18, 2009 5:04 PM
To: Max Hensley
Cc: Nielson, Jack C (HSS); Hefley, Patrick B (HSS); Kesterson, Linda L (LAW); Hogan, William H (HSS)

Subject: RE: SB 32 draft language

Max,
I wanted to get back to you with our comments on the proposed committee substitute. The department appreciates the willingness of the Senator and the Committee to consider suggestions from us and our partners at the Department of Law.

First, as we discussed, the Department does not support tying the rate setting authority to specific criteria, such as those listed in the proposed AS 47.07.069(b).

The Department of Law recommends the following changes to the proposed substitute (CSSB 32( ) 26-LS0218\P Luckhaupt/Mischel 2/13/09) to make sure that the same language is used throughout to mean the same thing and to preclude overbroad references that might lead to unintended consequences.

- Replace the phrase "personal care attendants" with "provision of personal care services in a recipient's home" at Page 1, Lines 2, 5, and 8. This is necessary as the phrase 'personal care attendants' does not currently appear in the relevant statutes. AS 47.07.070 (referenced in Line 8) includes many optional services, but does not use the phrase "personal care attendants". However, it does include providing 'personal care services in a recipient's home' as an allowed service. 'Personal care services in a recipient's home' is defined at AS 47.07.900(15)
- Page 1, Line 9-10. Limit statutory reference for assisted living homes to "under AS 47.24.017(d) and AS 47.25.195(e)" as rates for assisted living homes are only referenced in those two subsections. The broad reference used in this draft [AS 47.25.120 – 47.25.300] includes all general relief, including an appeal provision at 47.25.180 for fair hearings which would be entirely inappropriate for provider rates. The broad statutory reference [AS 47.25.120 – 47.25.300] is not a problem when used on Page 2, Line 4 in .069(b) – as the reference there is the same as in AS 47.07.070(b) and does not specifically address whose rates are being set.

Also, if we are going to base rates on reasonable costs, as proposed in AS 47.07.069(b), the department will need audit authority. The Department of Law would prefer that if an audit section is included, it be separate (even if identical language is used) from the audit and inspection reports for health care facilities at 47.07.074. Rather than amending .074, a separate provision could be enacted allowing the audits. It would be necessary to require the same type of reports and audits from all providers included within the same statutory provision. Dept. of Law and our department are concerned that requiring the same kind of audits and reports for these providers as are required for health care facilities might prove overly burdensome for some of the smaller providers.

The Department also believes that the medical care services component of the CPI is not the right measure to use for a producer price inflation factor because it is a measure of consumer prices. Instead, our rate setting folks recommend the Home Health Agency Market Basket, which measures provider input prices.

With regard to payment to assisted living homes, federal law prohibits Medicaid from paying for room and board costs for people residing in non-institutional settings, such as assisted living facilities. So assisted living rates set for Medicaid under the proposed AS 47.07.069 must exclude the portion of the cost attributed to room and board. However, assisted living rates set under AS 47.24.017(d) and AS 47.25.195(e) are intended to include the room and board piece. As written, the proposed statutes would only require the department to pay the portion of the charge related to supportive services, not room and board. While the department is willing to consider the same factors when developing the rates under the different statutes, it is not possible to pay the same rates because the service purchased is not the same for Medicaid as for the other two statutes.

Let me know if you have questions. Oh, and please make sure to keep Linda Zaugg in the loop. Thanks. Jon

From: Max Hensley [mailto:Max_Hensley@legis.state.ak.us]
Sent: Friday, February 13, 2009 5:20 PM
To: Sherwood, Jon (HSS)
Subject: SB 32 draft language

I've attached what I received from our bill drafters regarding SB32. There are two components which are not currently included: first, we need to discuss a framework for the phase-in in order to find a way to define which groups will be included in the statute at which rates. Second, they need more time to work on the immunity language. I'm looking forward to hearing your thoughts, and would like to set up one more meeting for next week to discuss this version with the Senator. Thank you.

Max Hensley
Office of Sen. Johnny Ellis
State Capitol, Room 103
Juneau, AK 99801
(907) 465-3704; (888) 330-3704
http://ellis.aksenate.org

Lynda Zaugg

From: Max Hensley
Sent: Monday, February 09, 2009 2:04 PM
To: Lynda Zaugg
Cc: Sen. Johnny Ellis
Subject: SB32 - rate review

I wanted to follow up with you in regards to the proposed language from the Department that we received this morning so that Sen. Davis can be kept in the loop. We are working with the supporters of the original bill and trying to come up with some compromise language that will satisfy our intent and the Department's cost concerns. I will keep you informed as soon as we have something the committee can work on. Let me know if you have any questions – we are working quickly to bring it back to the committee as soon as possible. Thanks for your help.

Max Hensley
Office of Sen. Johnny Ellis
State Capitol, Room 103
Juneau, AK 99801
(907) 465-3704; (888) 330-3704
http://ellis.aksenate.org

SB 32

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Monday, February 09, 2009 9:23 AM
To: Max Hensley
Cc: Lynda Zaugg; Kim, Anna C (GOV); Gallagher, Gerald L (GOV); Sherwood, Jon (HSS)
Subject: SB 32 language
Attachments: Modifided HCBS rate setting language.pdf

I'm attaching the department's suggested language for SB 32, home and community based services. The Administration is OK with this. Let me know if you need anything else.
w.

2/11 ✓ Sen Ellis office (Anna) how copy of att. & work on language —

2/12 talked w Max — they are meeting w Comm @ 5 today — Both Sen D + 2 are mem the welcome — Sen D. heads to Anch. / 2 other dep input Rep — Per Max they will bring suggested language & Sen Dan for her review —

2/13 Talked w Max — make progress — here a draft proposal — (attached)
A.) Ann report for 5 yrs (w sunset of the 5th).
to beg
B.) delay effective date
C.) HSS would like to pharmacist — but that can be saved for a later committee & waiver —
Rate review to occur annually —
— Plan to meet w Dept again next week — for purpose & discuss new draft

Rate review yes

Section 1. 47.07 is amended by adding a new section to read:

Sec. 47.07.068 Payment rates for assisted living homes and home and community based services. (a) The department shall, by regulation, set rates of payment under this chapter for assisted living homes (AS 47.24.017 and AS 47.25.195(e)) and home and community-based services (AS 47.07.045) in accordance with 42 U.S.C. 1396 (Title XIX, Social Security Act, Medical Assistance).

(b) the department shall review annually the rates set under this section for compliance with federal standards under 42. U.S.C. 1936.

(c) the department shall submit a report to the governor containing the information required under this subsection. The department shall send a copy of the report to the persons chairing the house and senate finance committees and the persons chairing the house and senate health and social services committees and shall notify the full legislature that the report is available to all legislators. The report must

(1) identify trends in rates of payment established under subsection (a);

(2) explain how the department has determined that the rates set under this section are in compliance with the requirements of subsection (b);

(3) indicate that written or electronic copies of regulations and reports developed by the department under this section are available.

Section 2. AS 47.07.068(c) is repealed June 30, 2014.

26-LS0218\P
Luckhaupt/Mischel
2/13/09

CS FOR SENATE BILL NO. 32( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS ELLIS, Davis, Paskvan

A BILL

FOR AN ACT ENTITLED

"An Act relating to medical assistance payments for home and community-based services, personal care attendants, and assisted living homes; and providing for an effective date."

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

*** Section 1.** AS 47.07 is amended by adding a new section to read:

Sec. 47.07.069. Payment rates for personal care attendants, home and community-based services, and assisted living homes. (a) The department shall, by regulation, set rates of payment for personal care attendants under AS 47.07.030, home and community-based services under AS 47.07.045, and assisted living homes under AS 47.24.017 and AS 47.25.120 - 47.25.300 in accordance with 42 U.S.C. 1396 (Title XIX, Social Security Act, Medical Assistance) and this section. A rate established under this section takes effect under AS 44.62 (Administrative Procedure Act) but not until approved in writing by the commissioner. The commissioner may delegate the performance of these functions.

(b) The department shall review the rates of payment established under of (a) of this section for a fiscal year. In reviewing the rates, the department shall, within the limit of appropriations made by the legislature for the department's programs under this chapter and under AS 47.25.120 - 47.25.300 for that fiscal year, including anticipated available federal revenue for that fiscal year, set rates that are based on

(1) reasonable costs related to patient care;

(2) audit and inspection results and reports, when the audit or inspection is conducted under AS 47.07.074; and

(3) the rate of inflation contained in the medical care services section of the Consumer Price Index, as determined by the Bureau of Labor Statistics, United States Department of Labor.

*** Sec. 2.** AS 47.07.074(a) is amended to read:

(a) As a condition of obtaining payment under **AS 47.07.069 or 47.07.070, a provider of personal care attendant services, a provider of home and community-based services, an assisted living home, and** [AS 47.07.070,] a health facility shall allow

(1) the department reasonable access to the records of medical assistance recipients and providers; and

(2) audit and inspection of the records by state and federal agencies.

*** Sec. 3.** AS 47.24.017(d) is amended to read:

(d) If the protective services under this section include the placement of a vulnerable adult in an assisted living home at the state's expense, the minimum daily reimbursement rate to the assisted living home for the vulnerable adult is **the amount set under AS 47.07.069 for assisted living homes** [$70]. The department may, under its regulations, provide for a daily rate higher than **the amount set under AS 47.07.069** [$70] if the additional care provided to the vulnerable adult in the assisted living home justifies the additional reimbursement. In this subsection, "assisted living home" means an assisted living home licensed under AS 47.32.

*** Sec. 4.** AS 47.25.195(e) is amended to read:

(e) Notwithstanding other provisions of this section and the provisions of AS 47.07, if the assistance provided to a needy person under AS 47.25.120 -

47.25.300 includes the initiation or continuation of placement of the person in an assisted living home at the state's expense, the department's minimum daily reimbursement rate to the assisted living home for the person is **the amount set under AS 47.07.069** [$70. THIS MINIMUM RATE IS NOT SUBJECT TO REDUCTION UNDER (c) OF THIS SECTION]. The department may, under its regulations and under the procedures of AS 47.07.070 - 47.07.075, provide for a daily rate higher than **the amount set under AS 47.07.069** [$70] if the care provided to the needy person in the assisted living home justifies the higher reimbursement. [A DAILY RATE HIGHER THAN $70 FOR ASSISTED LIVING HOMES MAY BE REDUCED UNDER (c) OF THIS SECTION, BUT NOT BELOW $70.]

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REPORT ON MEDICAL ASSISTANCE PAYMENT RATES. (a) The Department of Health and Social Services shall prepare and submit an annual report on medical assistance payment rates established under AS 47.07.069 to the governor that

(1) identifies trends in established rates of payment;

(2) explains how the department has complied with AS 47.07.069(b) in establishing the rates; and

(3) includes a cross reference to regulations adopted under AS 47.07.069 and the availability of the regulations.

(b) The department shall notify all legislators of the availability of the report prepared under (a) of this section and provide a copy of the report to the

(1) presiding officers of each house of the legislature;

(2) chairs of the senate and house finance committees; and

(3) chairs of the senate and house health and social service committees.

*** Sec. 6.** Section 5 of this Act is repealed June 30, 2014.

*** Sec. 7.** This Act takes effect July 1, 2011.

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Monday, February 09, 2009 9:23 AM
To: Max Hensley
Cc: Lynda Zaugg; Kim, Anna C (GOV); Gallagher, Gerald L (GOV); Sherwood, Jon (HSS)
Subject: SB 32 language
Attachments: Modifided HCBS rate setting language.pdf

I'm attaching the department's suggested language for SB 32, home and community based services. The Administration is OK with this. Let me know if you need anything else.
w.

2/11 v Sen Ellis off-(Amory) have copy of att.-o
way on language

Section 1. 47.07 is amended by adding a new section to read:

Sec. 47.07.068 Payment rates for assisted living homes and home and community based services. (a) The department shall, by regulation, set rates of payment under this chapter for assisted living homes (AS 47.24.017 and AS 47.25.195(e)) and home and community-based services (AS 47.07.045) in accordance with 42 U.S.C. 1396 (Title XIX, Social Security Act, Medical Assistance).

(b) the department shall review annually the rates set under this section for compliance with federal standards under 42. U.S.C. 1936.

(c) the department shall submit a report to the governor containing the information required under this subsection. The department shall send a copy of the report to the persons chairing the house and senate finance committees and the persons chairing the house and senate health and social services committees and shall notify the full legislature that the report is available to all legislators. The report must

(1) identify trends in rates of payment established under subsection (a);

(2) explain how the department has determined that the rates set under this section are in compliance with the requirements of subsection (b);

(3) indicate that written or electronic copies of regulations and reports developed by the department under this section are available.

Section 2. AS 47.07.068(c) is repealed June 30, 2014.

2/12

Max, what's happening with SB 32? I understand you have a meeting with the Comm of H&SS re SB 32 today? Lynda

Lynda Zaugg

From: Yerkes, Reuben A (GOV) [reuben.yerkes@alaska.gov]
Sent: Tuesday, February 03, 2009 8:18 AM
To: Sen. Johnny Ellis; Lynda Zaugg; Jennifer Thorsteinson
Subject: SB 32 Fiscal Note
Attachments: SB032-DHSS-RR-02-02-09.pdf; SB032-DHSS-SDMS-01-29-09.pdf

Attached are two fiscal notes for SB 32. Please let me know if I can be of further assistance.

Have a great day,

Reuben Yerkes
Governor's Legislative Office
Office of the Governor
(907)465-4021

Date: 1/26/09

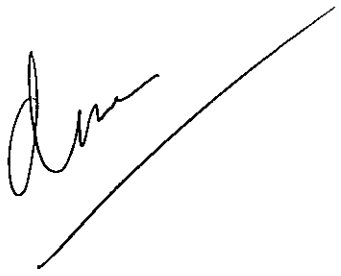
To: Sen. Davis

From: L Zaugg

Re: SB 32 Medicaid: Home/Community Based Services

Quick reminder: You indicated you were interested in co-sponsoring this bill and would need to bring it up on the floor. L

Cc: Don Burrell



STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SARAH PALIN, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

December 12, 2008

Senator Ellis
716 West 4th Ave. Suite 440
Anchorage, AK 99501

Dear Senator Ellis:

Alaska is home to more than 76,500 older Alaskans (people at least 60 years old), comprising 11% of the state's population, according to the Alaska Department of Labor 2007 estimates. Alaska's senior population is growing faster than any other state's except Nevada. Over the next 25 years, the growth of the Alaska senior population will be strong and continuous; the number of seniors is expected to grow at a rate of almost 6% annually statewide, increasing the number of seniors by nearly 5,000 each year. Most of this increase is attributable to the aging of our state's large baby boomer population.

The increasing cost of long-term care services, ranging from community services and in-home supports to assisted living and nursing home care, is a critical issue facing Alaska's Medicaid and senior grants programs, as the Alaska senior population continues to build and grow older. According to the Department of Health and Social Services, the cost of Medicaid will quadruple from 2006 to 2026 due to population growth, aging of the population, greater utilization of Medicaid services, and increased health care costs (The Lewin Group Report: February 2006).

On the bright side, Alaska is one of the leading states in establishing a balance between home- and community-based services and institutionalized care for elderly and disabled people, as stated in a recent AARP report. While other states have built nursing homes and other institutional long-term care facilities, Alaska has prudently invested in a continuum of long-term service supports that allow individuals to remain in their homes and communities for as long as possible close to family, friends, and tradition and are less costly. Alaska's senior home- and community-based grants program, using a combination of federal Older Americans Act funds with state funds, provides services to seniors of modest income who are not eligible for Medicaid. Like Medicaid, these services also face the pressures of rising demand.

The Alaska Commission on Aging (ACoA) is a State agency within the Department of Health and Social Services, established in 1982. Our mission is to plan, advocate, and educate on behalf of all older Alaskans and their caregivers to ensure their dignity and independence so that they may lead useful and meaningful lives.

We know that you value your senior constituents as active, well-informed members of your community. As the 2009 legislative session begins, we would like to share with you our recommendations on a number of senior issues before the Alaska Legislature.

1. Increase the availability of home- and community-based services to the growing senior population by supporting an increment of $2.0 million for the **Senior Home- and Community-Based Grants** budget within Senior and Disabilities Services (for senior nutrition programs, senior transportation, adult day

services, family respite, care coordination, chore services, and Alzheimer's Disease and Related Dementia education); **establish regular Medicaid waiver rate reviews for all home- and community-based service providers** serving Alaska seniors and Alaska Mental Trust Authority beneficiaries; and support funding for the **Aging and Disability Resource Centers** under Senior and Disabilities Services to help individuals and their families navigate the long-term care system with information, referral, and options counseling services.

2. Support the re-authorization of the **Adult Dental Medicaid Program** that is scheduled to sunset on June 30, 2009. Continuation of this program is important for older Alaskans and all vulnerable adults who are Medicaid eligible to have access to prevention and intervention dental services that are not covered by the regular Medicaid dental program.

3. Support high quality, affordable, and accessible **health care for seniors** by strengthening workforce development efforts for health care professionals and direct service staff, providing adequate funding for Community Health Centers that serve senior patients and offering incentives to physicians and dentists to accept Medicare and Medicaid patients.

4. Create an **Alaskan Public Transportation Fund** for operation of local coordinated transportation systems that address barriers to access experienced by people with disabilities and fund development of coordinated transportation efforts in communities without public transit systems.

5. Enact legislation creating the **Alaska Housing Trust** and appropriate sufficient funds to support meaningful services for homeless Alaskans (17% of whom are age 55 and older) and those who are at risk of becoming homeless, including those Alaska seniors who are diagnosed with a mental illness and are unable to find a licensed assisted living or nursing home facility to care for them.

Public policy often focuses on the potential costs of services for seniors and may overlook the social and economic benefits of an increased retired senior population. Older Alaskans provide a wealth of experience, wisdom, historical perspective, and volunteer time. They also contribute to the state's economy with their retirement income and health care spending that totaled almost $1.5 billion in 2004. Taking into account the social and economic assets Alaska seniors offer, we do well to invest in programs and services to ensure their ability to continue living here and contributing to the progress of our state.

Please feel free to contact Denise Daniello, ACoA's executive director by phone (465-4879) or email (Denise.Daniello@alaska.gov) for information about these issues or with any questions concerning Alaska's senior population.

The Alaska Commission on Aging will be meeting in Juneau on February 10th-12th, 2009 and hopes to schedule a meeting with you to discuss our priorities in person. We truly appreciate your support of important senior legislation in prior years and look forward to working with you this legislative session. Thank you for your consideration of these advocacy priorities.

Sincerely,

Sharon Howerton-Clark, Chair
Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

The Anchorage Press
December 24, 2008

NEWS

The least among us

Alaska's developmental disabilities providers look for allies in the state government

By Brendan Joel Kelley

IS COMING SATURDAY, on his Fox News program *Geraldo at Large*, Geraldo Rivera is devoting the show to the long waiting lists where people with developmental disabilities languish while waiting to receive services.

"The waiting list is, in essence, the new institution," Rivera told a Pennsylvania blogger associated with The Arc, a national network of service providers for the developmentally disabled. "It's imprisoning in some ways, handicapping the families of the developmentally disabled, really handcuffing them in ways that put tremendous stress and strain on their lives."

Though it's doubtful that Alaska will be mentioned on the show, our state also maintains a list of developmentally disabled people who are eligible for services but aren't receiving them due to inadequate funding. Each year the Department of Health and Social Services prepares a report on this list, and the report for 2008 is due any day now. When the last annual report was released last December, there were 943 individuals on the waiting list. They've been waiting for services an average of 3.7 years.

At the beginning of December, a couple of weeks before Republican Governor Sarah Palin released her budget, state Senator Johnny Ellis (D-Anchorage) wrote Palin a letter asking her to address the waiting list, known officially as the Developmental Disabilities Registry.

"During your time on the campaign trail with Senator John McCain as the Vice Presidential nominee, I was very pleased to hear you speak on multiple occasions about the problems faced by special needs children in our country," Ellis wrote. He then pointed out that as of October 1, the registry contained 993 individuals, mostly between the ages of 4 and 17. "I respectfully request that you do your very best to provide the funding necessary to fully eliminate the Waitlist," Ellis continued, before asking Palin to include funding recommended by the governor's Ad Hoc Committee on the DD Registry in her budget.

But that money wasn't included in the budget that Palin released on December 15. And for service providers in the developmental disabilities community, the waiting list is far from the only problem. Organizations like The Arc of Anchorage, Hope Community Resources, and many other home and community-based service providers are barely afloat financially, because the rates at which they're reimbursed aren't commensurate with the actual costs.

Ellis is hoping to change that with a bill he'll introduce in the next legislative session. The bill would evaluate reimbursement rates for home and community-based service providers annually.

"THE NUMBER ONE THING we want [the legislature] to do is establish a regular rate review process for how they pay us," says Gwendolyn Lee, executive director of The Arc of Anchorage. "The current system is not equitable."

Even if the waiting list were eradicated by sufficient funding from the state, Lee says, it would bring those people to a service provider system "that's weakened in its ability to deliver high quality services, and can't find the workers to meet the needs of the existing people."

At The Arc, which offers a large variety of services to those with developmental disabilities, under-funding has resulted in high turnover despite cost-cutting measures. "We have deferred maintenance; we have cut health insurance; we do not give raises; we ask people to do more," Lee says. "We are stretched; the rubber band is truly stretched."

Simply put, The Arc can only afford to hire workers at the lowest possible wages, making for high turnover and training costs. This means that the person with a disability has a constant revolving door of people coming and going from their life, each one having to learn the individual's critical issues, health issues, and personality nuances. "It's really depressing for the staff who are trying to deliver quality if they're constantly hiring and retraining people to do the very basics," Lee says.

There's a real danger to not addre[illegible] the financial concerns of home a[illegible] community-based

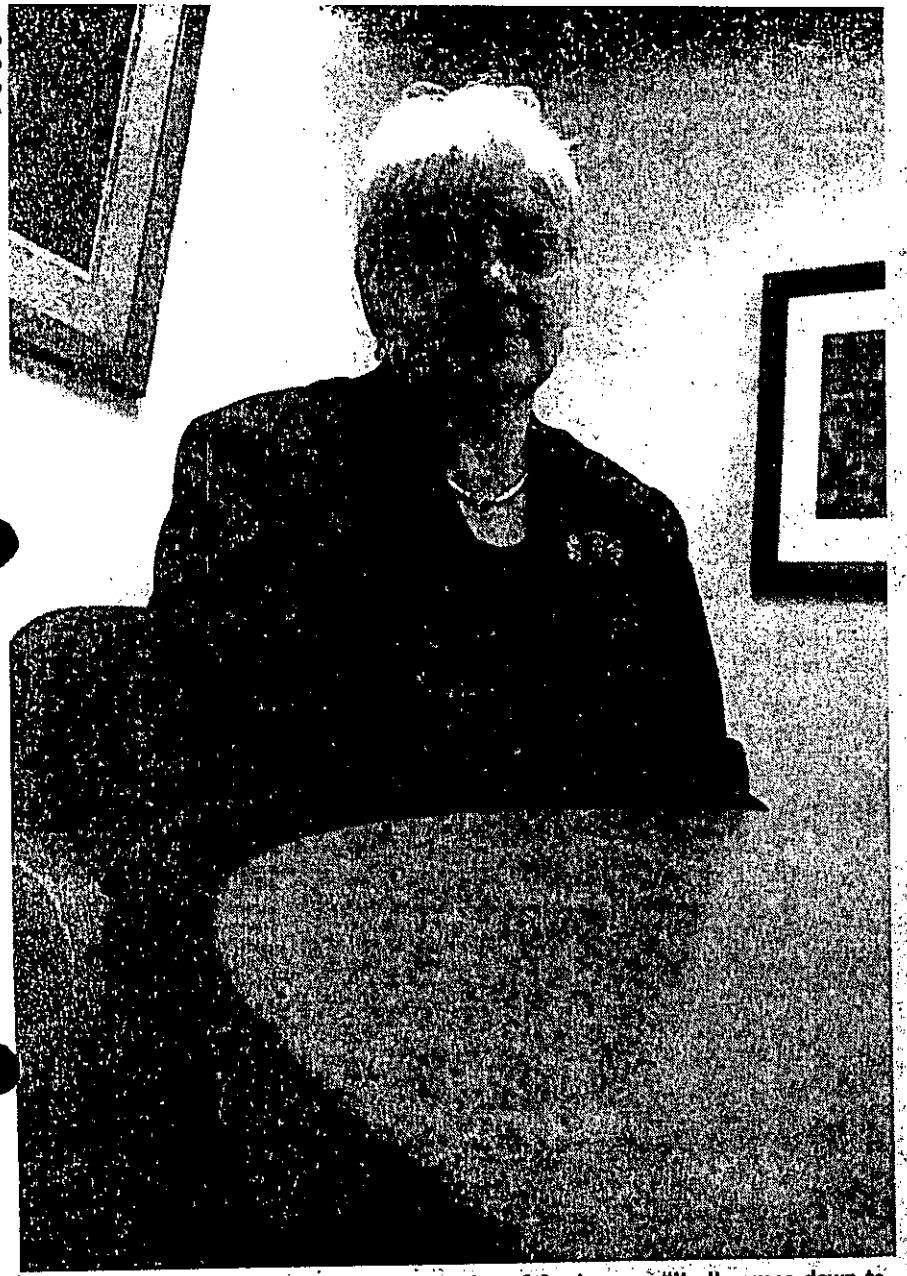
> "... this would be a real opportunity for Sarah Palin and myself and other legislators from both sides of the aisle to work together and put our money and our commitment where our mouths are. And I expect that she will, I just hope that we do enough to help those people that need the help the most."
>
> —*State Senator Johnny Ellis*

rates were as low as 9 percent, while only a couple categories gathered responses from over 50 percent of the providers, due to the complexity of the audits.

Meanwhile, hospitals and nursing homes are reimbursed for their costs based on an annual rate review, which is what the home and community-based developmental disabilities providers are asking for. The difference between the two groups, Ellis says, is that "frankly, hospitals and nursing homes have powerful lobbyists in Juneau. These community-based services have never been joined together in a really organized group and have never really had effective lobbyists to get what they need.

"I'm going to put this bill in to the legislature, but it's a really difficult bill to get through, to do what the service providers want—regular rate review and adjustment. I've said to them that they need to create a coalition of people all over the state, clients and service providers and workers to say, 'we need the same thing that the hospitals and nursing homes have.' I think maybe the time has come."

IT'S NOT JUST GERALDO RIVERA that's put the spotli[illegible] on the issues the developmental disabilities community f[illegible]



Gwendolyn Lee, Executive Director of The Arc of Anchorage: "It all comes down to how we think about our fellow human beings."

ger provide these services because they can't afford to, based on the poor reimbursement from the state and/or the feds under Medicaid, then there will be people without services in the community who will have to be institutionalized at greater public expense and more human tragedy."

"It all comes down to how we think about our fellow human beings," Lee says. "Do we have an attitude that the least of these is the most important, and everyone is entitled to fair access to basic community life?"

SIX YEARS AGO, THE STATE realized that the system for reimbursing service providers was flawed and froze the reimbursement rates while studying the issue. Last year, for the first time, the legislature granted an increase in rates, which varied according to the type of services provided. But there is still no mechanism in place for rates to keep up with inflation and cost of living increases.

To study the problem, the state hired an auditing firm, Myers and Stauffer, which attempted to analyze the service providers' costs versus reimbursements. The technique that the firm used, however, was unwieldy for many of the smaller sized organizations that provide services for the developmentally disabled.

"I don't think they got great participation," Ellis says. Indeed, some of the provider response would find an ally in her, while she held her baby boy Trig, who has Down syndrome.

"I understand that statement," Lee says. "As a parent of a new child with disabilities, it's easy to say 'I feel your pain, I understand your situation, I'll work to improve it.' It's easier said than done to really be an advocate. She is in a very different position than a lot of our families that may not have the circle of support that she has. I think that every family that heard that statement is watching now. We are now anxious to work with her to make that her legacy. It's an incredible opportunity for her, but she has to be willing to do it."

"This morning I heard Governor Palin say that we need to tighten our belts," says Ann WingQuest, The Arc of Anchorage's director of public affairs. "We're beyond tightened anymore. It frightens me when I hear her say that, because we have been so weakened and so stretched. She did say that we're not supposed to look to the government to make us healthy; the problem with our population is that their health care needs are not something that they elected. It wasn't like they were smoking and drinking and becoming obese. These are genetic or birth defects or whatever, and they need help."

Ellis is also looking to the governor to stand by what she campaigned on. "[Palin] got a lot of acclaim on the campaign trail as an advocate for kids with disabilities, not just kids with Down syndrome, but kids with disabilities. Now it's time to live up to that, and I'm hoping and inviting the governor to work with me to pare down the waiting list for DD services, to consider the bill on rate adjustment for DD providers and other community-based service providers. So this would be a real opportunity for Sarah Palin and myself and other legislators from both sides of the aisle to work together and put our money and our commitment where our mouths are. And I expect that she will, I just hope that we do enough to help those people that need the help the most."

There's still a chance that agencies such as The Arc and their advocates in the legislature might get their wishes. Governor Palin's communications director Bill McAllister says, "all of this is pending. The Department of Law is evaluating the rate re-basing issue. And the wait list is under review in the [Department of Health and Social Services] commissioner's office." ◆

bjk@anchoragepress.com

Advisory Board on Alcoholism and Drug Abuse

abada amhb

Alaska Mental Health Board

Governor's Council on Disabilities and Special Education

Alaskan Seniors Living Longer Growing Stronger

from the Alaska Commission on Aging

The TRUST

The Alaska Mental Health Trust Authority

Establish a Regular and Periodic Schedule of Rate Reviews for Home and Community-Based Services

The Governor's Council on Disabilities and Special Education, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse and the Alaska Commission on Aging, in collaboration with the Alaska Mental Health Trust Authority, the Alaska Brain Injury Network and the Alaska Suicide Council, have identified the establishment of a regular and periodic schedule of rate reviews for home and community based services one of their four legislative priorities for 2009. Regular and periodic rate reviews, for both Medicaid and grant-funded services, are imperative to maintaining the systems of care that serve Alaska's most vulnerable populations. The provisions for this legislation are in SB 32, sponsored by Senator Ellis.

- Before last year's rate rebasing for FY09, most home and community-based services providers had been over a decade without a rate review or increase. This resulted in an erosion of the system, as frozen rates resulted in a diminishing pool of resources – reducing the quality and availability of services.

- In FY07, home and community based services were provided to nearly 57,000 people who would have otherwise been served by costly institutional or nursing home care.

- In order for the Department of Health and Social Services (DHSS) and the State of Alaska to create and maintain a 10-year fiscal plan that adequately budgets for the costs of home and community-based services, a schedule of rate reviews is necessary.

- Our system of care for Alaskans with special needs is based on a network of non-profit providers. Without adequate funding, our providers cannot continue to provide quality services. Without our providers, we have no system of care.

Overview

Home and community-based services include a wide range of Medicaid and grant-funded services for Trust beneficiaries and other vulnerable Alaskans. Mental health care, infant learning, personal care attendant services, assisted living services, senior care, substance abuse counseling, and services for Alaskans with developmental disabilities are all examples of services provided at home or in our communities. These services maintain individuals' quality of life and reduce the need for more costly institutional, emergency and nursing home care.

For more that 10 years, providers have struggled to meet the demand for services while maintaining an acceptable quality of service because there has been no structure for reviewing the rates paid for those

services. Not only does the lack of periodic reviews prevent adequate fiscal planning by providers, it prevents adequate fiscal planning by the State. By establishing a regular schedule (e.g. every 2 or 4 years), providers and DHSS can plan and allocate resources so that rate reviews create a minimal administrative burden. This is turn will permit the Legislature to engage in more effective management of our state's budget and the responsibility to care for our most vulnerable neighbors.

Our network of non-profit providers touch the lives of thousands of Alaskan families. In FY 2007, over 30,000 Alaskans received behavioral health services from non-profit providers. Provider associations report that almost 20,000 Alaskan seniors received home and community based services; 3,807 Alaskans received personal care attendant services; 2,636 Alaskans with developmental disabilities received services; 1,500 Alaskans received care through assisted living homes; and an estimated 1,400 children were enrolled in early intervention/infant learning programs.. This is nearly 60,000 Alaskans who receive care at home and in their communities, so that they do not require nursing home or other institutional care.

This is why we advocate for a schedule of home and community based rate reviews, inclusive of Medicaid and grant-funded services, to be established by statute.

Supporters:

Alaska Mental Health Trust Authority
Governor's Council on Disabilities and Special Education
Alaska Mental Health Board
Advisory Board on Alcoholism and Drug Abuse
Alaska Commission on Aging
Alaska Association on Developmental Disabilities, serving 2,636 Alaskans
AgeNet, serving 18,953 Alaskans
Personal Care Attendant Provider's Association, serving 3,807 Alaskans
Assisted Living Association – Alaska, serving 1,500 Alaskans
Alaska Behavioral Health Association, serving 26,285 Alaskans

The TRUST

The Alaska Mental Health Trust Authority

February 3, 2009

Senator Johnny Ellis
Senate Health and Social Services Committee
Alaska State Capitol, Room 103
Juneau, AK 99801-1182

Subject: Support Letter for SB 32

Dear Senator Ellis:

The Alaska Mental Health Trust Authority (The Trust) encourages support of SB 32, a bill to establish a schedule of regular and periodic rate reviews for home and community based services (HCBS) in statute sponsored by you and co-sponsored by Senator Davis. This issue is one of our Coordinated Advocacy Agenda priorities with our six advisory groups and is critical to the providers who serve our beneficiaries. Unlike hospitals and nursing homes there are no mechanisms in place that provide for regular rate review or periodic adjustments for home- and community-based providers that serve Medicaid-eligible persons. Adequate funding for HCBS is essential for maintaining the foundation of care for vulnerable Alaskans close to home.

Prior to last year's rebasing of FY09 rates for HCBS providers rates had been frozen for 10 years without a review or increase, despite cost increases and mounting demand for services which The Trust study in FY 2008 on grant funding and Medicaid funding from 2000 through 2007 documented. Investment in the foundation of HCBS is prudent to assure services meet the needs of all vulnerable Alaskan with 2006 estimates provided by Senior and Disabilities Services showing the average annual cost of a semi-private room in a nursing facility was $172,685 compared to $25,026 for Medicaid Personal Care Attendant services and $21,436 for the Medicaid waiver.

Home- and community-based services touch the lives of thousands of Alaskan families daily. In FY07, HCBS were provided to more than 59,000 Alaskans of all ages and included 30,000 recipients of behavioral health services; 2,636 Alaskans with developmental disabilities; an estimated 1,400 children enrolled in early intervention/infant learning programs; 3,807 Alaskans who received personal care attendant services; 1,500 Alaskans who received care through assisted living homes; and 20,000 older Alaskans who received senior home and community based services.

Regular rate reviews promote sound fiscal planning by the State and providers, which is essential for providing consistently high quality services and responsible state budget management.

Sincerely,

-for Melissa Culpepper

Jeff Jessee
Chief Executive Officer

3745 Community Park Loop, Suite 200 Anchorage, Alaska 99508 Tel: 907-269-7960 Fax: 907-269-7966 www.mhtrust.org

AARP

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

February 3, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

Dear Chair Davis: RE: SB 32-Ellis--Support

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 32, authored by your Committee colleague Senator Johnny Ellis and co-sponsored by you.

SB 32 would allow annual rate reviews of all home and community based services similar to the process for hospitals. Rates for HCBS services under Medicaid have remained the same for several years, discouraging needed providers from entering the field and forcing current providers to reduce their services and cut back on clients.

As we age, many of us would prefer to stay at home or with our families but sometimes we need extra help to do so. With the growing numbers of older people who need support to live on their own, private and public organizations now offer many different options to allow us to "age in place" in our homes and communities. These options form the continuum of home and community based services, ranging from meals on wheels to adult day care. In addition to meeting our personal preferences to remain home and in our communities, HCBS services are much less expensive than institutional care.

Younger persons with disabilities are also primary users of HCBS services to allow them to continue their education, work and participate as full citizens in their communities and with their families.

We cannot expect the providers of HCBS to continue to operate on rates often set years ago. It makes sense to review HCBS rates every year just as we do with hospitals.

AARP requests an "AYE" vote on SB 32.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-752-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

abha

Alaska Behavioral Health Association

alaskabehavioralhealth.net

The Honorable Senator Johnny Ellis
State Capitol
Juneau, Alaska 99801-1182

Dear Senator Ellis;

I am writing in support of SB 32 on behalf of the membership of the Alaska Behavioral Health Association. The issues of rates and the mechanism and frequency of adjusting those rates are the primary issue for our membership this year.

We support the effort to put into place rate setting mechanisms for the home and community based services and that this model will be applied to the other providers that contract with the State of Alaska to deliver services. It is difficult to manage a business that is focused on delivering health care services when the cost for reimbursement does not keep pace with inflation and cost of living. Fixed costs don't go away and agencies have been trying to meet their grant obligations while keeping the business solvent. Employers are not able to offer competitive wage and benefit packages because of insufficient reimbursement rates.

Please let me know what else our members can do to support your legislation.
Thank you.

In Health,

Steve Horn
Executive Director

Attachment

Kristan Jez
PO Box 774376
Eagle River, AK 99577

The Honorable Bettye Davis
Chair – Senate Health & Social Services
State Capital, Room 30
Juneau, AK 99801

Re: Support for Senate Bill 32 – An Act relating to medical assistauce payments for home and community-based services.

Dear Senator Davis:

I want to thank you for taking the time to hold a hearing in regards to Senate Bill 32, which was sponsored by Senator Johnny Ellis. I strongly support this legislation and feel that community based service providers for the developmentally disabled should be treated as fairly and equally as hospitals and nursing homes.

As someone who has worked for one of the agencies for the past 23 years, I know first hand the effects of rate freezes. Not only are the lives of our support recipients being under minded and diminished, the negative impact on the workforce is taking its toll.

Families are not receiving the quality of services they should be due to lack of an inadequate workforce. Families are being penalized because agencies are unable to offer reasonable wages, and maintain decent benefits. In addition, the escalating cost of heating fuel, gasoline, utilities, insurance and other supplies are crippling agencies.

We need something that is fair and equitable if agencies are to survive and provide the much needed services to Alaskan who experience a disability.

Thank you for your time and I urge the committee to pass this legislation on to the next step.

Sincerely,

Kristan Jez

Assets, Inc.

Matthew J. Jones M.A., Executive Director

February 3, 2009

The Honorable Bettye Davis
Chair – Senate Health & Social Services
State Capital, Room 30
Juneau, AK 99801

Re: Support for Senate Bill 32 – An Act relating to medical assistance payments for home and community-based services.

Dear Senator Davis:

Thank you for scheduling Senate Bill 32, sponsored by Senator Johnny Ellis, for a hearing in Senate H&SS on Wednesday, February 4th. As a provider of services to individuals experiencing developmental disabilities, Assets Inc. strongly supports this legislation and greatly appreciates the added authority of your co-sponsorship.

All too frequently I have to account to families and guardians our inability to hire and keep employees qualified to work with their family member. Years of frozen rates and no manner in which to regularly review them have been very destructive to the goal of maintaining meaningful therapeutic relationships between our clients and staff.

Each year about this time I have to make the painful decisions about what part of employee benefits to reduce or eliminate. It impacts our ability to recruit and maintain employees and destroys morale. These good people aren't leaving to work for another provider, but rather are leaving the field altogether.

We are extremely grateful that Senator Ellis has introduced this much needed legislation and urge the Committee to pass it on to the next Committee of Referral.

Thank you for your consideration.

Respectfully,

Matthew J. Jones M.A.
Assets Inc.
Executive Director

cc: the Honorable Johnny Ellis
State capital, RM 9
Juneau, AK 99801

6311 DeBarr Road Suite L-2 Anchorage, AK 99504
Phone: (907) 336-3365 and Fax: (907) 336-3397

February 3, 2009

Senator John Ellis
Senator Bettye Davis
via email

Dear Senator Ellis and Senator Davis,

I am writing to support SB 32, which establishes periodic rate reviews for home and community-based services. Ensuring consistent rate increases for providers enables less expensive care for the elderly and develops a workforce aimed at the medical field.

As the second largest provider of in-home care services, we are intimately familiar with the associated challenges. The cost of doing business has increased while rates have been flat. Without entrepreneurial incentive, providing direct care may rest on the more expensive option; state-managed assisted living facilities and state-managed skilled nursing facilities

Workforce development for the medical field starts with our in-home care staff. Our Personal Care Assistants (PCA's) can receive certification and provide low level care for the elderly. Many family members and college-age PCA's get their first glimpse at the medical field.

Thank you for your support of SB 32. Please contact me with any questions. My direct line is extension 104 at (907) 336-3365.

Best regards,

Brian Richardson
Chief Executive Officer

Don Burrell

From: Walter Majoros [walterm@jys.org]
Sent: Sunday, February 01, 2009 7:51 PM
To: Sen. Bettye Davis
Subject: Support SB 32: Rate reviews for home and community-based services

Walter Majoros
8250 North Douglas Highway
Juneau, AK 99801-7635

RECEIVED
FEB 0 2 2009

February 1, 2009

Bettye Davis

Dear Bettye Davis:

I support SB 32, establishing periodic rate reviews for home and community-based services.

Home and community-based services include a wide range of Medicaid and grant-funded services for vulnerable Alaskans.

Mental health care, infant learning, personal care attendant services, assisted living services, senior care, substance abuse counseling, and services for Alaskans with developmental disabilities are all examples of services provided at home or in our communities.

Home and community-based services maintain individuals' quality of life and reduce the need for more costly institutional, emergency and nursing home care.

Both Medicaid and grant-funded services, are imperative to maintaining the systems of care that serve Alaska's most vulnerable populations.

Before last year's rate rebasing for FY09, most home and community-based services providers had been over a decade without a rate review or increase.

In FY07, home and community based services were provided to nearly 57,000 people who would have otherwise been served by costly institutional or nursing home care.

Our system of care for Alaskans with special needs is based on a network of non-profit providers. Without adequate funding, our providers cannot continue to provide quality services. Without our providers, we have no system of care.

For more that 10 years, providers have struggled to meet the demand for services while maintaining an acceptable quality of service because there has been no structure for reviewing the rates paid for those services. Not only does the lack of periodic reviews prevent adequate fiscal planning by providers, it prevents adequate fiscal planning by the State.

By establishing a regular schedule (e.g. every 2 or 4 years), providers and DHSS can plan and allocate resources so that rate reviews create a minimal administrative burden. This is turn will permit the Legislature to engage in more effective management of our state's budget and the responsibility to care for our most vulnerable neighbors.

The Alaska network of non-profit providers touch the lives of thousands of Alaskan families. In FY 2007, over 30,000 Alaskans received behavioral health services from non-profit providers. Provider associations report that almost 20,000 Alaskan seniors received home and community based services; 3,807 Alaskans received personal care attendant services; 2,636 Alaskans with developmental disabilities received services; 1,500 Alaskans received care through assisted living homes; and an estimated 1,400 children were enrolled in early intervention/infant learning programs.

This is nearly 60,000 Alaskans who receive care at home and in their communities, so that they do not require nursing home or other institutional care.

This is why we advocate for a schedule of home and community based rate reviews, inclusive of Medicaid and grant-funded services, to be established by statute.

Sincerely,

Walter Majoros
723-6938

This message has been verified by CapwizXC as authentic and sent by this individual.
Authentication ID: [NLS31Cx6]

Don Burrell

From: Walter Majoros [walterm@jys.org]
Sent: Sunday, February 01, 2009 7:55 PM
To: Sen. Bettye Davis
Subject: Support Reauthorizing Adult Dental Services!

Walter Majoros
8250 North Douglas Highway
Juneau, AK 99801-7635

February 1, 2009

RECEIVED
FEB 0 2 2009

Bettye Davis

Dear Bettye Davis:

I support reauthorizing preventive and restorative dental services for adult Medicaid recipients. Medicaid coverage for these services will sunset June 30, 2009 without legislative reauthorization. The provisions for this are in both SB 65 and SB 82.

The Department of Health and Social Services reports that approximately 7,600 adult Medicaid recipients received these dental services in FY08 with 252 participating dental providers.

The American Dental Association recommends adult preventive and restorative dental services be included in all state Medicaid programs.

Dental pain, missing and decayed teeth and infection can affect employment and job advancement, contribute to missed work, dietary choices for seniors, and complicate management of other chronic diseases.

Dental infections due to periodontal disease have been associated with pre-term births, management problems for individuals with diabetes, risks for pneumonia in nursing homes, and other chronic diseases including cardiovascular disease.

The bacteria involved with the dental decay process are typically passed parent to child. Part of the efforts to reduce dental decay in young children relates to reducing the level of dental infection in the caregiver. Additionally, parents with dental coverage are more likely to access dental services for their children.

The coverage of preventive and restorative dental care for adult Medicaid recipients along with necessary behavioral changes, over the long term, offer a reduced likelihood of using more expensive services, like the hospital emergency room for management of a dental infection.

Sincerely,

Walter Majoros
723-6938

This message has been verified by CapwizXC as authentic and sent by this individual.
Authentication ID: [i9050SEJ]

Don Burrell

From: Eric Holland [ericholland1@hotmail.com]
Sent: Sunday, February 01, 2009 8:25 PM
To: Sen. Bettye Davis
Subject: Support SB 32: Rate reviews for home and community-based services

Eric Holland
BX 1462
Dillingham, AK 99576-1462

RECEIVED
FEB 0 2 2009

February 2, 2009

Bettye Davis

Dear Bettye Davis:

I support SB 32, establishing periodic rate reviews for home and community-based services.

Mental health care, infant learning, personal care attendant services, assisted living services, senior care, substance abuse counseling, and services for Alaskans with developmental disabilities are all examples of services provided at home or in our communities.

The Alaska network of non-profit providers touch the lives of thousands of Alaskan families. In FY 2007, over 30,000 Alaskans received behavioral health services from non-profit providers. Provider associations report that almost 20,000 Alaskan seniors received home and community based services; 3,807 Alaskans received personal care attendant services; 2,636 Alaskans with developmental disabilities received services; 1,500 Alaskans received care through assisted living homes; and an estimated 1,400 children were enrolled in early intervention/infant learning programs.
This is nearly 60,000 Alaskans who receive care at home and in their communities, so that they do not require nursing home or other institutional care.

This is why we advocate for a schedule of home and community based rate reviews, inclusive of Medicaid and grant-funded services, to be established by statute.

Sincerely,

Eric Holland

This message has been verified by CapwizXC as authentic and sent by this individual.
Authentication ID: [55xlcds2]

Don Burrell

From: regina savchuk [gina6ak@yahoo.com]
Sent: Sunday, February 01, 2009 7:56 PM
To: Sen. Bettye Davis
Subject: Support Reauthorizing Adult Dental Services!

RECEIVED
FEB 0 2 2009

regina savchuk
po#597
kasilof, AK 99610-5971

February 1, 2009

Bettye Davis

Dear Bettye Davis:

The Department of Health and Social Services reports that approximately 7,600 adult Medicaid recipients received these dental services in FY08 with 252 participating dental providers.

Dental pain, missing and decayed teeth and infection can affect employment and job advancement, contribute to missed work, dietary choices for seniors, and complicate management of other chronic diseases.

Dental infections due to periodontal disease have been associated with pre-term births, management problems for individuals with diabetes, risks for pneumonia in nursing homes, and other chronic diseases including cardiovascular disease.

Dental infections due to periodontal disease have been associated with pre-term births, management problems for individuals with diabetes, risks for pneumonia in nursing homes, and other chronic diseases including cardiovascular disease.

The coverage of preventive and restorative dental care for adult Medicaid recipients along with necessary behavioral changes, over the long term, offer a reduced likelihood of using more expensive services, like the hospital emergency room for management of a dental infection.

Sincerely, a consumer of services

Regina Savchuk/ Kenai Peninsula NAMI
907-260-5646

This message has been verified by CapwizXC as authentic and sent by this individual.
Authentication ID: [a2147GAI]

Don Burrell

From: Patricia Chapman [patchapman@peacehealth.org]
Sent: Sunday, February 01, 2009 10:10 PM
To: Sen. Bettye Davis
Subject: Support SB 32: Rate reviews for home and community-based services

Patricia Chapman
3233 Emma court
Ketchikan, AK 99901-5791

RECEIVED
FEB 0 2 2009

February 2, 2009

Bettye Davis

Dear Bettye Davis:

My personal story is I have a disabled daughter with a TBI, getting and keeping qualified home care-providers is very hard. Once you have them trained and they develope good skills they go to work in the hospital or pioneer home where they can get more money. Or they are offered a job whee they not only make more money but are offered health care benefits for them and their family.

It is unsafe to leave a disabled person who is unable to speak or move to care for them selves with unqualified providers. Yet I have a full time job that I use to try to provide insurance for my daughter's care so not to be a drain on the state. Many times I have had to stay home or come home early due to no providers.

It is imperative to the care of the seniors and disabled that are in their homes or assisted living facilities to compete in wages with the rest of the community. Without the assistance of the state helping with the pay for providers we would be living in proverty and she would not have the care as my health would become impacted.

I urge you to increase the rate of pay for qualified personnel in home and community based services.

Sincerely,

Patricia Chapman
907-617-5704

This message has been verified by CapwizXC as authentic and sent by this individual.
Authentication ID: [03rxmpn7]

Don Burrell

From: Mary Fries [sheppardfries@gmail.com]
Sent: Monday, February 02, 2009 7:30 AM
To: Sen. Bettye Davis
Subject: Support SB 32: Rate reviews for home and community-based services

Mary Fries
PO Box 2229
Homer, AK 99603-2229

RECEIVED
FEB 0 2 2009

February 2, 2009

Bettye Davis

Dear Bettye Davis:

I support SB 32, establishing periodic rate reviews for home and community-based services.

My personal story is ... that I have been a care coordinator with South Peninsula Hospital working to provide these services to the lower Kenai Peninsula for 10 years. I have seen the enormous value to the recipients of these services and the increased quality of life it provides to the elderly and disabled first hand, not to mention the savings to the state by preventing Long Term Care admissions. While the cost of providing these services has increased dramatically, the reimbursement has not kept pace. Please fund these programs adequately. We have an enormous wave of elderly citizens who are in need of these services heading our way. The Baby Boomers have arrived! The reality is there are not enough expensive long term care beds to service all who need this level of care.

Home and community-based services maintain individuals quality of life and reduce the need for more costly institutional, emergency and nursing home care.

Before last year s rate rebasing for FY09, most home and community-based services providers had been over a decade without a rate review or increase.

Sincerely,

Mary Fries
907-235-0302

This message has been verified by CapwizXC as authentic and sent by this individual. Authentication ID: [61jlukh5]

Don Burrell

From: T. Frank Box [tfbox000@acsalaska.net]
Sent: Sunday, February 01, 2009 2:25 PM
To: Sen. Bettye Davis
Subject: Support SB 32: Rate reviews for home and community-based services

T. Frank Box
1231 W Northern Lights #461
Anchorage, AK 99503-2337

RECEIVED
FEB 0 2 2009

February 1, 2009

Bettye Davis

Dear Bettye Davis:

I support SB 32, establishing periodic rate reviews for home and community-based services.
Home and community-based services include a wide range of Medicaid and grant-funded services for vulnerable Alaskans.

My personal story is ...
I am a 2 time brain tumor survivor, That needed immediate assistance inorder to survive the brutal treatment regimes of radiation & 1 year of chemotherapy. In an adled cognitive state, I went looking for answers and found the Head Injury Support Group @ Access Alaska Inc. After 2 & a Half years of speech therapy & 2 years of volnteering w/ the group. II graduated from DVR, was retrained & hired as a peer support specialist, so I get to relive the struggles of my past, every day in advocacy efforts for the under served populations of our state.

I also work as the coordinator for the Home E-Mods grant projects @ Access Alaska, I have seen the benifits first hand, as the institutionalized are set free to be care for by people they choose.

Home and community-based services maintain individuals a quality of life and reduce the need for more costly institutional, emergency and nursing home care. Family members can be trained to provide care to a person they know and are able to communicate with.

The Alaska network of non-profit providers touch the lives of thousands of Alaskan families. In FY 2007, over 30,000 Alaskans received behavioral health services from non-profit providers. Provider associations report that almost 20,000 Alaskan seniors received home and community based services; 3,807 Alaskans received personal care attendant services; 2,636 Alaskans with developmental disabilities received services; 1,500 Alaskans received care through assisted living homes; and an estimated 1,400 children were enrolled in early intervention/infant learning programs.
This is nearly 60,000 Alaskans who receive care at home and in their communities, so that they do not require nursing home or other institutional care.

This is why we advocate for a schedule of home and community based rate reviews, inclusive of Medicaid and grant-funded services, to be established by statute.

Sincerely,

T. Frank Box
9073514977

This message has been verified by CapwizXC as authentic and sent by this individual.
Authentication ID: [v5511IFI]

Don Burrell

From: KATHY HUSKEY [kahuskey@hotmail.com]
Sent: Sunday, February 01, 2009 7:53 PM
To: Sen. Bettye Davis
Subject: Support SB 32: Rate reviews for home and community-based services

KATHY HUSKEY
PO BOX 772482
EAGLE RIVER, AK 99577-2482

February 1, 2009

RECEIVED
FEB 0 2 2009

Bettye Davis

Dear Bettye Davis:

I support SB 32, establishing periodic rate reviews for home and community-based services.

Home and community-based services include a wide range of Medicaid and grant-funded services for vulnerable Alaskans.

Mental health care, infant learning, personal care attendant services, assisted living services, senior care, substance abuse counseling, and services for Alaskans with developmental disabilities are all examples of services provided at home or in our communities.

Home and community-based services maintain individuals quality of life and reduce the need for more costly institutional, emergency and nursing home care.

Both Medicaid and grant-funded services, are imperative to maintaining the systems of care that serve Alaska s most vulnerable populations.

Before last year s rate rebasing for FY09, most home and community-based services providers had been over a decade without a rate review or increase.

In FY07, home and community based services were provided to nearly 57,000 people who would have otherwise been served by costly institutional or nursing home care.

Our system of care for Alaskans with special needs is based on a network of non-profit providers. Without adequate funding, our providers cannot continue to provide quality services. Without our providers, we have no system of care.

For more that 10 years, providers have struggled to meet the demand for services while maintaining an acceptable quality of service because there has been no structure for reviewing the rates paid for those services. Not only does the lack of periodic reviews prevent adequate fiscal planning by providers, it prevents adequate fiscal planning by the State.

By establishing a regular schedule (e.g. every 2 or 4 years), providers and DHSS can plan and allocate resources so that rate reviews create a minimal administrative burden. This is turn will permit the Legislature to engage in more effective management of our state s budget and the responsibility to care for our most vulnerable neighbors.

The Alaska network of non-profit providers touch the lives of thousands of Alaskan families. In FY 2007, over 30,000 Alaskans received behavioral health services from non-profit providers. Provider associations report that almost 20,000 Alaskan seniors received home and community based services; 3,807 Alaskans received personal care attendant services; 2,636 Alaskans with developmental disabilities received services; 1,500 Alaskans received care through assisted living homes; and an estimated 1,400 children were enrolled in early intervention/infant learning programs.

This is nearly 60,000 Alaskans who receive care at home and in their communities, so that they do not require nursing home or other institutional care.

This is why we advocate for a schedule of home and community based rate reviews, inclusive of Medicaid and grant-funded services, to be established by statute.

Sincerely,

KATHY A. HUSKEY
907-696-3387

This message has been verified by CapwizXC as authentic and sent by this individual.
Authentication ID: [aqisREP4]

Don Burrell

From: Patricia Chapman [patchapman@peacehealth.org]
Sent: Sunday, February 01, 2009 10:00 PM
To: Sen. Bettye Davis
Subject: Support Reauthorizing Adult Dental Services!

Patricia Chapman
3233 Emma court
Ketchikan, AK 99901-5791

RECEIVED
FEB 0 2 2009

February 2, 2009

Bettye Davis

Dear Bettye Davis:

The American Dental Association recommends adult preventive and restorative dental services be included in all state Medicaid programs.

Dental pain, missing and decayed teeth and infection can affect employment and job advancement, contribute to missed work, dietary choices for seniors, and complicate management of other chronic diseases.

Dental infections due to periodontal disease have been associated with pre-term births, management problems for individuals with diabetes, risks for pneumonia in nursing homes, and other chronic diseases including cardiovascular disease.

The bacteria involved with the dental decay process are typically passed parent to child. Part of the efforts to reduce dental decay in young children relates to reducing the level of dental infection in the caregiver. Additionally, parents with dental coverage are more likely to access dental services for their children.

The coverage of preventive and restorative dental care for adult Medicaid recipients along with necessary behavioral changes, over the long term, offer a reduced likelihood of using more expensive services, like the hospital emergency room for management of a dental infection.

I support reauthorizing preventive and restorative dental services for adult Medicaid recipients. Medicaid coverage for these services will sunset June 30, 2009 without legislative reauthorization. The provisions for this are in both SB 65 and SB 82.

I work in an emergency room that sees many patients who have no dental care and they suffer many other complaints due to the poor dental health.
This ultimately costs us more in medical care.

Sincerely,

Patricia Chapman
907-617-5704

Employer Name: Ketchikan General Hospital Employer City: Ketchikan
Position: ER Coder
Are you a registered voter?: Yes
Did you vote in the last election?: Yes
Age: 67
Gender: Female
Organization: AKHIMA
Interest Group: Health related fields

Would you like a reply?: Yes
Have you visited our website?: No

This message has been verified by CapwizXC as authentic and sent by this individual.
Authentication ID: [jiemXUT5]

Don Burrell

From: Helen Simmonds [simmondsfamily@barrow.com]
Sent: Sunday, February 01, 2009 1:16 PM
To: Sen. Bettye Davis
Subject: Support SB 32: Rate reviews for home and community-based services

Helen Simmonds
P.O. Box 786
Barrow, AK 99723-0786

RECEIVED
FEB 0 2 2009

February 1, 2009

Bettye Davis

Dear Bettye Davis:

I support SB 32, establishing periodic rate reviews for home and community-based services.

My personal story is ...my 28 year old son who was dual diagnosed at the age of 15. He was going in and out of jail from the time he turned 18 to the age of 25. Since the time he became eligible for home and community based services, he has only been there once. The services also has given him a sense of stability due to the structured atmospere of homes. This has made considerable improvements with his impulsive behavior. I have observed however, that the rate of pay for day hab employees may affect his behavior. He gets used to a person but the person does not stay. I have become acqainted with some of the day hab workers and they want to stay but cannot because of the minimum rate of pay. The providers spend monies to train the staff and unfortunately a good majority of them do not stay. With continued support, this could be a great opportunity for both the consumers and the providers.

Mental health care, infant learning, personal care attendant services, assisted living services, senior care, substance abuse counseling, and services for Alaskans with developmental disabilities are all examples of services provided at home or in our communities.

Home and community-based services maintain individuals quality of life and reduce the need for more costly institutional, emergency and nursing home care.

Both Medicaid and grant-funded services, are imperative to maintaining the systems of care that serve Alaskas most vulnerable populations.

Before last years rate rebasing for FY09, most home and community-based services providers had been over a decade without a rate review or increase.

In FY07, home and community based services were provided to nearly 57,000 people who would have otherwise been served by costly institutional or nursing home care.

Our system of care for Alaskans with special needs is based on a network of non-profit providers. Without adequate funding, our providers cannot continue to provide quality services. Without our providers, we have no system of care.

For more that 10 years, providers have struggled to meet the demand for services while maintaining an acceptable quality of service because there has been no structure for reviewing the rates paid for those services. Not only does the lack of periodic reviews prevent adequate fiscal planning by providers, it prevents adequate fiscal planning by the state.

By establishing a regular schedule (e.g. every 2 or 4 years), providers and DHSS can plan and allocate resources so that rate reviews create a minimal administrative burden. This is turn will permit the Legislature to engage in more effective management of our states

budget and the responsibility to care for our most vulnerable neighbors.

The Alaska network of non-profit providers touch the lives of thousands of Alaskan families. In FY 2007, over 30,000 Alaskans received behavioral health services from non-profit providers. Provider associations report that almost 20,000 Alaskan seniors received home and community based services; 3,807 Alaskans received personal care attendant services; 2,636 Alaskans with developmental disabilities received services; 1,500 Alaskans received care through assisted living homes; and an estimated 1,400 children were enrolled in early intervention/infant learning programs.
This is nearly 60,000 Alaskans who receive care at home and in their communities, so that they do not require nursing home or other institutional care.

This is why we advocate for a schedule of home and community based rate reviews, inclusive of Medicaid and grant-funded services, to be established by statute.

Sincerely,

Helen Simmonds
9078523006

This message has been verified by CapwizXC as authentic and sent by this individual.
Authentication ID: [s2026URN]

SB 35

Alaska State Legislature

Senator Bettye Davis, Chair
Senator Joe Paskvan, Vice Chair
State Capitol, Room 30
Juneau, Alaska 99801
Phone: (907) 465-3822
Fax: (907) 465-3756

Committee Members:
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

Senate Health & Social Services Committee

February 18, 2009

To: Legislative Legal 465-2029

From: Lynda Zaugg, ~~aide to~~ Sen. Davis

Re: CS for SB 35 (SBS)

Sen. Davis is requesting a CS for SB 35 to make the attached proposed changes in Suicide Council Membership.

Attachment: Recommended changes to Statewide Suicide Council Membership

Recommended changes to Statewide Suicide Council Membership Compositions. Recommendations made by the SSPC membership at their quarterly meeting, February 4, 2009 in Juneau, AK.

Proposed changes:

1. The four (4) legislative members appointed by the Legislature would become advisory in nature and would no longer be voting members. This would reduce the difficulty obtaining a quorum at meetings.
2. Change the "two members who are employed in the executive branch of state government" (a.) to add the language: one person representing the DHSS and one person representing the DEED.
3. Change "one person who is a counselor in a secondary school to "(e.) an employee from a secondary school system such as, but not limited to, a teacher, administrator, counselor, nurse or other school personnel.
4. Change "one adult who is active in a statewide youth organization" (f.) to one person who is active in a youth organization.
5. Change "one person who is under the age of 18" (j.) to one person who is enrolled in high school.
6. Add one public member at large.

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Friday, February 13, 2009 4:04 PM
To: Lynda Zaugg; Casto, L Diane (HSS); Thomas Obermeyer; Sen. Johnny Ellis
Subject: SB 35 Suicide prevention council membership
Attachments: SSPC Recommended changes to Membership Compositions--02-09.doc

The Governor's office and Department of Health and Social Services support the attached recommendations for changes to membership of the Statewide Suicide Prevention Council.

Please let me know if you need anything else on this.
w.

Name DAVIS	SUICIDE PREVENTION COUNCIL	
Senator Bunde		
Senator Davis	BJ	
Senator Dyson		
Senator Ellis		
Senator Elton		
Senator French		
Senator Hoffman		
Senator Huggins		
Senator Kookesh		
Senator McGuire		
Senator Menard		
Senator Meyer		
Senator Olson		
Senator Paskvan		
Senator Stedman		
Senator Stevens		
Senator Therriault		
Senator Thomas		
Senator Wagoner		
Senator Wielechowski		

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Finance

Date of 5-Day Notice: 1/22/09
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/25/09

Health and Social Services Committee considered SENATE BILL NO. 35

SB 35 EXTEND SUICIDE PREVENTION COUNCIL

"An Act extending the termination date of the Statewide Suicide Prevention Council; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [✓] **CS** SB 35 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of In

[ ] further referral to _____ Committe

CS Forth Coming

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS	1/23/09	✓			1
DHS	1/23/09	✓			2

OTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	✓			
	THOMAS	✓			
	PASKVAN	X			
	DYSON	X			
CHAIR: Betty Davis	DAVIS	✓			

3420

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB035
() Publish Date:

Identifier (file name): SB035-DHSS-SPC-01-23-09
Dept. Affected: Health & Social Services
Title: Extend Suicide Prevention Council
RDU: Behavioral Health
Component: Suicide Prevention Council
Sponsor: Davis
Requester: Senate Health & Social Services
Component Number: 2651

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel		35.0	35.0	35.0	35.0	35.0	35.0
Contractual		30.6	30.6	30.6	30.6	30.6	30.6
Supplies		17.2	17.2	17.2	17.2	17.2	17.2
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**82.8**	**82.8**	**82.8**	**82.8**	**82.8**	**82.8**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health		82.8	82.8	82.8	82.8	82.8	82.8
Other Interagency Receipts							
TOTAL	**0.0**	**82.8**	**82.8**	**82.8**	**82.8**	**82.8**	**82.8**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The proposed bill extends the termination date of the Statewide Suicide Prevention Council (SSPC or council) to June 30, 2013. The SSPC will continue to be assigned to the Division of Behavioral Health (DBH). The costs to DBH would include expenses related to the council meetings, teleconferences, presentations and suicide prevention public awareness campaigns.

Prepared by: Melissa Stone
Phone 269-3410
Division: Behavioral Health
Date/Time 1/23/09 12:00 AM

Approved by: William H. Hogan, Commissioner
Date 1/23/2009
Dept. of Health & Social Services

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB035
() Publish Date:

Identifier (file name): SB035-DHSS-BHA-01-23-09
Dept. Affected: Health & Social Services
Title: Extend Suicide Prevention Council
RDU: Behavioral Health
Component: Behavioral Health Administration
Sponsor: Davis
Requester: Senate Health & Social Services
Component Number: 2665

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services		46.3	46.3	46.3	46.3	46.3	46.3
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**46.3**	**46.3**	**46.3**	**46.3**	**46.3**	**46.3**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health		46.3	46.3	46.3	46.3	46.3	46.3
Other Interagency Receipts							
TOTAL	**0.0**	**46.3**	**46.3**	**46.3**	**46.3**	**46.3**	**46.3**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time		0.5	0.5	0.5	0.5	0.5	0.5
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The proposed bill extends the termination date of the Statewide Suicide Prevention Council (SSPC or council) to June 30, 2013. The 0.5 FTE administrative support position, hired by the council, will continue to be assigned to the Division of Behavioral Health.

Prepared by: Melissa Stone
Division: Behavioral Health
Phone: 269-3410
Date/Time: 1/23/09 12:00 AM

Approved by: William H. Hogan, Commissioner
Dept. of Health & Social Services
Date: 1/23/2009

(Revised 9/10/2008 OMB)

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 2, 2009

SUBJECT: Sectional summary of SB 35 (Work Order No. 26-LS0229\A)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Alpheus Bullard
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Extends the termination date of the Statewide Suicide Prevention Council to 2013.

Section 2. Provides an effective date.

TLAB:ljw
09-052.ljw

Audit dofs should be mandated

26-LS0229\A

SENATE BILL NO. 35

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY SENATORS DAVIS, Ellis, Therriault

Introduced: 1/21/09
Referred: Health and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

"An Act extending the termination date of the Statewide Suicide Prevention Council; and providing for an effective date."

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

*** Section 1.** AS 44.66.010(a)(8) is amended to read:

(8) Statewide Suicide Prevention Council (AS 44.29.300) - June 30, **2013** [2009];

*** Sec. 2.** This Act takes effect immediately under AS 01.10.070(c).

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Office of Senator Bettye Davis

April 10, 2009
Senator Charlie Huggins, Chair
Senate Rules Committee

RE: Request to calendar SB 35, "An Act extending the termination date of the Statewide Suicide Prevention Council; and providing for an effective date."

Dear Senator Huggins,

Senator Davis respectfully requests that Senate Rules promptly calendar SB 35 which extends the termination date of the Statewide Suicide Prevention Council to June 30, 2013. The Statewide Suicide Prevention Council Suicide sunsets June 30, 2009, so immediate action is required if the state is to help curtail this avoidable loss of life by suicide, particularly by so many young people each year. The mission of the Statewide Suicide Prevention Council is to advise the governor and the legislature on issues relating to suicide. In collaboration with communities, faith-based organizations, and public-private entities, the Council works to improve the health and wellness of Alaskans by reducing suicide and its devastating effect on individuals, families, and communities. Over 125 Alaskans die each year by suicide, which is twice the national average per capita. Suicide is four times more prevalent among young males than females. Guns, alcohol, drugs, and unattended depression are often involved.

Attached in order are the following:

1. Sponsor Statement
2. The most recent version of the bill
3. Sectional analysis
4. Fiscal Notes
5. Additional Documentation

Sincerely,

Thomas S. Obermeyer
Legislative Administrative Assistant

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Sponsor Statement

SB 35 **"An Act extending the termination date of the Statewide Suicide Prevention Council; and providing for an effective date."**

SB 35 extends the termination date of the Statewide Suicide Prevention Council to June 30, 2013. Suicide is a very serious public health concern in Alaska, particularly among young males and the Alaska native population. Extension of the Statewide Suicide Prevention Council is important in curtailing this avoidable loss of life. The mission of the Statewide Suicide Prevention Council is to advise the governor and the legislature on issues relating to suicide. In collaboration with communities, faith-based organizations, and public-private entities, the Council works to improve the health and wellness of Alaskans by reducing suicide and its effect on individuals and communities.

The Executive Summary of the July, 2005 study by the Alaska Injury Prevention Center funded by Alaska Mental Health Trust Authority "Alaska Suicide Hospitalizations, 2001-2002," reported that in 2002 32,000 people took their own lives in the United States, and 20 times that number sought treatment for self-inflicted injuries. Alaska had the highest age-adjusted suicide rate of all the states in 2002 at 21.12 per 100,000 population, which is nearly twice that of the U.S. rate of 10.99 per 100,000. An average of 125 people die from suicide each year in Alaska, making it the number one cause of death for Alaskans under the age of 50 years (if unintentional injuries are examined individually instead of in groups).

Hospitalizations for suicide per the above study make a compelling case for the prevention of suicide and new insights into this dramatic public health problem. Over $4 million in hospital costs alone is spent in public funds each year to care for suicide attempts. This did not include physicians' and specialists' costs. While the toll on society and family members by suicide may be incalculable, significant numbers were revealed:

- The average age for the patients was 30 years.
- The average length of each hospital stay was 4 days, with a range of 1 to 366.
- The average cost per case was $8,986.
- Over 75% of the hospital costs were paid through public funding sources.
- 15% of hospital costs had to be written-off for patients' inability to pay.

The unabated high rate of suicide in Alaska demands continued attention and effort and earnestly urges, if not compels, the extension of the Statewide Suicide Prevention Council. A subsequent study to the above by the Alaska Injury Prevention Center from 9/1/03-8/31/06 found 426 suicides in Alaska during this 36-month period, with the continuing rate of suicide at over 21/100,000. Males outnumbered females 4 to 1. The age-group 20-29 had both the greatest number of suicides and the highest rate per 100,000 population. Alaska Natives had a significantly higher average rate of suicide than the non-Native population (51.4/100,000 compared to 16.9/100,000). The leading cause of death was firearms with toxicology reports in 1/3 of the cases. Alcohol was found in 44% of the toxicology tests and marijuana was found in 15%.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 2, 2009

SUBJECT: Sectional summary of CSSB 35(HSS), relating to the Statewide Suicide Prevention Council (Work Order No. 26-LS0229\E)

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Thomas Obermeyer

FROM: Alpheus Bullard TLAB
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds a member to the Statewide Suicide Prevention Council (Council), and changes the composition of the Council.

Section 2. Provides that legislative members of the Council are nonvoting members.

Section 3. Clarifies that the Council's presiding officer, and other officers that the Council may consider necessary, are elected by a majority of the Council's voting membership.

Section 4. Establishes that seven voting members of the Council constitute a forum.

Section 5. Extends the termination date of the Council to 2013.

Section 6. Provides an effective date.

TLAB:plm
09-130.plm

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSSB 35(HSS)
(S) Publish Date: 2/27/09

Identifier (file name): SB035-DHSS-SPC-01-23-09
Dept. Affected: Health & Social Services
Title: Extend Suicide Prevention Council
RDU: Behavioral Health
Component: Suicide Prevention Council
Sponsor: Davis
Requester: Senate Health & Social Services
Component Number: 2651

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel		35.0	35.0	35.0	35.0	35.0	35.0
Contractual		30.6	30.6	30.6	30.6	30.6	30.6
Supplies		17.2	17.2	17.2	17.2	17.2	17.2
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**82.8**	**82.8**	**82.8**	**82.8**	**82.8**	**82.8**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health		82.8	82.8	82.8	82.8	82.8	82.8
Other Interagency Receipts							
TOTAL	**0.0**	**82.8**	**82.8**	**82.8**	**82.8**	**82.8**	**82.8**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The proposed bill extends the termination date of the Statewide Suicide Prevention Council (SSPC or council) to June 30, 2013. The SSPC will continue to be assigned to the Division of Behavioral Health (DBH). The costs to DBH would include expenses related to the council meetings, teleconferences, presentations and suicide prevention public awareness campaigns.

Prepared by: Melissa Stone
Phone 269-3410
Division: Behavioral Health
Date/Time 1/23/09 12:00 AM

Approved by: William H. Hogan, Commissioner
Date 1/23/2009
Dept. of Health & Social Services

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: CSSB 35(HSS)
(S) Publish Date: 2/27/09

Identifier (file name): SB035-DHSS-BHA-01-23-09
Dept. Affected: Health & Social Services
Title: Extend Suicide Prevention Council
RDU: Behavioral Health
Component: Behavioral Health Administration
Sponsor: Davis
Requester: Senate Health & Social Services
Component Number: 2665

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services		46.3	46.3	46.3	46.3	46.3	46.3
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**46.3**	**46.3**	**46.3**	**46.3**	**46.3**	**46.3**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health		46.3	46.3	46.3	46.3	46.3	46.3
Other Interagency Receipts							
TOTAL	**0.0**	**46.3**	**46.3**	**46.3**	**46.3**	**46.3**	**46.3**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time		0.5	0.5	0.5	0.5	0.5	0.5
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The proposed bill extends the termination date of the Statewide Suicide Prevention Council (SSPC or council) to June 30, 2013. The 0.5 FTE administrative support position, hired by the council, will continue to be assigned to the Division of Behavioral Health.

Prepared by: Melissa Stone
Phone 269-3410
Division: Behavioral Health
Date/Time 1/23/09 12:00 AM

Approved by: William H. Hogan, Commissioner
Date 1/23/2009
Dept. of Health & Social Services

(Revised 9/10/2008 OMB)

3430

Alaska Suicide Hospitalizations
2001 - 2002

Alaska Injury
Prevention Center

Ron Perkins, MPH

Anchorage, Alaska
July 2005

This research was made possible with funding from:

The Alaska Mental Health Trust Authority

3431

EXECUTIVE SUMMARY

INTRODUCTION

In 2002, nearly 32,000 people took their own lives in the United States, and estimates indicate that 20 times that number sought treatment for self-inflicted injuries. Alaska had the highest age-adjusted suicide rate of all the states in 2002 at 21.12, which is nearly double the U.S. rate of 10.99 per 100,000 population. An average of 125 people die from suicide each year in Alaska, making it the number one cause of death for Alaskans under the age of 50 years (if unintentional injuries are examined individually instead of grouped). The epidemiology for suicide deaths is very different from the epidemiology for suicidal acts that result in hospitalization. This analysis looks at the epidemiology and costs associated with hospitalizations for self inflicted injuries.

RESULTS

Using data supplied by the Alaska Trauma Registry (ATR) and funding from the Alaska Mental Health Trust, the Alaska Injury Prevention Center (AIPC) conducted a thorough analysis of the 1,223 hospitalized suicide attempts in Alaska for 2001 and 2002. The epidemiology and hospital costs associated with this injury group are reported below.

A few of the interesting facts revealed by this study for Alaska's suicide attempts:

- ✓ The average age for the patients was 30 years.
- ✓ The average length of each hospital stay was 4 days, with a range of 1 to 366.
- ✓ The average hospital costs per year were $5,508,363.
- ✓ The average cost per case was $8,986.
- ✓ Over 75% of the hospital costs were paid through public funding sources.

More than $4 million in "public funds" is spent each year to care for suicide attempts, and those are just the documented hospital costs. Physician's fees and other specialist's fees are usually not included in the hospital costs. Also not included in hospital costs are self-inflicted injuries that result in death or long-term disabilities. These suicidal acts take a huge toll on individuals and families and are very difficult to quantify.

CONCLUSIONS

The *Alaska Suicide Hospitalizations* analysis makes a compelling case for the prevention of suicide, and gives new insights into this dramatic public health problem. Hospitals must accept the loss of at least 15% of the costs due to the patients' inability to pay.

Alaska Suicide Follow-back Study Final Report

Study period September 1, 2003 to August 31, 2006

Prepared for the:
Alaska State-wide Suicide Prevention Council
Alaska Department of Health and Social Services
Alaska Mental Health Trust Authority

Submitted by the:
Alaska Injury Prevention Center
Critical Illness and Trauma Foundation, Inc.
American Association of Suicidology

3433

Acknowledgements

The investigators gratefully acknowledge the support and cooperation of the following agencies and organizations in the completion of this study:

Alaska Statewide Suicide Prevention Council

Office of the Alaska State Medical Examiner

Alaska Department of Health and Social Services

Alaska Mental Health Trust Authority

Alaska Dept. of Public Safety – Alaska State Troopers

Anchorage Police Department

Other local police departments

Funding support:

The Alaska Suicide Follow Back Study was prepared for the Statewide Suicide Prevention Council and was substantially funded through the Alaska Mental Health Trust Authority and the Alaska Department of Health and Social Services.

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Executive Summary

Goals

There were two goals for the study: (1) to do an in-depth demographic analysis of the suicides in Alaska for three years from September 1, 2003 through August 31, 2006 and (2) to conduct interviews with key informants for as many suicide cases as possible. This report is divided into two sections, Section 1 addressing the epidemiological data and Section 2 addressing the data derived from the interviews.

Purpose

The purpose of the data gathering, reporting, and analysis was to better understand the etiology and antecedents of suicide among Alaskans, in order to identify potential points of intervention and strategies to reduce the rate of suicide.

Methods

Death certificates attributed to suicides occurring in Alaska between September 1, 2003 and August 31, 2006 were reviewed retrospectively. Information from the Alaska State Medical Examiner, State Troopers, and other law enforcement agencies was collated and reviewed for each suicide death. A cadre of Native and non-Native interviewers was trained in how to use the interview protocol and how to conduct follow-back interviews with survivors of the decedents. All information was entered into a secure database. All efforts to protect confidentiality were in accordance with the Institutional Review Board requirements of the Alaska Native Medical Center, the University of Alaska – Anchorage, and the National Institutes of Health (Certificate of Confidentiality).

Results

There were 426 suicides during the 36 month study period. The average annual suicide rate for the three year study period was 21.4/100,000 (U.S. Census, 2005 estimated population). Males out-numbered females 4 to 1. The age-group of 20 to 29 had both the greatest number of suicides and the highest rate per 100,000 population. Alaska Natives had a significantly higher average rate of suicide than the non-Native population (51.4/100,000 compared to 16.9/100,000). The leading mechanism of death was firearms, accounting for 63% of the suicides. The use of handguns was more prevalent in the non-Native population whereas long guns were used more often by Alaska Natives. The EMS region with the greatest number of Native suicides was Region 4, which includes Bethel and the Yukon-Kuskokwim Delta. Region 2, which includes the Northwest Arctic census area had the highest overall rate of suicide deaths. Follow-back interviews were conducted with 71 informants for 56 of the suicide decedents. Reported alcohol/drug use was the same for Urban as for Rural Native decedents. The same alcohol/drug use pattern was seen for Urban and for Rural non-Native decedents. Toxicology results were received for 33% of all the suicide cases. Alcohol was found in 44% of the toxicology tests and THC (marijuana) was found in 15%.

Conclusion

This study adds volumes of information to our existing knowledge of suicide in Alaska. More in-depth studies are already in progress, which will continue to add to our knowledge base while bringing in additional resources for prevention and treatment. The report also highlights the need for better death data collection, to quantify alcohol and drug involvement and other contributing factors.

Our Mission

The Statewide Suicide Prevention Council advises the governor and legislature on issues relating to suicide. In collaboration with communities, faith-based organizations, and public-private entities, the Council works to improve the health and wellness of Alaskans by reducing suicide and its effect on individuals and communities.

- **The meaning of our logo**
- ***Alaska Suicide Follow-back Study Final Report - Feb. 2007***
  Alaska Injury Prevention Center; Ron Perkins
- ***The Lifeline National Number***
- Alaska Suicide Attempt Hospitalizations, 2001-2002 (pdf)
  Alaska Injury Prevention Center, Ron Perkins
- ***Moving Forward***, the DHSS Comprehensive Integrated Mental Health Plan (CIMHP), can be downloaded at the following website address:
- Discussion Assistance for Ramy's DVD

30 Second Radio Spots:

- Suicide Hurts (mp3)
- Tell Someone (mp3)
- Video Game (mp3)

Associated in-state links

- The Alaska Mental Health Board
- The Advisory Board on Alcoholism and Drug Abuse
- The Alaska Mental Health Trust Authority
- ASIST - Applied Suicide Intervention Skills Training

Annual Reports

- 2008 Annual Report (689 Kb .pdf file)
- 2007 Annual Report (550 Kb .pdf file)
- 2006 Annual Report (1.2 MB .pdf file)
- 2005 Annual Report (561 Kb .pdf file)
- 2004 Annual Report (1.2 Mb .pdf file)
- 2003 Annual Report (515 Kb .pdf file)
- 2002 Annual Report (291 Kb .pdf file)

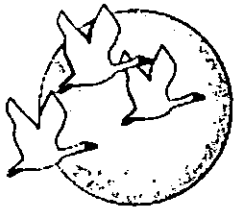
Alaska State Suicide Prevention Plan

- Download the State Plan (611 Kb)

Scheduled Meetings

Upcoming Meeting

- Statewide Suicide Prevention Council February 4-5, 2009, Goldbelt Hotel, In Juneau



Resources

Alaska Suicide-Related Resources

Alaska Suicide-Related Resources
Alaska Directories and Information Resources
Suicide, Mental Health and Related Issues in Alaska Native and American Indian Populations

National and International Resources

National Suicide Prevention Plans
National/International Suicide Prevention Organizations
National Youth Suicide Prevention Organizations
Suicide Prevention Resource Center NEW!
Center for Safe and Responsible Internet Use NEW!
Substance Abuse and Mental Health Services Administration (SAMSA)

Alaska State Suicide Prevention Plan

Alaska Suicide Prevention Plan *(611 Kb pdf file)*

Organizations Addressing Depression and Suicide

Suicide Training and Curricula/Programs
Clinical Resources

Looking for Help?

If you are feeling down or are looking for help for yourself or others, please talk to someone. Here are some resources.

National Suicide Prevention Lifeline
1-800-273-8255

Alaska Community Mental Health Centers

CARELINE
1-877-266-HELP

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

April 9, 2009

The Honorable Lyman Hoffman, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 518
Juneau, AK 99801-1182

The Honorable Bert Stedman, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 516
Juneau, AK 99801-1182

RE: SB 35 (Davis)--Support

Dear Co-Chairs Hoffman and Stedman:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Finance Committee to support SB 35, authored by Senator Bettye Davis and co-sponsored by Senators Johnny Ellis and Gene Therriault.

Unfortunately, Alaska has a high rate of suicide. Many of these suicides include mid-life and older Alaskans. The Statewide Suicide Prevention Council needs to continue its work and address this issue for our citizens. The Council still has much to do and, in our opinion, should be allowed to continue for another four years.

AARP requests an "AYE" vote on SB 35.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Joe Thomas
Senator Charlie Huggins
Senator Donald Olson
Senator Johnny Ellis
Senator Bettye Davis

Jennie Chin Hansen, President
William D. Novelli, Chief Executive Officer

CS for SENATE BILL ~~123~~ 35 HB 123

Sam Trivette

- My wife and I lost our son to suicide on 6-28-07
- He worked half time as an intern at the University of Alaska/Fairbanks Police Department & won high praise
- He would have entered his Junior at UAS in the criminal justice program in the fall of 2007
- For two weeks straight after Pete's death, not ONE day went past without at least one person telling us of a suicide in their family or close friend's circle
- In a recent one year period, 7 young people took their lives in the Juneau area alone
- Young people, with the highest potential, have the highest suicide rate, with older seniors coming in a very close second
- We found out after Pete's death that he suffered from depression even while in high school
- At that time, there was no program in the school system to educate students, teachers or parents on depression and suicide issues
- Recently, the Juneau School District added a component in the high school curriculum that educates students on the basic issues regarding depression and provides them ideas to help their friends and classmates who might be experiencing depression. This program was piloted in another Alaska school district, which experienced NO suicides after its implementation
- This program has been supported by the SPC
- The SPC has implemented a number of other initiatives at various local levels [such as community task forces]
- The Suicide Prevention Council is the organization that is focused on getting out information to all our citizens, that THEY can help lower the rate of suicide. No one else is.
- Professional training, seminars, state wide and national teleconferences, are all issues the SPC has supported to help reduce the incidents of suicide.
- We believe the SPC is beginning to have an impact on depression and suicide in Alaska and urge you extend the Council for the next 4 years.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Office of Senator Bettye Davis

April 10, 2009
Senator Charlie Huggins, Chair
Senate Rules Committee

RE: Request to calendar SB 35, "An Act extending the termination date of the Statewide Suicide Prevention Council; and providing for an effective date."

Dear Senator Huggins,

Senator Davis respectfully requests that Senate Rules promptly calendar SB 35 which extends the termination date of the Statewide Suicide Prevention Council to June 30, 2013. The Statewide Suicide Prevention Council Suicide sunsets June 30, 2009, so immediate action is required if the state is to help curtail this avoidable loss of life by suicide, particularly by so many young people each year. The mission of the Statewide Suicide Prevention Council is to advise the governor and the legislature on issues relating to suicide. In collaboration with communities, faith-based organizations, and public-private entities, the Council works to improve the health and wellness of Alaskans by reducing suicide and its devastating effect on individuals, families, and communities. Over 125 Alaskans die each year by suicide, which is twice the national average per capita. Suicide is four times more prevalent among young males than females. Guns, alcohol, drugs, and unattended depression are often involved.

Attached in order are the following:

1. Sponsor Statement
2. The most recent version of the bill
3. Sectional analysis
4. Fiscal Notes
5. Additional Documentation

Sincerely,

Thomas S. Obermeyer
Legislative Administrative Assistant

Lynda Zaugg

From: Sam Trivette [samtriv@gci.net]
Sent: Thursday, April 09, 2009 2:28 PM
To: Lynda Zaugg
Subject: CS SB 35

Attachments: SENATE BILL 35 4-9-09.doc

SENATE BILL 35
4-9-09.doc (25...

Lynda,
Attached is the essence what I will be saying at tomorrow's hearing.
Haven't timed it, but should be well under 3 minutes?
Look forward to getting the bill to the floor.
Sam

Presented before Sen Fin on 4/10/09

Lynda Zaugg

From: Casto, L Diane (HSS) [l.casto@alaska.gov]
Sent: Wednesday, February 25, 2009 3:07 PM
To: Lynda Zaugg
Subject: CS for SB 35

Hello Lynda – Would it be possible to get a copy of the CS for SB 35 that was adopted and passed out of committee today? I realize it will eventually be on BASIS, but was hoping you could provide a scanned or faxed copy in the interim. My fax number is 465-1189. Thanks so much.

L. Diane Casto, MPA

Manager, Prevention & Early Intervention Services

DHSS, Behavioral Health

907-465-1188

Partners Promoting Healthy Communities

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Friday, February 13, 2009 4:04 PM
To: Lynda Zaugg; Casto, L Diane (HSS); Thomas Obermeyer; Sen. Johnny Ellis
Subject: SB 35 Suicide prevention council membership
Attachments: SSPC Recommended changes to Membership Compositions--02-09.doc

The Governor's office and Department of Health and Social Services support the attached recommendations for changes to membership of the Statewide Suicide Prevention Council.

Please let me know if you need anything else on this.
w.

SB 35

here now as drafted up

DHSS Vanguard

Recommended changes to Statewide Suicide Council Membership Compositions. Recommendations made by the SSPC membership at their quarterly meeting, February 4, 2009 in Juneau, AK.

Proposed changes:

1. The four (4) legislative members appointed by the Legislature would become advisory in nature and would no longer be voting members. This would reduce the difficulty obtaining a quorum at meetings.
2. Change the "two members who are employed in the executive branch of state government" (a.) to add the language: one person representing the DHSS and one person representing the DEED.
3. Change "one person who is a counselor in a secondary school to "(e.) an employee from a secondary school system such as, but not limited to, a teacher, administrator, counselor, nurse or other school personnel.
4. Change "one adult who is active in a statewide youth organization" (f.) to one person who is active in a youth organization.
5. Change "one person who is under the age of 18" (j.) to one person who is enrolled in high school.
6. Add one public member at large.

Gary, the two folks

From: Gary Miller [mailto:gmiller_juneauak@hotmail.com]
Sent: Thursday, April 09, 2009 7:40 AM
To: Lynda Zaugg
Cc: Sam RPEA_Trivette
Subject: Ketchikan

Lynda, Sam Trivette said that you know two people who live in Ketchikan who may be interested in forming an RPEA chapter. Would you mind giving me their names? Sam and I would love to see a chapter form in Ketchikan.

Thanks.

Gary Miller
20135 Cohen Dr
Juneau, AK 99801-8211
789-3757
gmiller_juneauak@hotmail.com

Rediscover Hotmail®: Now available on your iPhone or BlackBerry Check it out.

2/12

SB 35

Wilda, my note to myself reflects on the 5th was that H&SS was reviewing the proposed changes made by the Suicide Co at their quarterly meeting – what is the status of your review? Lynda

2/13 - T.C for Wilda
still working on a Gov. offic - what they want to do -
a not just a straight 5% add to "11" or
board proposal -

2/13 - email for Wilda —
Support -

Lynda Zaugg

re SB 35

From: Thomas Obermeyer
Sent: Monday, January 26, 2009 1:06 PM
To: Don Burrell; Lynda Zaugg
Subject: revised sponsor statement sb 35 to post
Attachments: SB 35 Sponsor Statement 1-23-09.doc

Revised: Adding word Alaska to "native population" in first paragraph.

Lynda Zaugg

From: Thomas Obermeyer
Sent: Monday, January 26, 2009 4:41 PM
To: Lynda Zaugg
Subject: RE: SB 35 sponsor statement

Lynda,

It is insignificant that I added one word: "Alaska" before "native" in the first paragraph. You can ignore it or re-post the revised on the web. I added "Alaska" before "native" in the first paragraph to be more accurate, i.e., less vague, and also to show more respect to Alaska natives.

The more important issue is that Senator Davis asked for review of composition of the council by the administration and department – for possible amendment – before rehearing the bill and approving termination date. Clearly, the 4-year extension of termination date versus the more common 8 years, as explained in audit by Pat Davidson, shows there may be problems with the council as well as the bill.

Tom

From: Lynda Zaugg
Sent: Monday, January 26, 2009 4:14 PM
To: Thomas Obermeyer
Subject: RE: SB 35 sponsor statement

Tom, is this an updated version? Lynda

From: Thomas Obermeyer
Sent: Monday, January 26, 2009 1:01 PM
To: Don Burrell; Lynda Zaugg
Subject: SB 35 sponsor statement

dothaneagle.com
DOTHAN EAGLE Dothan, Alabama

Partners: Enterprise Ledger | JC Floridan
Friday, January 23, 2009 |
Newton, AL 70° Feels Like: 70° Clear

Lilly Ledbetter Bill: House approves bill to fight wage discrimination

AP Photo/Ron Edmonds, FILE

Pay Equity pioneer Lily Ledbetter addresses the Democratic National Convention in Denver, Tuesday, Aug. 26, 2008 file photo. Democrats are ushering in what they believe will be a new labor-friendly era in Washington with House votes on two bills aimed at helping women fight pay discrimination in the workplace. The House was to vote on the bills Friday Jan. 9, 2009, and they could reach Barack Obama's desk soon after he enters the White House. One of the bills, the Lily Ledbetter Fair Pay Act, is a response to a 2007 Supreme Court decision that made it more difficult to sue over past pay discrimination.

Text size: small | medium | large

BY JIM ABRAMS
ASSOCIATED PRESS WRITER
Published: January 9, 2009

WASHINGTON (AP) — Energized by the prospects of a pro-labor president, House Democrats marked the first week of the new Congress Friday by pushing through two bills to help workers, particularly women, who are victims of pay discrimination.

Unlike President George W. Bush, who threatened to veto the two bills when they came up in the last session of Congress, President-elect Barack Obama has embraced them.

"Today we face a transformational moment," said Rep. Rosa DeLauro, D-Conn., chief sponsor of the Paycheck Fairness Act. "With a new Congress, a new administration, we have a chance to finally provide equal pay for equal work and make opportunity real for millions of American women."

The Lilly Ledbetter Act would reverse a 2007 Supreme Court ruling that a worker must file claims of wage discrimination within 180 days of the first decision to pay that worker less, even if the person was unaware of the pay disparity. The Paycheck Fairness Act would close loopholes that have enabled employers to evade the 1963 law requiring equal pay for equal work. The first passed 247-171, the second 256-163.

The Ledbetter bill could reach the Senate floor as early as next week. Democrats, who have increased their majority in the Senate, last year fell three votes short of shutting off a GOP-led filibuster that blocked the bill after it passed the House.

Republican opponents of the two measures argued that they would foster lawsuits against businesses and mainly benefit trial lawyers.

It sends a signal, said Rep. Howard "Buck" McKeon of California, senior Republican on the Education and Labor Committee, "that the first substantive order of business is not job creation or tax relief but rather a trial lawyer boondoggle that can put jobs and worker pensions in jeopardy."

Lilly Ledbetter was a supervisor at a Goodyear Tire & Rubber Co. plant in Gadsden, Ala. She sued the company over pay discrimination when she learned, shortly before retiring after a 19-year career there, that she earned less than any male supervisor. A jury ruled in her favor, but the Supreme Court, in a 5-4 vote, threw out her complaint, saying she had failed to sue within the 180-day deadline after a discriminatory pay decision was made.

"This ruling just doesn't make sense in the real world," Ledbetter said in a telephone news conference Thursday. "In a lot of places you could get fired for asking your co-workers how much they are making."

The House bill would clarify that each paycheck resulting from discrimination would constitute a new violation, extending the 180-day statute of limitations.

"It should not become the law of the land that if you are an employer and can hide discrimination for 180 days you can get away with it," said Rep. Robert Andrews, D-N.J.

The liberal Alliance for Justice said the Supreme Court decision already had seriously impacted worker rights: It said that since the 2007 ruling, federal and other courts had cited Ledbetter in 347 cases involving pay discrimination and other issues such as fair housing and the availability of sports programs for women.

The Paycheck Fairness Act puts gender-based discrimination on an equal footing with other forms of discrimination in seeking compensatory and punitive damages. It also puts the burden on employers to prove that any disparities in wages are job-related and not sex-based, and bars employers from retaliating against workers who discuss or disclose salary information with their co-workers.

The early foray into labor rights issues is a prelude to what could be the most controversial bill that Congress tackles in the first year of the Obama administration — legislation to take away the right of employers to demand secret-ballot elections by workers before unions could be recognized.

Business groups maintain the Employee Free Choice Act is an affront to democratic principles. Unions say companies have used secret ballots to intimidate pro-union workers and that the bill could help reverse the downward trend in union membership.

The Ledbetter bill is H.R. 11. The Paycheck Fairness Act is H.R. 12.

On the Net:

Congress: http://thomas.loc.gov

1) Ayscue v. Wenker ?
2) copy of Paycheck Fairness Act

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit

P.O. Box 113300
Juneau, AK 99811-3300
(907) 465-3830
FAX (907) 465-2347
legaudit@legis.state.ak.us

November 4, 2008

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 and Title 44 of the Alaska Statutes (sunset legislation), the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
STATEWIDE SUICIDE PREVENTION COUNCIL
SUNSET REVIEW
November 4, 2008

Audit Control Number
06-20055-08

The review was conducted as required by AS 44.66.050 and under the authority of AS 24.20.271(1). Currently, under AS 44.66.010(a)(8), the Statewide Suicide Prevention Council (council) is scheduled to terminate on June 30, 2009. We recommend the legislature extend the termination date of the council until June 30, 2013.

Four of the fifteen voting members of the council are legislators. Since the Legislative Audit Division is part of the legislative branch, our agency does not meet the independence standard required by generally accepted government auditing standards. Therefore, we are disclosing our lack of adherence to the independence auditing standard.

Except for the independence standard discussed above, the audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology.

Pat Davidson, CPA
Legislative Auditor

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OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Titles 24 and 44 of the Alaska Statutes, we have reviewed the activities of the Statewide Suicide Prevention Council (SSPC or council) to determine if there is a demonstrated public need for its continued existence and if it has been operating in an efficient and effective manner.

As required by AS 44.66.050(a), the legislative committee of reference shall consider this report as part of the oversight process in determining if the termination date of the council should be extended. State law currently specifies SSPC will terminate on June 30, 2009. If no action is taken by the legislature, the council will have one year from that date to conclude its administrative operations.

Objectives

The three central, interrelated objectives of our report are:

1. To determine if the termination date of the council should be extended.

2. To determine if the council is operating in the public interest.

3. To provide a current status on the recommendations made in the prior report.

Our assessment of the operations and performance of the council was based on criteria set out in AS 44.66.050(c). Criteria set out in this statute relate to the determination of a demonstrated public need for the council.

Scope and Methodology

Auditors and audit organizations are required to be independent in both fact and appearance to the entities being audited. Audit organizations are presumed to be organizationally independent per generally accepted government auditing standards under various situations. One of those situations, which is applicable to the Division of Legislative Audit, is when the,

> *. . .audit organization is in a different branch of government within the same level of government as the audited entity; for example, legislative auditors auditing an executive branch program.*

The Division of Legislative Audit does not meet the organizational independence requirements because four of the fifteen voting members of SSPC are members of the Alaska State Legislature. Readers of this report may not view the conclusions, findings, and

recommendations as impartial because of the lack of organizational independence. Nevertheless, we conducted the audit of SSPC as required by AS 24.20.271 and AS 44.66.050.

Our audit reviewed the operations and activities of the council from FY 05 through FY 08.

During the course of our examination, we reviewed and evaluated the following:

- Applicable statutes and regulations.
- Budget documents, session laws, and other legislative information related to the council's operations.
- Council meeting minutes, bi-laws, and website.
- Annual reports to the legislature and governor.
- Financial reports from the State Accounting System.
- The *Statewide Suicide Prevention Plan.*
- Alaska Injury Prevention Center's follow-back studies to the council.
- Other documents related to the council's operations and mission, as necessary.

In addition, we interviewed:

- Various SSPC members, SSPC coordinators, and staff under the Department of Health and Social Services.
- Board members, executive directors and other staff of the Alaska Mental Health Trust Authority (AMHTA), Alaska Mental Health Board (AMHB) and Advisory Board on Alcoholism and Drug Abuse (ABADA).

We also attended the following meetings:

- May 5-6, 2008 meeting of SSPC.
- June 13, 2008 meeting of representatives from SSPC, Division of Behavioral Health, Division of Senior and Disability Services, the Alaska Commission on Aging, AMHTA, ABADA, AMHB, and the Governor's Council on Disability and Special Education.
- June 17, 2008 SSPC teleconference for a working session on the revision of the Suicide Prevention Plan.

ORGANIZATION AND FUNCTION

Under AS 44.29.350, the Statewide Suicide Prevention Council (SSPC or council) is charged with advising the legislature and the governor on,

> *...actions that can and should be taken to improve health and wellness throughout the state by reducing suicide and its effect on individuals, families, and communities.*

In addition to this advisory role, the council's activities include planning, coordinating, educating, training, and providing technical support on the prevention of suicide.

The council consists of 15 members. There are two senators, two representatives, two executive branch employees, and nine public members. The senate seats and the representative seats are appointed by the president of the senate and the speaker of the house, respectively. The executive branch and public seats are appointed by the governor.

Exhibit 1

Council Members
As of September 30, 2008

Officers:
- Brenda Moore, Public, Chair
- Pat Donelson, Public, Chair-Elect
- Renee Gayhart, DHSS, Treasurer

Other Members:
- Charles Jones, Public
- Celena Powder, Public
- William Martin, Public
- Bernard Gatewood, Public
- Vacant, Public
- Vacant, Public
- Vacant, Public
- Bill Hogan, DHSS
- Johnny Ellis, Senate
- Kim Elton, Senate
- Woodie Salmon, House
- Reggie Joule, House

Alaska Statute 44.29.300 specifies the public seats be filled by,

> *...one member of the Advisory Board on Alcoholism and Drug Abuse; one member of the Alaska Mental Health Board; one person recommended by the Alaska Federation of Natives, Inc.; one person who is a counselor in a secondary school; one adult who is active in a statewide youth organization; one person who has experienced the death by suicide of a member of the person's family; one person who resides in a rural community in the state that is not connected by road or the Alaska marine highway to the main road system of the state; one person who is a member of the clergy; and one person who is under the age of 18.*

Except for the members of the House of Representatives who serve two years, council members serve staggered four-year terms.

The council is staffed by a coordinator, who, by statute, is employed by the council and directly responsible to the council. As of July 1, 2008, the coordinator is the project manager for the Prevention and Early Intervention section. The coordinator is employed for the council on a part-time basis and is assisted by a project coordinator from the same division.

The council receives administrative assistance from the Department of Health and Social Services.

REPORT CONCLUSIONS

Under AS 44.66.010(a)(8), the Statewide Suicide Prevention Council (SSPC or council) will terminate on June 30, 2009. If the legislature does not take action to extend the termination date, the council will have one year to administratively conclude its affairs.

Alaska Statute 44.29.350 defines the purpose of the council.

> *The council shall serve in an advisory capacity to the legislature and the governor with respect to what actions can and should be taken to...*

The statute continues, listing the six areas where the council should advise the legislature and the governor. In addition to advising the legislature through testimony to the House and Senate Committees, the council has taken on a direct role in various areas. These areas include broadening the public awareness of suicide and the related risk factors, the development of a statewide suicide prevention plan, and other examples which are discussed in more detail in the Analysis of Public Need section of this report.

Suicide remains a major public health problem in Alaska. Over the last seven years, the crude rate[1] for suicide has ranged from over 16 to 23, while the national average crude rate for suicide was 11 in 2005[2].

Exhibit 2

Suicides of Alaska Residents By Year*

	Year of Death						
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Deaths	103	131	123	154	127	132	146
Crude Rate	16.3	20.5	19	23.4	19.1	19.7	21.6

*2006 and 2007 data is still provisional and subject to change.

Source: Alaska Bureau of Vital Statistics

In addition to the rate of suicide being significantly higher than the national average, the profile of those committing suicide is also substantially different. In national statistics, elderly individuals are more likely to commit suicide; in Alaska, suicide is most commonly committed by individuals in their 20s. Suicide rates in Alaska are also disproportionately high in the native population.

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[1] Crude rate is the number of suicides per 100,000 population.

[2] USA Suicide: 2005 Official Final Data, from American Association of Suicidology on its website, http://www.suicidology.org.

In developing our conclusion on whether SSPC's termination date should be extended, we evaluated SSPC's operations using the 11 factors set out in AS 44.66.050(c) to determine if the council has demonstrated a public need for its continued operation.

We found no direct correlation between the activities of the council and the change in the suicide rate for any particular year. However, given that the council's role is primarily advisory and suicide is a public health concern that is often linked with mental illness and substance abuse, both which are long term health issues, it is unlikely that a direct identifiable correlation will ever be clearly visible.

However, through the efforts of the council we have seen a broader and more public acknowledgement of the problem of suicide in Alaska. We saw the council responding to communities by working to revise the statewide suicide prevention plan, making it less clinical and more user-friendly. The council and the Department of Health and Social Services, Division of Behavioral Health (DHSS, DBH) have proposed an initiative to develop a cross-disciplinary, community-driven, and research-based approach to reducing the number of deaths by suicide in Alaska. A Suicide Prevention Strategy and Implementation Plan will be available to the legislature by December 15, 2008.

Overall, we found that the council is operating in the public interest and spearheading efforts that are necessary to address the public health concern of suicide. Therefore, we recommend the legislature extend the termination date of the council to June 30, 2013.

The four year extension is recommended because of the following issues:

- At the end of FY 08, the council was organizationally aligned with the Prevention and Early Intervention section, Division of Behavioral Health. A key to enhancing the effectiveness of the council is a good working relationship between the council and DBH, each focused on its own mission – coordinating but not duplicating. A limited extension will allow for a reevaluation of whether the closer alignment with DBH has impeded the independent voice of the council.

- Secondly, the membership requirements for appointment to the council make it difficult to fill all the seats and to ensure sufficient participation to meet quorum requirements. Again, a limited extension will allow a timely reexamination of this problem.

These issues are more fully discussed in the Findings and Recommendations section of this report.

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The Statewide Suicide Prevention Council (SSPC or council) should, in accordance with statutes, appoint its own coordinator and perform annual performance reviews.

Effective July 1, 2008, the Department of Health and Social Services (DHSS) assigned SSPC coordinator responsibilities to the Prevention and Early Intervention section[3] manager in the Division of Behavioral Health (DBH). This SSPC coordinator appointment was not made in accordance with the statutes and appears to diminish SSPC's autonomy and independent voice with the governor and legislature. Also, the coordinator may be placed in a position with potentially conflicting responsibilities between the council and DBH.

DHSS' decision was based on department personnel resource needs and a desire to align the activities of the council and the section.

The hiring, supervision, and evaluation of the SSPC coordinator are part of the council's rights and responsibilities per the statutes.[4] DHSS has traditionally assisted the council with the coordinator's selection. However, SSPC was not involved in the latest selection. Also, the council has not annually evaluated the coordinator's performance for at least the past four years. Neglecting these statutory requirements may have diminished the council's ability to maintain an independence voice.

We recommend the council either accept the current coordinator through a formal vote or initiate actions to hire a new coordinator. In addition, it is critical that the council conduct annual performance evaluations as required by statute, particularly if the coordinator is a DBH employee. Only through the council's interest in remaining autonomous can its independent voice be assured.

Recommendation No. 2

The legislature should consider modifying the composition of council membership.

During FY 05 – FY 08, there were excessive vacancies on the council and significant absences by council members at its meetings. Additionally, those being appointed to the

[3] Prevention and Early Intervention is the section responsible for DHSS programs that address suicide prevention.
[4] Alaska Statute 44.29.330(b) states,

> *The council may employ a coordinator to assist the council. The coordinator is in the partially exempt service. The coordinator shall be directly responsible to the council in the performance of the coordinator's duties. The council shall annually review the performance of the coordinator.*

council did not always meet the statutory qualifications for the position. Exhibit 3 illustrates the extent of vacancies and absences over the last four years.

Exhibit 3

Statutory Qualifications	Do incumbents meet the qualifications	Rate of attendance at SSPC meeting FY 05 – FY 08
Four legislator seats: Senate majority member Senate minority member House majority member House minority member	 Yes No No Yes	Overall 15%
Two persons employed by the executive branch of state government	Yes	Overall 73%
A member of the Advisory Board on Alcoholism and Drug Abuse	Yes	60%
A member of the Alaska Mental Health Board	Yes	100%
A person recommended by the Alaska Federation of Natives, Inc.	Yes	100%
A person who is a secondary school counselor	No[5]	80%
A person who is an adult and active in statewide youth organizations	Yes	73%
A person whose family has experienced death by suicide	Vacant[6]	33%
A person who lives in a rural community – not connected by either the road system or the marine highway	Vacant[7]	0%
A member of the clergy	Yes	93%
A person under the age of 18	Yes	33%
Overall Average[8]		**54%**

The composition of the council's membership is established in AS 44.29.300 and includes very specific qualifications which have created difficulties in filling the positions. Vacancies combined with low attendance rates make it difficult for the council to establish a quorum at its meetings.

The legislature should consider changes to AS 44.29.300 to broaden the qualifications of council members to ensure that appointees are interested in the work of the council and can

[5] The current incumbent is a secondary school principal.
[6] This position has been vacant since November 2005.
[7] This position has been vacant for more than 3 of the 4 years between FY 05 and FY 08.
[8] This average includes one member appointed to the council that does not meet any of the statutory criteria. This member's attendance over the last 4 years has been at 87%.

make the time commitment necessary to serve. Additionally, consideration should be given to making legislative members non-voting to prevent potential quorum issues.

Current Status of Prior Audit Recommendations

Prior Recommendation No. 1

The Division of Behavioral Health Community-based Suicide Prevention Program coordinator should ensure prevention programs conform to the statewide suicide prevention plan.

Current Status

This recommendation is no longer an issue. Starting in FY 06, the State has followed a national trend to provide grants on a more comprehensive programmatic basis. Grant funds are awarded in a way that allows communities to focus the funds according to local priorities, rather than awarding separate grants for mental health, substance abuse, or suicide programs.

Additionally, the council has undertaken a rewrite of the statewide suicide prevention plan to make it more user-friendly, so Alaskan communities can better use the plan in developing their grant activities and community plans.

Prior Recommendation No. 2

The administrative manager for Department of Health and Social Services Boards and Commission and the Statewide Suicide Prevention Council coordinator should develop a more formalized information system of reporting financial information to the council.

Current Status

This recommendation has been resolved. Council members are receiving budget and financial reports as part of their meeting packets.

Prior Recommendation No. 3

The council should ensure it provides public notice of all council meetings as required by Alaska Statute 44.62.310.

Current Status

This recommendation has been resolved.

Prior Recommendation No. 4

The Office of the Governor should make appointments to the council in a timely manner.

Current Status

Appointments to the council continue to be a problem. See current Recommendation No. 2.

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ANALYSIS OF PUBLIC NEED

The following analysis of commission activities relates to the public need factors defined in the sunset law, AS 44.66.050. This analysis was not intended to be comprehensive, but to address those areas we were able to cover within the scope of our review.

Determine the extent to which the board, commission, or program has operated in the public interest.

To assess whether the Statewide Suicide Prevention Council (SSPC or council) has operated in the public interest, we measured the council's activities against objectives set out by the legislature for SSPC in state law, at AS 44.29.350.[9] From our review of council activities, we conclude SSPC has reasonably addressed its statutory objectives.

The council, as an advisory body, has made presentations to the House and Senate Committees on Health, Education and Social Services. Additionally, they provide the legislature and the governor with the council's annual report.

The council also actively participates in the six areas in which they are intended to advise the legislature and the governor. The following discussion describes the council's areas of active participation:

1. Actions to be taken to improve health and wellness by reducing suicide.

   During FY 08, the council, in partnership with Department of Health and Social Services, Division of Behavioral Health (DHSS, DBH), proposed the Alaska Suicide Prevention Initiative to the governor and the legislature. The initiative proposed developing a cross-disciplinary, community-driven and research-based approach to reduce the number of deaths by suicide in Alaska. The initiative addressed potential activities from FY 09 through FY 13. The FY 09 budget included an increment dedicated to the development of the Suicide Prevention Strategy and Implementation Plan, which is to be completed by December 15, 2008.

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[9] Alaska Statute 44.29.350 states,

> *The council shall serve in an advisory capacity to the legislature and the governor with respect to what actions can and should be taken to (1) improve health and wellness throughout the state by reducing suicide and its effects on individuals, families, and communities; (2) broaden the public's awareness of suicide and the risk factors related to suicide; (3) enhance suicide prevention services and programs throughout the state; (4) develop healthy communities through comprehensive, collaborative, community-based and faith-based approaches; (5) develop and implement a statewide suicide prevention plan; and (6) strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.*

2. Increasing public awareness of suicide and the related risk factors.

The council has become increasingly diligent in this area. The council continues to maintain a website[10] that provides suicide statistics, risk factors, and prevention. Additionally, the website provides links to resources such as the council's annual reports and statewide suicide prevention plan.

The council participated in many conferences and workshops during FY 05 through FY 08, making presentations or providing information displays. The council also purchased and distributed items such as pens, pencils, magnets, and posters to those needing support for suicide prevention related functions.

In 2006 the council initiated the "Live Your Dream" bracelet campaign which targets the State's youth population. This has been viewed as particularly popular and successful in spreading suicide awareness.

The council has contributed to the "YOU KNOW ME" media campaign which focuses on suicide prevention awareness. The Alaska Mental Health Trust Authority (AMHTA) has sponsored the council in this endeavor since 2005.

3. Enhance suicide prevention services and programs throughout the State.

Overall, the council enhances suicide prevention services and programs by directly providing information or providing direction to other knowledgeable sources. Throughout the year, the council receives two to three requests per week for information or technical assistance. Their web site generates questions from the public and other organizations who then request informational materials from the council. As appropriate, they also provide studies, DVDs, books, and other materials on suicide and suicide prevention.

Other examples of SSPC's enhancement of suicide prevention services include:

- Involvement in the certification of Careline[11] and DBH's targeted gatekeeper training.[12]

- Having the Careline phone number placed in phone books across the State.

[10] http://health.hss.state.ak.us/suicideprevention/default.htm
[11] Careline is Alaska's statewide toll-free crisis intervention and assistance hotline.
[12] DBH has contracted for the development of a training curriculum specific to Alaska. Gatekeepers are individuals who have face-to-face contact with large numbers of people in their community. The council's role in the initiative is to review the developed curriculum and provide feedback.

- Sponsoring travel for communities that needed assistance to attend gatekeeper training.

- Providing funds which allowed the Careline project manager, the Boys & Girls Club representative, and the Survivor Group representative to attend the American Association of Suicidology Conference in 2006.

4. Develop healthy communities though comprehensive, collaborative, community-based and faith-based approaches.

   The council has maintained faith-based partnerships through some SSPC members' participation in faith-based organizations. Other community approaches have included:

   - Sponsoring an Alaska State Council on the Arts workshop in Bethel to orient artists and arts organizations to programs, resources, and grant opportunities.

   - Providing a liaison to assist grassroots community members as they researched and established a nonprofit organization whose mission is suicide prevention, awareness, and support of the survivors.

   - Providing technical support to community programs providing suicide prevention services via research, best practices updates, referral resources, training, and conference opportunities.

   - Recommending the Boys & Girls Clubs' staff development director receive training and certification as a gatekeeper[13] trainer.

5. Develop and implement a statewide suicide prevention plan.

   SSPC completed its first statewide plan in 2004, and it followed the format of the National Strategy for Suicide Prevention and existing plans from other states. However, communities did not find the plan user-friendly in providing guidance in aligning their grant activities and community plans with the statewide plan. The council is now revising the statewide plan to make it more relevant to the granting process for the Comprehensive Behavioral Health Prevention and Early Intervention Services grants.

6. Collaborating on planning activities with other related agencies.

   In 2005 SSPC established a memorandum of agreement (MOA) with the Advisory Board on Alcoholism and Drug Abuse (ABADA), the Alaska Mental Health Board (AMHB), and DHSS. In 2006 an MOA was established with AMHTA. The purpose of the MOAs is coordination and collaboration to achieve the best outcomes for their targeted

[13] See footnote 12 for more information about gatekeepers.

beneficiaries. Their websites are interlinked and these entities participate in reciprocal reporting.

Other boards that SSPC collaborates with include Alaska Commission on Aging, Alaska Brain Injury Network, Governor's Council on Disabilities and Special Education, Faith-Based and Community Initiatives, and Division of Behavioral Health. While there is reciprocal reporting between these boards, MOAs have not yet been established.

Determine the extent to which the operation of the board, commission, or agency program has been impeded or enhanced by existing statutes, procedures, and practices that it has adopted, and any other matter, including budgetary, resource, and personnel matters.

SSPC has not operated in strict compliance with the statutes in regards to the composition of the council and some personnel matters. Specifically:

1. SSPC was not involved in hiring its latest coordinator, a position directly responsible to the council; nor has the council reviewed the coordinator's performance for any of the past four years. These are requirements stated in AS 44.29.330. At least in appearance, these moves could impede the council's independence and autonomy when advising the legislature and the governor. (See Recommendation No. 1)

2. Some council members either do not meet the positions' requirements as presented in the statutes or have excessive absences from the board meetings and other SSPC activities. (See Recommendation No. 2)

Exhibit 4

Schedule of Operating Expenditure and Funding Sources
(Unaudited)

	FY 05	FY 06	FY 07	FY 08
Expenditures				
Personal Services	$ 18,300	$ 26,028	$ 22,307	$ 35,915
Travel	23,847	32,636	41,155	51,072
Services	33,335	37,515	19,821	18,205
Commodities	14,383	6,336	8,461	2,142
Total Operating Expenditures	$ 89,865	$ 102,515	$ 91,744	$ 107,334
Funding Sources				
General Fund Appropriations	$ 89,865	$ 102,515	$ 91,744	$ 107,334
Total Funding	$ 89,865	$ 102,515	$ 91,744	$ 107,334

Determine the extent to which the board, commission, or agency has recommended statutory changes that are generally of benefit to the public interest.

The council has not pursued any statutory changes.

Determine the extent to which the board, commission, or agency has encouraged interested persons to report to it concerning the effect of its regulations and decisions on the effectiveness of service, economy of service, and availability of service that it has provided.

The council provided public notices to all but one of their meetings. However, public comment periods occurred during all of the meetings. The council has conscientiously made efforts to conduct at least one of their four meetings in a remote location such as Bethel, Kotzebue, and Sitka. They have held three town hall meetings, usually following one of their regularly scheduled meetings. Additionally, the public has the opportunity to contact the council, through its website, to offer feedback and request information.

Determine the extent to which the board, commission, or agency has encouraged public participation in the making of its regulations and decisions.

Under AS 44.29.350, the council has developed and implemented a statewide suicide prevention plan. The existing plan is currently under major revision to increase its usability. The council has requested input from participants outside the council such as the grantees, gatekeepers,[14] and members of other boards. Once the plan has been approved by the council, it will be sent out for public testimony. Further revisions, as a result of public testimony, may be made before its release.

Determine the efficiency with which public inquiries or complaints regarding the activities of the board, commission, or agency filed with it, with the department to which a board or commission is administratively assigned, or with the office of victims' rights or the office of the ombudsman have been processed and resolved.

Neither the Office of the Ombudsman nor the Office of Victim's Rights reported any complaints filed with them regarding SSPC.

Determine the extent to which a board or commission that regulates entry into an occupation or profession has presented qualified applicants to serve the public.

This criterion is not applicable since SSPC does not regulate any occupations or professions.

Determine the extent to which state personnel practices, including affirmative action requirements, have been complied with by the board, commission, or agency to its own activities and the area of activity or interest.

Nothing in our review of the council indicated that there were any complaints involving SSPC personnel practices.

[14] See footnote 12 for more information about gatekeepers.

Determine the extent to which statutory, regulatory, budgeting, or other changes are necessary to enable the agency, board, or commission to better serve the interests of the public and to comply with the factors enumerated in this subsection.

As discussed in Report Conclusions, we recommend the council be continued. However, in Recommendation No. 1, we also suggest that the appointment of the council's coordinator be approved by the council and annual performance reviews of the coordinator's performance should be conducted as set out in statute. This is important for SSPC to maintain its autonomy in the future for advising the legislature and governor. Due to personnel resource concerns and the desire for closer alignment between the council and DBH, DHSS has organizationally moved the administration of the council to DBH, specifically the Prevention and Early Intervention section. It is essential that DHSS and the council develop means to assure the council maintains an independent voice.

As discussed in Recommendation No. 2, the council should ensure that appointed members meet the qualifications of AS 44.29.300. We suggest the legislature consider broadening the qualifications for membership to ensure sufficient qualified and interested individuals are available and willing to serve on the council.

Determine the extent to which the board, commission, or agency has effectively attained its objectives and purposes and the efficiency with which the board, commission, or agency has operated.

The council established performance measures which are detailed in the annual reports to the legislature. For the FY 08 annual report, the measures were:

- Reduction of the three-year average rate of Alaska suicides.

  SSPC has been unable to achieve this objective at this time. During FY 08, the council has partnered with DHSS, DBH in an initiative, attempting to accomplish this by FY 13.

- Review and update the statewide suicide prevention plan.

  SSPC members are currently reviewing the plan with the objective of making it more relevant to the granting process for the Comprehensive Behavioral Health Prevention and Early Intervention Services grants.

- Consistently review data to identify trends, make analyses, and provide recommendations regarding suicide prevention, education and services needed in the State.

  The Follow-Back Study, which presented Alaska suicide data and analysis for the period from September 1, 2003 through August 31, 2006, was received by SSPC in February 2007. The council has and continues to use this study to make recommendations to the legislature, executive branch agencies, and the public.

- Support and assist Alaskans in starting a state Suicide Prevention Awareness Network (Network).

  The council supported the Alaska Suicide Prevention Action Coalition (ASPAC) in its research into becoming a Network affiliate. Although the Coalition decided to incorporate and maintain its autonomy, its goals are similar to the Network and further the goals of the council.

- Increase the number of communities that can recognize the warning signs of suicide through increasing the number of community-based suicide prevention grantees who align their community funding with the statewide suicide prevention plan.

  The Prevention and Early Intervention section gave comprehensive prevention grants to communities for the FY 06 - FY 08 three-year grant cycle. A comprehensive prevention grant can be used to address any alcohol, drug, mental health, or suicide related issue. Since none of the grants during this grant cycle were specifically for suicide prevention, no tracking was done to determine whether grantees aligned their funding with the statewide plan. As comprehensive prevention grants continue to be made by DBH, the council should revise this performance measure.

Determine the extent to which the board, commission, or agency duplicates the activities of another governmental agency or the private sector.

The Statewide Suicide Prevention Council mission overlaps with other state entities such as the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Trust Authority. However, the council was established to bring attention and focus, specifically, to the suicide issue in Alaska, so overlapping missions are to be expected.

While the council actively collaborates with various other boards and commissions with related missions, there does not appear to be any duplication of activities between the council and these other governmental agencies or in the private sector.

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STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

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December 1, 2008

RECEIVED
DEC 01 2008
LEGISLATIVE AUDIT

Pat Davidson
Legislative Auditor
Alaska State Legislature, Division of Legislative Audit
PO Box 113300
Juneau, AK 99811-3300

Dear Ms. Davidson:

Thank you for this opportunity to provide a written response to the *Preliminary Audit Report on the Statewide Suicide Prevention Council, Sunset Review, November 4, 2008.* I have reviewed the report and offer the following comments.

First, we appreciate your staff's careful attention to detail and the thorough nature of the audit process, including the many interviews and opportunities for individuals to be heard and to voice their opinions. Suicide is a critical social issue for the State of Alaska and the Statewide Suicide prevention Council (SSPC) has a significant responsibility to find strategies and solutions to begin reducing the rate of suicide throughout our state.

As stated in the audit report, the SSPC has recently undergone a significant change in location within the department and in their staff coordination. Beginning July 1, 2008, the SSPC is now under the direction of the Division of Behavioral Health, section of Prevention & Early Intervention Services. The reason for this change of location was to allow for better coordination of statewide suicide prevention efforts between the SSPC and Behavioral Health and to promote a more seamless and coordinated approach to suicide prevention in Alaska. While this transition is complete, the SSPC members and Behavioral Health staff are continuing to define and develop their relationship and structure. We are confident this change will accomplish its intended purpose and provide for better statewide alignment in issues related to suicide prevention.

The Department of Health and Social Services (DHSS) supports and agrees with the audit findings and recommendations. We are pleased with the recommendation to extend the SSPC for four more years, with a new sunset date of June 30, 2013. We believe the DHSS and the SSPC are at a critical juncture to make significant progress in reducing and preventing suicide in Alaska. DHSS, in partnership with the council and others, recently received a 3-year federal Garrett Lee Smith Youth Suicide Prevention grant to focus on developing regional strategies to 'turn the corner' on suicide data. In addition, with one-time funding from the FY08 Legislature, we are offering regional suicide prevention planning grants focusing on those regions of Alaska with the highest rates of suicide. It is our intent that these planning grants will become the foundation of the Statewide Suicide Prevention Initiative, a joint effort of the DHSS and the Council. The four (4) year extension will allow these projects to become embedded in our statewide strategy and to develop sustainability of community/regional efforts.

In response to the other two recommendations, again we are in agreement with the findings and recommendation, with the following comments and suggestions.

Recommendation No. 1:

The Statewide Suicide Prevention Council should, in accordance with statues, appoint its own coordinator and perform annual performance reviews.
With the change in location of the SSPC to the Division of Behavioral Health, and the departure of Kathryn Craft as Coordinator, interim decisions were made with minimal input from the council. One decision was to have two current Behavioral Health staff share the role of providing support to the council. L. Diane Casto, Section Manager and James Gallanos, Project Coordinator, are currently sharing the task of providing staff support to the council. It was never the intent that these two staff would be the Council Coordinator, but would be available to provide support and guidance as requested from Council Chairperson Brenda Moore.

Due to limited funding, there are not enough funds for a full-time coordinator, and in fact, Ms. Craft provided approximately .25 FTE services to the council. At the most recent SSPC meeting in September, and again during a November telephonic executive work session of the council , it was decided that the personnel money available in the SSPC budget will be used to hire a . 50 FTE Project Assistant, hired by the council, to provide day-to-day support. We are beginning the process to reclass the current Position Control Number (PCN) previously assigned to Ms. Craft. Once completed, we will begin the solicitation and hiring process, with input and direction from the council. The position will be located in the Juneau offices of the Division of Behavioral Health.

We also support the audit recommendation for the council to conduct annual evaluations of the council staff person and will provide assistance as requested.

Recommendation No. 2:

The legislature should consider modifying the composition of council membership.

As stated in the audit, there have been "excessive vacancies on the council and significant absences by council members at its meetings. "In addition, it is noted that "those being appointed to the council did not always meet the statutory qualifications for the position." We agree with both of these conclusions and support the recommendation to consider modifying the composition of the council membership.

In July, when the SSPC came into the Division of Behavioral Health, section of Prevention & Early Intervention Services, Ms. Casto began a dialogue with the Director of Boards and Commissions about the current vacancies and how best to recruit and/or encourage applications to fill these positions. Through this process, it became evident that the current membership did not directly meet the statutory qualifications for council membership. Discussions with the office of Boards and Commissions continue with DBH staff to make sure vacant positions are

filled in a timely manner and that applicants meet the statutory requirements. The office of Boards and Commissions is currently reviewing a number of applications for SSPC membership.

In addition, at the September meeting of the SSPC, there was a discussion about these current qualifications or categories of representation, and the council agrees that some modifying of the council composition would be beneficial. Providing more flexibility and broader definitions (i.e. expanding a secondary school counselor to a school counselor or K-12 school personnel) would allow for a larger pool of potential candidates.

Another area that has concerned the council is the large number of legislators required as council members. While the council is not concerned with having legislative representation and in fact supports their membership, it is difficult for legislators to be available for meetings, creating difficulty having a quorum for conducting council business. As reported in the audit, legislative members have attended meeting 15% of the time over the last 4 years.

With the challenges the current statutory qualifications have created, the DHSS supports the recommendation to modify the membership and, upon request, will work with the council to develop broader and more flexible categories of representation for possible legislative action.

I want to thank you for the opportunity to review and respond to the preliminary audit report. We support the work of the Legislative Audit team, and believe your recommendations will strengthen the Statewide Suicide Prevention Council, the collaboration with Behavioral Health, and the council outcomes.

Please do not hesitate to contact me if you have questions or would like additional information.

Sincerely,

William H. Hogan

William H. Hogan
Commissioner

cc: Melissa Stone, Director, Division of Behavioral Health

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To: Legislative Budget and Audit Committee
Division of Legislative Audit

RECEIVED
NOV 30 2008
LEGISLATIVE AUDIT

From: Statewide Suicide Prevention Council
Brenda Moore, Chair

Re: Department of Health and Social Services
Statewide Suicide Prevention Council, Sunset Review, November 4, 2008

November 28, 2008

Recommendation No. 1

The Statewide Suicide Prevention Council (SSPC or council) should, in accordance with statutes appoint its own coordinator and perform annual performance reviews.

During an executive session, Nov. 24, 2008, the council discussed hiring a part-time coordinator to work in conjunction with the Division of Behavioral Health, Office of Prevention and Early Intervention manager and prevention specialist that currently provides administrative support to the council. There was consensus among council members that it could develop its own goals and implementation plans with input and assistance from its current administrative support staff. A coordinator is needed to organize and carry out operational activities necessary to support the council in achieving its goals. The council determined to form a committee to review the budget and job classification in order to hire a coordinator. A performance review schedule and procedure will also be established.

Recommendation No. 2

The legislature should consider modifying the composition of council membership.

The council is in agreement with the recommendation to broaden the qualifications of council members to ensure that appointees are interested in the work of the council and can make the time commitment necessary to serve. In addition the council agrees to the recommendation that consideration should be made to making legislative members non-voting to prevent potential quorum issues.

3477

SB

38

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Labor and Commerce
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: 4/3/09

Health and Social Services Committee considered SENATE BILL NO. 38

SB 38 PHARMACY BENEFITS MANAGERS; MANAGED CARE

"An Act relating to insurance; removing references, definitions, and confidentiality of information provisions relating to managed care entities, substituting health care insurers in the former role of managed care entities, and amending the definitions of 'covered person,' 'managed care plan,' and 'utilization review,' as those terms relate to the administration of managed care insurance plans; authorizing persons to act as pharmacy benefits managers subject to oversight by the division of insurance; and amending the definition of 'health care insurer' as it relates to health care insurance."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
CED	4/1			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	✓			
	DYSON				✓
	PARKINSON	X			
CHAIR:	DAVIS	✓			

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 38
() Publish Date:

Identifier (file name): SB038-DOA-DRB-03-31-09
Dept. Affected: Administration
Title: An Act relating to insurance...and amending the definition of health care insurer' as it relates to health care insurance."
RDU: Centralized Administrative Services
Component: Group Health Insurance
Sponsor: SENATOR(S) ELTON, French
Requester: (S)HSS
Component Number: 2152

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	60.0	0.0	65.0	70.0	76.0	82.0	89.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	60.0	0.0	65.0	70.0	76.0	82.0	89.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1017 Group Benefits	60.0	0.0	65.0	70.0	76.0	82.0	89.0
TOTAL	**60.0**	**0.0**	**65.0**	**70.0**	**76.0**	**82.0**	**89.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Part-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Temporary	0.0	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: *(Attach a separate page if necessary)*

This legislation acts to remove references, definitions, and confidentiality of information provisions relating to managed care entities, and substitute health care insurers in the former role of managed care entities. It also amends the definitions of 'covered person,' 'managed care plan,' and 'utilization review,' as those terms relate to the administration of managed care insurance plans. The bill authorizes persons to act as pharmacy benefits managers subject to oversight by the division of insurance and amends the definition of 'health care insurer' as it relates to health care insurance.

Attached to this fiscal note is a letter from Buck Consultants upon which the estimates within this note are based. It is difficult to estimate the costs of the proposed changes in this bill because there is no experience with this arrangement in Alaska. The studies used to create these estimates are cited in the attached letter from Buck Consultants. Increased drug claim spend may exceed $77 million from FY10 through FY15. The increased drug claim spend would be paid through increased personal services costs in all State agencies and SB 125 payments to the retirement health trusts in FY11.

Prepared by: Patrick Shier, Director — Phone 465-4817
Division: Retirement and Benefits — Date/Time 3/31/09 3:02 PM
Approved by: Rachael Petro, Deputy — Date 3/31/2009
Department of Administration

(Revised 03/30/08 OMB)

buckconsultants
an ACS company

March 30, 2009

VIA EMAIL

Ms. Kathy Lea
Retirement Manager
Division of Retirement and Benefits
State of Alaska
333 Willoughby Avenue
6th Floor State Office Building
Juneau, AK 99811-0208

RE: Fiscal Note for SB 38 – PBM Portion

Dear Kathy:

As requested, we are providing you the information for a Fiscal Note on SB 38 regarding the pharmacy benefit manager (PBM) contracting portion of the bill. This bill defines allowable contract provisions to be overseen by the Division of Insurance. The following table includes brief comments on various sections of the bill and indicates if any cost estimate for each item is included below or instead if there is not yet a reasonable estimate of potential costs for such item:

Section Number	Description	Fiscal Impact
21.07.100(a)	Subjects PBM contracts to DOI oversight.	Potential cost increase to DRB attributable to assimilation of contract provisions not determined by the DRB (as with remainder of DRB contracting). Cost not estimated.
21.07.100(b)	Specified list of services PBMs are allowed to provide.	Potential cost increase to DRB as new cost-saving services are developed but excluded from allowed services, or through delay of inclusion of such cost-saving services. Specialty pharmacy services may already be in this category. Cost not estimated.
21.07.100(c)	Prohibited PBM contract provisions.	Potential cost increase to DRB to the extent current or newly developed cost-saving contract provisions are developed. Cost not estimated.

Tabor Center, 1200 17th Street, Suite 1200 • Denver, CO 80202
720.359.7700 • 720.359.7701 (fax)

21.07.100(d)	Requirement that uniform patient out-of-pocket features apply to prescriptions filled by contracted retail and mail-order pharmacies.	Cost increase to DRB through removal of patient incentives to use mail-order services; cost estimate included below. Potential cost increase to DRB to the extent all prescriptions under a given plan are required to have the same out-of-pocket feature(s). For example, if a plan uses a fixed-dollar copay approach and this copay may not be varied by formulary, brand, generic or specialty pharmacy category, the DRB will experience significant cost increases; cost for this potential impact not estimated.
21.07.100(e)	PBM fiduciary requirement.	Potential cost increase to DRB if PBMs charge a fee for fiduciary liability and/or additional administrative services attributable to this provision. Cost estimate included in general TPA admin cost increase estimate.
21.07.105	Prohibited practices.	Potential cost increase to DRB to the extent practices listed interfere with or inhibit application of disease management programs. Cost not estimated.
21.07.115	Basis of PBM reimbursement to contracted pharmacies.	Cost increase to DRB to the extent allowable bases for reimbursement lag industry developments. This is likely already the case for First DataBank and Facts and Comparisons databases as products of both firms are part of pending class action settlements regarding overpricing. Cost increases to DRB will be significant to the extent allowable reimbursements exceed any ingredient-cost based contracting the DRB may be otherwise able to develop in the future. Cost not estimated.
21.07.125	Requirements regarding PBM payments to and audits of pharmacies.	Potential cost increase to DRB to the extent additional compliance costs are passed through and to the extent that costs currently recoverable through prohibited retroactive adjustments and audits are forgone in future. Cost estimate included in general TPA admin cost increase estimate.
21.07.130 – 140	Drug substitution, complaint process and pharmacy compensation	Potential cost increase to DRB to the extent additional compliance costs are passed through. Cost estimate included in general TPA admin cost increase estimate.
21.07.145	Required pricing disclosures	Potential "loss of competition" cost increase to DRB to the extent PBMs anticipate disclosure of proprietary data (despite confidentiality provisions) and decide not to do business in Alaska. Cost not estimated.

The table below shows the cost of the bill for Fiscal Years 2010 through 2015. Dollars are in thousands.

AlaskaCare	FY10	FY11	FY12	FY13	FY14	FY15
Increase in third-party administrative cost	$60	$65	$70	$76	$82	$89
Increase in prescription claims cost	$10,759	$11,657	$12,485	$13,221	$14,000	$14,823
Total	$10,819	$11,722	$12,555	$13,297	$14,082	$14,912

Summary for Analysis Continuation Section of Fiscal Note

Cost estimates are based on AlaskaCare claims information used for setting 2009 (retiree) and FY2010 (active) premiums, health care cost trend assumptions used for the June 30, 2008 retiree health care valuations, and the following research:

- 2004 Rhode Island press release referencing "data from studies in the impact of any willing provider laws in other states point to a related increase in health insurance premiums." http://www.rilin.state.ri.us/News/pr1.asp?prid=1050
- 2003 Academy of Managed Care Pharmacy posting indicating that any willing pharmacy laws "*result in increased costs to the health care system" through loss of* "economies of scale, "*laws that do not require the pharmacy to meet the terms and conditions of the health plan's contract undermine managed care's ability to control the quality of clinical services provided," and that* "the Federal Trade Commission has held that any willing provider laws discourage competition in the health care marketplace for both pharmaceutical services and managed care programs, restricting consumer access to affordable health care." http://www.amcp.org/amcp.ark?p=AA21D611
- 2002 Journal of Health Politics, Policy and Law study *Any-Willing-Provider Laws: Their Financial Effects on HMOs* that indicates "Our results show that 'all-provider' AWP (any willing provider) laws have a very limited effect on the financial performance measures we examine. 'Pharmacy' AWP laws have a more significant effect." This study indicates that HMO administrative costs are 5.6% higher in states with any willing pharmacy laws (result is significant at the 5% level). http://www.oregonmentalhealth.info/Any-Willing-Provider%20Laws%20Carrol.pdf
- 2001 Ohio fiscal note indicating "potential negligible (cost) increase" for any willing pharmacy legislation that did NOT impact any PBM contracting provisions (i.e., some costs will increase even if PBMs continue to contract per usual but open such contracts to any pharmacy willing to accept terms) http://www.lbo.state.oh.us/fiscal/fiscalnotes/124ga/HB0053IN.HTM

We estimate a 0.5% increase in TPA fees. Prescription claim cost increases are estimated using calendar 2008 average retail and mail-order ingredient costs and duration, current employee and retiree copays and by assuming that if any copay-based incentive to use mail-order is eliminated, 50% of the current lower average duration-adjusted mail-order costs will be lost. This 50% factor accounts for the fact that some members will still use mail-order due to lack of local retail options, and conservatively understates lost savings due to the underlying difference in the type of prescriptions currently dispensed by mail-order versus retail.

Kathy, please let us know if you need any further information.

Sincerely,

Christopher R. Hulla
Principal, Health and Productivity

Aaron P. Jurgaitis, A.S.A.
Consultant, Health and Productivity

CRH:mw

c: Mr. Pat Shier, State of Alaska
Mr. Kevin Worley, State of Alaska
Ms. Michelle DeLange, Buck Consultants
Mr. Dave Slishinsky, Buck Consultants
Ms. Monica DeGraff, Buck Consultants

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 38
() Publish Date:

Identifier (file name): SB38-CED-INS-03-27-09
Dept. Affected: DCCED
Title: Pharmacy Benefits Managers; Managed Care
RDU: Insurance (116)
Component: Insurance
Sponsor: Senator Elton, French
Requester: Senate Health and Social Services Committee
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 38 provides for regulation of pharmacy benefit managers by the Division of Insurance. It updates the terminology to be consistent throughout Title 21 with the use of "health care insurer". It also proposes to require registration of pharmacy benefit managers as third-party administrators, details the functions that can be performed, describes prohibited practices, requires disclosures and regulates medication reimbursement rates. These changes should have no fiscal impact to the Division of Insurance.

Prepared by: Linda S. Hall, Director
Phone 907-269-7900
Division: Insurance
Date/Time 3/27/09 1:28 PM
Approved by: Emil R. Notti, Commissioner
Date 4/1/2009
Commerce, Community, and Economic Development

(Revised 9/10/2008 OMB)

SENATE DISTRICT B

MEMORANDUM

TO: Senator Bettye Davis, Health & Social Services Chair

FROM: Senate District B Kristen Bressette

SUBJECT: SB 38 Hearing Request

DATE: 3/25/2009

I respectfully request a hearing on SB 38, "An Act relating to insurance; removing references, definitions, and confidentiality of information provisions relating to managed care entities, substituting health care insurers in the former role of managed care entities, and amending the definitions of 'covered person,' 'managed care plan,' and 'utilization review,' as those terms relate to the administration of managed care insurance plans; authorizing persons to act as pharmacy benefits managers subject to oversight by the division of insurance; and amending the definition of 'health care insurer' as it relates to health care insurance."

SB 38 would regulate and bring transparency to the business practices of pharmacy benefit mangers in Alaska. Pharmacy benefit managers are the largely unregulated drug middlemen that administer the prescription drug benefit portion of health insurance plans for governments, private companies, and unions. The three major pharmacy benefit managers are Medco, CVS Caremark, and Express Scripts. Premera Blue Cross Blue Shield, the State of Alaska's health insurance provider, has a contract with Medco to administer prescription drug benefits for state employees.

Sixteen states as well as the District of Columbia have enacted laws that regulate the business practices of pharmacy benefit managers. In addition, the federal government and many states have sued pharmacy benefit managers and won. Other states have led the way with legislation regulating the business practices of pharmacy benefit managers and it is time for the Alaska Legislature to do the same.

Thank you for considering a hearing on SB 38. Please feel free to contact Kristen Bressette at 465-4790 if you have any questions.

ALASKA SENATE
STATE CAPITOL • JUNEAU, ALASKA 99801-1182 • (907) 465-4947 • FAX (907) 465-2108

SENATE DISTRICT B

SB 38 - PHARMACY BENEFITS MANAGERS; MANAGED CARE

"An Act relating to insurance; removing references, definitions, and confidentiality of information provisions relating to managed care entities, substituting health care insurers in the former role of managed care entities, and amending the definitions of 'covered person,' 'managed care plan,' and 'utilization review,' as those terms relate to the administration of managed care insurance plans; authorizing persons to act as pharmacy benefits managers subject to oversight by the division of insurance; and amending the definition of 'health care insurer' as it relates to health care insurance."

Sponsor Statement

SB 38 would regulate and bring transparency to the business practices of pharmacy benefit mangers in Alaska. Pharmacy benefit managers are the largely unregulated drug middlemen that administer the prescription drug benefit portion of health insurance plans for governments, private companies, and unions. The three major pharmacy benefit managers are Medco, CVS Caremark, and Express Scripts. Premera Blue Cross Blue Shield, the State of Alaska's health insurance provider, has a contract with Medco to administer prescription drug benefits for state employees.

Pharmacy benefit managers negotiate with drug manufacturers and pharmacies on behalf of health insurance plans. These negotiations include cash rebates that drug manufacturers pay for drugs placed on lists of approved drugs. The confidential and proprietary nature of these contracts and financial arrangements with drug manufacturers and pharmacies creates the opportunity for pharmacy benefit managers to engage in unfair business practices. Pharmacy benefit managers increase profits by accepting incentives from drug manufacturers that are not shared with health plan sponsors, such as the State of Alaska. SB 38 would prohibit pharmacy benefit managers from intervening in the delivery or transmission of prescriptions.

Twenty-nine states and the District of Columbia have sued Express Scripts and won, resulting in a settlement of $9.3 million to states and up to $200,000 to affected patients in May of 2008. Twenty-eight states and the District of Columbia have sued CVS Caremark and won, resulting in a settlement of $41 million in February of 2008. The federal government and twenty states have sued Medco and won, resulting in a settlement of $184.1 million in 2006. The lawsuits were filed under the federal False Claims Act and/or state False Claims Acts and/or statutes.

In addition to lawsuits against pharmacy benefit managers, sixteen states as well as the District of Columbia have enacted laws that regulate the business practices of pharmacy benefit managers. Other states have led the way with legislation regulating the business practices of pharmacy benefit managers and it is time for the Alaska Legislature to do the same.

ALASKA SENATE
STATE CAPITOL • JUNEAU, ALASKA 99801-1182 • (907) 465-4947 • FAX (907) 465-2108

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 7, 2009

SUBJECT: Managed care insurance, pharmacy benefits manager; sectional summary (Work Order No. 26-LS0244\A)

TO: Senator Kim Elton
Attn: Kristen Bressette

FROM: Dennis C. Bailey
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. In this summary, for ease of reading, instead of using the phrase "pharmacist and pharmacy," I have used only the term "pharmacy" to refer to both. Also, please be aware that in previous correspondence I have identified issues with the draft summarized in this memorandum that have not been resolved.

Sections 1 - 16. Replaces statutory references to a "managed care entity" with a "health care insurer" with regard to the regulation of managed care insurance plans.

Section 17. Sec. 21.07.100 requires a pharmacy benefits manager to operate under the terms of a written agreement approved by the director; defines what benefits may be managed by a pharmacy benefits manager; defines what matters may not be included in an agreement between a health care insurer and a pharmacy benefits manager; and, requires that a pharmacy benefits manager that receives payment for the services of a pharmacy acts as a fiduciary of the pharmacy that provided the services.

Sec. 21.07.105 prohibits certain activities by a pharmacy benefits manager.

Sec. 21.07.110 limits the terms under which an agreement between a pharmacy benefits manager and a pharmacy may be terminated; requires notice of termination before a pharmacy is excluded from a network, allows immediate termination of the agreement if the pharmacy loses a license or is convicted of fraud; and prohibits discrimination against a pharmacy acting within the scope of a license or certification with respect to participation in a network or reimbursement plan.

Sec. 21.07.115 designates the method for determining reimbursement payments to pharmacies, including reimbursement for equivalent and interchangeable products.

Sec. 21.07.120 establishes time limits for electronic or non-electronic payments; requires price adjustment within 24 hours of notice of a price increase from a supplier; prohibits retroactive denial of certain claims; prohibits an extrapolation audit as a condition of participating in a contract, network, or program; and prohibits disputed setoff payments to the pharmacy benefits manager or health care insurer until review by the director.

Sec. 21.07.125 requires a health care insurer using the services of a pharmacy benefits manager to notify a covered person of the relationships among the pharmacy benefits manager, the health care insurer, and the covered person.

Sec. 21.07.130 authorizes a pharmacy benefits manager to substitute a lower priced generic or equivalent drugs if approved by the health professional; requires that the substitute of a higher cost drug must be made for a medical reason; requires a pharmacy benefits manager to disclose information to the covered person related to the substitution; and requires a pharmacy benefits manager to compensate a health care insurer for a benefit received by the pharmacy benefits manager as a result of a substitution.

Sec. 21.07.135 requires the director of the division of insurance to adopt regulations for the investigation of complaints concerning the activity of a pharmacy benefits manager.

Sec. 21.07.140 prohibits certain compensation to a pharmacy benefits manager based on claims experience, but does not prohibit payment based on the total number of claims paid or processed.

Sec. 21.07.145 requires a pharmacy benefits manager to provide financial and use information requested by a heath care insurer; allows a pharmacy benefits manager to designate the information as confidential and prohibits disclosure of the information by a covered entity without the consent of the pharmacy benefits manager or when required by a court; requires a pharmacy benefits manager to disclose to a health insurer the financial arrangement between the pharmacy benefits manager and a drug manufacturer or labeler; requires a pharmacy benefits manager to disclose whether there is a difference between the price paid to a retail pharmacy and the amount billed to the health care insurer; and allows a health care insurer to audit a pharmacy benefits manager's records.

Sec. 21.07.150 requires a pharmacy benefits manager to register as a third-party administrator.

Sec. 21.07.155 allows the division of insurance to regulate fees from a pharmacy benefits manager for costs of administration and prescribes penalties for failure to pay fees and for failure to register.

Sec. 21.07.160 applies the regulation of pharmacy benefits managers to the state when it provides group insurance by means of self insurance for eligible state employees or under a collective bargaining agreement, and for certain others receiving benefits; and applies

the regulation of pharmacy benefits managers to certain collective bargaining units

Section 18. Amends the definition of a "managed care plan" to remove a reference to a "managed care entity."

Section 19. Amends the definition of a "participating health care provider" substituting a "health care insurer" in place of a "managed care entity."

Section 20. Rewrites the definition of a "utilization review."

Section 21. Adds definitions to AS 21.07 for "Board of Pharmacy" or "board," "covered person," "health care insurer," "pharmacist," and "pharmacy."

Section 22. Amends the definition of a "health care insurer" to include a person subject to Title 21 (the Insurance Code) who provides coverage for the cost of medical care and to remove references in the definition relating to a church plan, a governmental plan, and an exception related to nonfederal governmental plans.

Section 23. Defines a "pharmacy benefits manager" for purposes of Title 21.

Section 24. Repeals AS 21.07.040, relating to confidentiality medical and financial information in the care of a managed care entity; and repeals AS 21.07.250(8) - 21.07.250(10), removing definitions for "managed care," a "managed care contractor," and a "managed care entity."

If I may be of further assistance, please advise.

DCB:plm
09-004.plm

LAWS THAT PROVIDE REGULATION OF THE BUSINESS PRACTICES OF PHARMACY BENEFIT MANAGERS

ARKANSAS
Title 17, Chapter 92
Section 17-92-1201, et.seq.

- Sets forth standards for audits by a managed care company, an insurance company, a third-party payor or any entity that represents such companies or groups.
- Pharmacy must be given at least one week advance notice of an audit.
- If clinical or professional judgment is required audit must be conducted by or in consultation with a pharmacist.
- Pharmacy may use records of a hospital, physician or other authorized practitioner to validate the pharmacy record.
- Recoupment of claims has to be based on actual overpayment unless it is part of a settlement with the pharmacy.
- Period covered by audit cannot exceed 24 months from the date the claim was submitted to or adjudicated by the entity.
- Unless consented to by the pharmacy, the audit cannot take place during the first 7 days of the month due to high volume of prescriptions filled during that time.
- Preliminary audit report must be delivered within 120 days after the conclusion of the audit - final report must be delivered within 6 months.
- Use of extrapolation audits for calculation of recoupments or penalties is prohibited.
- Copy of the final audit report to be provided to the plan sponsor.
- Applies to audits of claims submitted after January 1, 2008.
- Effective: 04.03.07

CONNECTICUT
Public Act No. 07-200
Registration of Pharmacy Benefit Managers

- PBM must obtain a certificate of registration from the Insurance Department.
- PBM must complete an application form and include the name and address for an agent for service of process, pay a fee and provide evidence of a surety bond.
- PBM operating as a line of business or affiliate of a health insurer or other entity does not have to obtain a certificate of registration but must provide annual notification to the Commissioner of its status.
- Registration may be denied and a hearing process is provided for an appeal.
- Commissioner has the authority to suspend, revoke or refuse to issue or renew for conduct of a character likely to mislead, deceive or defraud the public or the commissioner, unfair or deceptive business practices or nonpayment of renewal fee.
- Effective: 01.01.08

GEORGIA
Title 26, Chapter 26-4.110.1

- Requires a PBM to be licensed as a pharmacy, with a few exceptions, if it provides the services or benefits that constitute the practice of pharmacy.
- If the PBM is licensed then the Board can inspect its premises whether they are located within or outside the state.
- Effective: 05.22.02

Title 26, Chapter 4 – 26-4-118
The Pharmacy Audit Bill of Rights

- Requires certain procedures when an audit of pharmacy records is undertaken by a managed care company, insurance company, third-party payor or any entity that represents such companies (which would include PBMs).

NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

- Pharmacy must be given notice at least one week prior to conducting the audit.
- Any audit that requires clinical or professional judgment must be conducted by or in consultation with a pharmacist.
- A finding of an overpayment or underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs; however recoupment of claims must be based on the actual overpayment or underpayment unless the pharmacy agrees as part of a settlement.
- Pharmacy must be allowed at least 30 days following the receipt of the audit report to produce documentation to address any discrepancy found during the audit.
- Period covered by the audit may not exceed two years from the date that the claim was submitted to or adjudicated by the entity.
- An audit may not be scheduled during the first 7 calendar days of any month without the consent of the pharmacy.
- The preliminary report must be delivered to the pharmacy within120 days after conclusion of the audit.
- Extrapolation is prohibited in calculating recoupments or penalties for audits.
- Each entity conducting an audit shall establish an appeals process.
- Plan sponsor must be provided with a copy of the audit report.
- Effective: 04.19.06 (applies to audits to claims submitted for payment after 07.01.06)

IOWA
Title XIII Commerce
Subtitle 1 Insurance and Related Regulation
Chapter 510B.1 – 510B.9

- PBM must obtain a certificate as a third party administrator.
- PBM must perform its duties exercising good faith and fair dealing.
- PBM must notify the covered entity in writing of any conflicts.
- PBM cannot contact a covered individual without permission of the covered entity.
- PBM cannot require more stringent record keeping than that required by state or federal law or regulation.
- PBM must notify the pharmacy when it receives notice from a covered entity of a contract cancellation within 10 working days.
- Within 3 business days of a price increase notification by a manufacturer or supplier the PBM must adjust its payment to the pharmacy consistent with the price increase.
- Commissioner must enforce the provisions and adopt rules concerning timely payment of pharmacy claims and a process for adjudication of complaints and settlement of disputes between a PBM and a pharmacy related to auditing practices and termination of pharmacy agreements.
- Legislative Council is directed to establish an interim committee on PBMs to review transparency, disclosure, confidentiality protections, ability of covered entities to audit PBMs and appropriate remedies for covered entities to enforce the provisions in the Act.
- Effective: 01.01.08

KANSAS
Chapter 154
Pharmacy Benefits Manager Registration Act

- Requires PBMs to obtain a valid certificate of registration issued by the insurance commissioner in order to operate in the state.
- PBM must file an application form which includes:
  (a) Name, address, official position and professional qualification of each individual who is responsible for the conduct of the affairs of the PBM, including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the PBM.

(b) Name and address of the applicant's agent for service of process in the state and
(c) A nonrefundable application fee of $140.

- Registration expires on March 31st of each year and the renewal fee is $140.
- If the fee is not paid the registration may be revoked or suspended.
- PBMs must register within 90 days after the effective date of the act.
- Insurance commissioner may adopt rules.
- If a PBM acts without registering, it will be subject to a fine of $500 per violation.
- Effective: 04.28.06

LOUISIANA
Title 22: Sections 250:51 – 61

- Provides that nonelectronic "clean" claims submitted must be paid within 45 days and not more than 60 days after a corrected claim is submitted.
- Provisions must be made for late payment adjustments equal to one percent of the unpaid balance due for each month or partial month that such claim remains unpaid. An additional one percent will be added for those payments more than 25 days after the due date.
- Provides for electronic "clean" claims to be paid within 15 days after receipt, if not late payment adjustments are applicable.
- Reimbursement must be calculated according to a nationally recognized reference and the most current price or amount must be used based on the date of service shown on the claim.
- Recoupment of amounts owed to a pharmacy must begin with a notice to the pharmacy and a 30 day period for the pharmacy to respond.
- Effective: 01.01.2005

MAINE
Title 22, Chapter 603, Subchapter 4, Section 2699
Prescription drug practices

- Provides that a PBM owes a fiduciary duty to a covered entity and must discharge that duty in accordance with the provisions of state and federal law.
- Requires PBM to perform its duties with care, skill, prudence and diligence in accordance with the standards of conduct applicable to a fiduciary in an enterprise of a like character and with like aims.
- Requires PBM to notify the covered entity in writing of any practice that is a conflict of interest.
- Upon request by the covered entity, the PBM must provide all financial and utilization information relating to services to that covered entity.
- The PBM may designate any information provided to the covered entity as confidential and the information may not be disclosed without the permission of the PBM except that disclosure may be ordered by a court. Also this provision does not limit the Attorney General's use of its investigative authority.
- Requires PBM to transfer in full to the covered entity any benefit or payment received as a result of a substitution.
- Requires PBM to disclose to the covered entity all financial terms and arrangements for remuneration of any kind that apply between the PBM and any drug manufacturer or labeler, including formulary management, drug-switch programs, educational support, claims processing and pharmacy network fees that are charged from retail pharmacies and data sales fees. The PBM may designate the information as confidential. However disclosure may be ordered by a court and this provision does not limit the Attorney General's use of its investigative authority.
- Provides that a violation of the Act is a violation of the Maine Unfair Trade Practices Act and subject to a fine of not more than $10,000.
- Applies to contracts executed or renewed on or after September 13, 2003.
- Effective: 04.13.05 (On 06.05.06, the U. S. Supreme Court denied the Petition for a Writ of Certiorari filed by PCMA seeking to overturn the Maine law on the grounds that ERISA preempted it. The Supreme Court ruling ended PCMA's legal challenges to the law.)

- Prior to entering into a contract, the PBM must inform the purchaser that the PBM may solicit and received manufacturer payments, pass through or retain those payments depending on the contract terms, sell aggregate utilization information and share aggregate utilization information with other entities.
- PBM must offer to provide to the purchaser a report that contains net revenue and manufacturer payments.
- If a purchaser has a rebate sharing agreement, the PBM must offer to provide a repot fore each fiscal quarter and each fiscal year that contains information on the net revenues, prescription drug expenditures, manufacturer payments and rebates.
- PBM may require purchaser to sign a nondisclosure agreement prior to releasing information.
- Ability of Attorney General or Insurance Commissioner to obtain information and use the information in any proceedings not affected by this section.
- PBM must disclose at the time of contracting with a pharmacist and at least 30 days before any contract change: the terms of reimbursement, process for verifying benefits and beneficiary eligibility, dispute resolution and audit appeals process and procedures for verifying drugs included on the formularies used by the PBM.
- PBM may not schedule an onsite audit to begin during the first 5 calendar days of a month unless requested by the pharmacist.
- PBM must use a pharmacist if the audit requires clinical or professional judgment.
- All pharmacies in the network must be audited under the same standards and parameters.
- Audit limited to claims submitted or adjudicated within the 2 year period immediately preceding the audit.
- Extrapolation audits are prohibited unless the pharmacist agrees to projected overpayments or denials as part of a settlement agreement.
- PBM must establish an internal appeals process for disputed audit claims.
- PBM must follow certain procedures for the timing of audit reports and payment of amounts due as a result of the audit,
- PBM may not request a therapeutic interchange unless certain criteria are met unless the proposed interchange is for medical reasons that benefit the beneficiary or it will result in financial savings and benefits to the purchaser or the beneficiary.
- PBM must follow disclose certain information to the prescriber when the PBM solicits the prescriber to make an interchange.
- If PBM receives payment from a manufacturer for making the interchange that payment must be disclosed to the prescriber at the time of the solicitation.
- If an interchange occurs, the PBM must provide certain information to the beneficiary.
- PBM must maintain a toll free number for prescribers, pharmacists and beneficiaries.
- PBM must register with the Insurance Commissioner and renew registration every 2 years.
- Commissioner may suspend, deny, revoke or refuse to renew a registration, PBM subject to administrative penalties.
- PBM may not ship, mail or deliver drugs through a non-resident pharmacy unless it holds a pharmacy permit from the Board of Pharmacy.
- Establishes requirements for the PBM's pharmacy and therapeutics (P&T) committee
- Members of a P&T committee must sign a conflict of interest statement.
- A majority of the P&T committee members must be practicing physicians or pharmacist.
- PBM must have policies and procedures including disclosure requirements to address potential conflicts of interest and a process to evaluate medical and scientific evidence concerning the safety and effectiveness of prescription drugs.
- PBM may not require a pharmacist to participate on the P&T committee.
- Effective: 10.01.08

Title 15, Subtitle 10B, Section 15-10B-20
Private Review Agents

- Requires the Insurance Department to conduct an examination of any PBM registered as a private review agent at least once every three years.
- Requires the Commissioner to issue a report based on the examinations.
- Effective: 05.13.03

MISSISSIPPI
Pharmacy Audit Integrity Act

- Establishes minimum and uniform standards and criteria for the audit of pharmacy records.
- Pharmacy contract must identify and describe in detail the audit procedures.
- Entity conducting an onsite audit must give the pharmacy at least 2 weeks prior written notice before conducting an initial audit.
- An audit that involves clinical and professional judgment must be conducted by or in consultation with a pharmacist.
- Entity conducting the onsite audit may not interfere with the delivery of pharmacy services.
- Pharmacy may use records of a hospital, physician or other authorized practitioner to validate the pharmacy record
- Recoupment of claims has to be based on actual overpayment.
- A finding of an overpayment shall include the dispensing fee amount unless the prescription was not dispensed.
- Period covered by the audit may not exceed two years from the date that the claim was submitted to or adjudicated by the entity.
- Audit cannot take place during the first 5 days of the month.
- Preliminary audit report must be delivered within 120 days after the conclusion of the audit - final report must be delivered within 180 days. Pharmacy has at least 30 days to review preliminary report. Audit report must be written.
- Recoupments of disputed funds or repayment of funds must occur after final internal disposition of the audit including the appeal, if any, process. If identified discrepancy exceeds $25,000 future amounts in excess of that amount may be withheld pending finalization of the audit.
- Interest may not accrue during the audit period.
- Entity conducting the audit must establish a written appeals process and if either party is not satisfied with the appeal, that party may seek mediation.
- Plan sponsor must receive a copy of the final report.

Effective: 07.01.08

Title 73 – Professions and Vocations
Chapter 21 – Pharmacists
Sections 73- 21-151 – 73-21-159
Pharmacy Benefit Prompt Pay Act

- Requires PBMs to file financial statements with the Insurance Department.
- PBMs must use a nationally recognized reference in pricing calculations when reimbursing pharmacies and must update that reference no less than every three business days.
- Clean claims filed electronically must be paid within 15 days (not later than 35 days if filed as a paper claim).
- The Board of Pharmacy shall monitor PBMs for compliance with the law and is authorized to subject PBMs to administrative penalties for non-compliance.
- Effective: 06.30.06

NEW MEXICO
Chapter 61 – Article 11
61-11-18.2

- Requires a managed care company, insurance company, third-party payor or representative of the managed care company, insurance company or third-party payor to conduct audits according to certain criteria.
- Must give pharmacy at least 2 weeks notice prior to conducting an initial on-site audit.
- An audit that requires clinical or professional judgment must be conducted by or in consultation with a pharmacist.
- Pharmacy can use the records of a hospital, physician or other authorized practitioner for the purposes of validating the pharmacy record.
- A finding of overpayment or underpayment cannot be based on a projection and recoupment of claims must be based on actual overpayment or underpayment unless a statistically justifiable method of projection is part of an agreed settlement.
- Pharmacy must be allowed at least 21 days, with reasonable extensions, to produce documentation to address any discrepancies.
- Audit period cannot exceed 2 years, unless agreed by contract, from the date that the claim was submitted or adjudicated.
- Audit may not be initiated or scheduled during the first 5 calendar days of a month unless consented to by the pharmacy.
- Preliminary audit report must be delivered within 120 days, with reasonable extensions allowed, after the conclusion of the audit.
- Final report must be delivered within 6 months after receipt of the preliminary audit report or final appeal, whichever is later.
- Audit criteria apply to all audits of claims submitted after July 1, 2007.
- Extrapolation audits are prohibited in calculating recoupments or penalties.
- Each entity conducting an audit must have an appeals process. If the discrepancy exceeds $25,000 future payments to the pharmacy may be withheld pending finalization of the audit.
- Law does not apply to any investigative audit that involves fraud or willful misrepresentation.
- Effective: 07.01.07

NORTH DAKOTA
Chapter 26.1-27

- Defines a PBM as an administrator and requires PBM to be registered as an administrator.
- Requires disclosure of ownership interest in the PBM by an insurer or a pharmaceutical manufacturer.
- Requires the PBM to notify the Commissioner in writing within 5 business days of any material change in the PBM's ownership.
- Requires PBM to comply with statutory provisions concerning substitution of one drug for another.
- PBM may not exclude an otherwise qualified pharmacy from its network if the pharmacy accepts the terms, conditions and reimbursement rates of the PBM's contract.
- PBM may not require a pharmacist or pharmacy to participate in one contract in order to participate in another contract.
- PBM must offer to the covered entity contracting options that must include: a transaction fee without a sharing of a payment received by the PBM, a combination of transaction fee and a sharing of the payment received by the PBM or a transaction fee based on the covered entity receiving all of the benefits of payments received by the PBM.
- Agreement between the PBM and the covered entity must include a provision allowing the covered entity to audit the PBM's books, accounts and records as necessary to confirm that the benefit of a payment received by the PBM is being shared as required by the contract.
- During an examination of a covered entity, the Commissioner may examine any contracts between the covered entity and the PBM in order to determine whether payments received from the PBM are being applied to reduce the covered entity's rates or have been distributed to covered individuals.

- Covered entity must disclose annually the benefits of the payments received and describe how the benefits received were applied towards reducing rates or distributed to covered individuals.
- Any information disclosed to the Commissioner is considered a trade secret.
- Commissioner may adopt rules as necessary.
- Effective: 08.01.05

OKLAHOMA
Title 59, Section 356
Pharmacy Audit Integrity Act

- Establishes minimum and uniform standards and criteria for the audit of pharmacy records.
- Pharmacy contract must identify and describe the audit procedures.
- Entity conducting an onsite audit must give the pharmacy at least 2 weeks prior written notice before conducting an initial audit.
- An audit that involves clinical and professional judgment must be conducted by or in consultation with a licensed pharmacist.
- Entity conducting the onsite audit may not interfere with the delivery of pharmacy services.
- Pharmacy may use records of a hospital, physician or other authorized practitioner to validate the pharmacy record
- Recoupment of claims has to be based on actual overpayment or underpayment; however a projection may be used as part of a settlement as agreed to by the pharmacy.
- A finding of an overpayment shall include the dispensing fee amount unless the prescription was not dispensed or a physician denied authorization.
- Each pharmacy must be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity.
- Period covered by the audit may not exceed two years from the date that the claim was submitted to or adjudicated by the entity.
- Audit cannot take place during the first 5 days of the month.
- Must disclose to the plan sponsor any money recouped in the audit.
- Preliminary audit report must be delivered within 120 days after the conclusion of the audit - final report must be delivered within 6 months after receipt of the preliminary report or final appeal. Pharmacy has at least 60 days to review preliminary report. Audit report must be written.
- Recoupments of disputed funds or repayment of funds must occur after final internal disposition of the audit including the appeal, if any, process. If identified discrepancy exceeds $25,000 future amounts in excess of that amount may be withheld pending finalization of the audit.
- Interest may not accrue during the audit period.
- Entity conducting the audit must establish a written appeals process.
- Plan sponsor must receive a copy of the final report.
- Act does not apply to any audit which involves fraud, abuse or willful misrepresentation.

Effective: 11.01.08

RHODE ISLAND
Title 27 – Insurance
Chapter 27-29.1

- Includes PBMs in the definition of third-party administrator under Chapter 20.7 which requires filing an annual report with the Department of Business Regulation.
- Annual report must include: contractual language that provides a complete description of the financial arrangements between the third-party administrator and each of the insurers covering benefit contracts delivered in Rhode Island.
- If the third-party administrator is owned by or affiliated with another entity or entities, it shall include an organization chart and brief description which shows the relationships among all affiliates within a holding company or otherwise affiliated.
- Report must be in a format required by the director and filed with the department as a public record.
- Effective: 07.05.04

SOUTH DAKOTA
Chapter 58-29E -- Pharmacy Benefits Management

- Requires PBMs to be licensed as a third party administrator.
- Requires PBM to perform its duties by exercising good faith and fair dealing toward the covered entity.
- Gives the covered entity the option to request information from the PBM on rebate revenues and retrospective utilization discounts.
- Gives the covered entity the option to request information on the nature, type and amount of all other revenue received from a pharmaceutical manufacturer or labeler for programs that the covered entity offers to its enrollees.
- Prohibits PBM from contacting a covered individual without express written permission of the covered entity.
- Provides that information disclosed to the covered entity shall be confidential and proprietary information; however insurance department may request information but it will be considered confidential and privileged and not open to public inspection or disclosure.
- Provides that the covered entity may audit the PBM's records as they relate to rebates and other information described in the law.
- Prescription may be substituted if it is a lower priced generic or if the substitution is for medical reasons but PBM must obtain prior approval from the prescriber.
- Allows the Division of Insurance to promulgate rules.
- Applies to contracts entered into or renewed after June 30, 2004.
- Effective: 03.09.04

TENNESSEE
Titles 56 and 63

- Establishes standards for audits of pharmacies conducted by PBMs.
- At least 2 weeks prior written notice must be given to the pharmacy before conducting the initial on-site audit.
- If clinical or professional judgment is required audit must be conducted in consultation with a pharmacist who has knowledge of the Tennessee Pharmacy Practice Act.
- Pharmacy may use records of a hospital, physician or other authorized practitioner to validate the pharmacy record.
- Unless consented to by the pharmacy, the audit cannot take place during the first 7 days of the month due to high volume of prescriptions filled during that time.
- Pharmacist must be given no less than 30 days following receipt of the audit report to produce documentation to address any discrepancy.
- PBM must establish an appeals process and provide the pharmacist a written explanation of the process.
- Use of extrapolation audits for calculation of recoupments or penalties is prohibited.
- Preliminary audit report must be delivered within 120 days and the final report must be delivered within 6 months after receipt of the preliminary audit report or final appeal, whichever is later.
- Period covered by an audit cannot exceed 2 years from the date the claim was submitted or adjudicated.
- Recoupment of any disputed funds cannot take place until after the final internal disposition of the audit including any appeal process.
- If PBM uses a nationally recognized reference to calculate reimbursement then the PBM must use the most current reference price or amount.
- Requires PBMs to provide timely updates to pharmacy product pricing files used to calculate prescription prices and reimburse pharmacies. Files must be updated no less than every 3 business days.
- Effective: 07.01.07

VERMONT
18 V[illegible]. Chapter 221, Sections 9421, 947[illegible]473
Pharmacy Benefit Managers

- PBM must discharge its duties with reasonable care and diligence and be fair and truthful.
- PBM must provide notice to a health insurer that the following terms may be included in its PBM contract:
  (1) all financial and utilization information requested by the insurer relating to the provision of benefits to beneficiaries through that insurer's health plan (information may be designated as confidential);
  (2) notification of any proposed or ongoing activity that, directly or indirectly, poses a conflict of interest;
  (3) if a substitute drug is to be dispensed which costs more than the prescribed drug and the PBM receives a payment or benefit then the cost of both drugs and the benefit or payment must be disclosed;
  (4) if PBM derives any benefit based on volume of sales for certain drugs or classes or brands of drugs, that payment or benefit must be passed on in full to the health insurer; and
  (5) disclosure of all financial terms and arrangement for remuneration of any kind that apply between the PBM and the drug manufacturer including formulary management and drug-switch programs, educational support, claims process and pharmacy network fees charged from retail pharmacies and data sales fees(information may be designated as confidential).
- PBM must register before doing business in the state.
- PBM must notify health insurers that they are entitled to a quote for an administrative-services-only (ASO) contract with full pass through of negotiated prices, rebates and other such financial benefits which would identify to the insurer external sources of revenue and profit generally available and whether the PBM offers that type of arrangement.
- In order to verify the pricing arrangements of ASO contracts, the PBM must allow access to the Commissioner to conduct an audit.
- Department's expenses in conducting the audit must be paid by the PBM.
- Applies to all contracts executed or renewed on or after September 1, 2007.
- Effective: 07.01.07

DISTRICT OF COLUMBIA
Title 48, Subtitle II, Chapter 8A, Subchapter II.
Transparent Business Practices Among Pharmacy Benefit Managers

- Requires a PBM to act as a fiduciary.
- PBM must perform its duties with care, skill, prudence and diligence.
- Requires the PBM to notify the covered entity in writing of any practice that is a conflict of interest.
- Requires any payments/benefits that a PBM receives from a drug manufacturer or labeler based on volume of sales or market share must be paid in full to the covered entity; however covered entity can agree to return a portion of the benefit or payment to the PBM.
- Upon request by the covered entity, the PBM must provide information on all rebates, discounts and other similar payments.
- Upon request by the covered entity, the PBM must disclose all financial terms and arrangements for remuneration of any kind between the PBM and a drug manufacturer or labeler including formulary management, drug substitution programs, educational support, claims processing and data sales fees.
- PBM may designate the information provided as confidential.
- If a PBM substitutes another prescription drug for a prescribed drug and if the substitute drug costs more than the prescribed drug, the PBM must disclose the costs of both drugs and any benefit or payment directly or indirectly that accrues to the PBM as a result of the substitution. Any benefit or payment received as a result of the substitution must be transferred in full to the covered entity.
- Violations are subject to a fine of not more than $10,000.
- Effective: 09.16.06 (This law is still the subject of a legal challenge by PCMA)

Federal and State Litigation Regarding Pharmacy Benefit Managers

David A. Balto
January 2009

From 2004 – 2008, the three major PBMs (Medco, CVS Caremark, and Express Scripts) faced six major federal or multidistrict cases over allegations of fraud; misrepresentation to plans, patients, and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. These cases resulted in over $371.9 million in damages to states, plans, and patients so far. Below is a summary of these six cases. Note that the regulatory provisions of many of these settlements will expire within 2-10 years.

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1. *United States v. Merck & Co., Inc., et. al* (also cited as *United States of America v. Merck-Medco Managed Care L.L.C., et al.)* (E.D. Pa.)

Settled: October 23, 2006
Damages: $184.1 million

States participating: Arizona, California, Connecticut, Delaware, Florida, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Nevada, New York, North Carolina, Oregon, Pennsylvania, Texas, Vermont, Virginia, and Washington.

Claims:

Whistleblower lawsuits, filed under the federal False Claims Act and state False Claims Acts against Medco Health Solutions, Inc., alleged that Medco:

- systematically defrauded government-funded health insurance by accepting kickbacks from manufacturers in exchange for steering patients to certain products;
- secretly accepted rebates from drug manufacturers;
- secretly increased long term drug costs by switching patients away from cheaper drugs; and
- failed to comply with state-mandated quality of care standards.

Settlement:

- A preliminary settlement in April of 2004:
  - Required Medco to pay $29.1 million to participating states and affected patients;
  - Placed restrictions on the company's ability to switch drugs;

3500

- Imposed measures to increase transparency; and
- Required Medco to adopt the American Pharmacists Association code of ethics for employees.

- The final settlement, brokered in October 2006 required Medco to:
  - Pay an additional $155 million;
  - Enter into a consent degree regulating drugs switching and mandating greater transparency; and
  - Enter into a Corporate Integrity Agreement (CIA) as a condition of Medco's continued participation in government health programs.

The Corporate Integrity Agreement will expire in 2011.

2. *United States of America, et al. v. AdvancePCS, Inc. (Case No. 02-cv-09236)(E.D. Pa.)*

Filed: 2002
Settled: September 8, 2005
Damages: $137.5 million

Claims:

Whistleblower lawsuit, filed under the Federal False Claims Act, alleging that Advance PCS (now part of CVS Caremark):

- Knowingly solicited and received kickbacks from drug manufacturers in exchange for favorable treatment of those companies' products;
- Paid improper kickbacks to existing and potential customers to induce them to sign contracts with the PBM;
- Submitted false claims in connection with excess fees paid for fee-for-service agreements; and
- Received flat fee rebates for inclusion of certain heavily utilized drugs.

Settlement:

A settlement in September, 2005 required Advance PCS, Inc., to:

- Pay a $137.5 million settlement and face a five-year injunction;
- Submit to regulations designed to promote transparency and restrict drug interchange programs;
- Enter into a five-year Corporate Integrity Agreement; and
- Develop procedures to ensure that any payments between them and pharmaceutical manufacturers, clients, and others do not violate the Anti-Kickback Statute of Stark Law.

3. ***United States of America, et al v. Caremark, Inc. (Case No. 99-cv-00914)(W.D. Tex.)***

Filed: 1999
Pending as of January 2009

States participating: Arkansas, California, DC, Florida, Hawaii, Illinois, Louisiana, Massachusetts, Nevada, New Hampshire, New Mexico, North Carolina, Tennessee, Texas, Utah and Virginia.

Claims:

Filed by an ex-employee, this case was prosecuted under the Federal False Claims Act and numerous state False Claims Statutes. It alleges that Caremark (now part of CVS Caremark):

- Submitted reverse false claims to the Government in order to avoid, decrease or conceal their obligation to pay the government under several federal health insurance programs including Medicaid, Indian Health Services, and Veterans Affairs/Military Treatment Facilities.

4. ***States Attorneys General v. Caremark, Inc.***

Filed: February 14, 2008
Settled: February 14, 2008
Damages: $41 million

States participating: Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia and Washington.

Claims:

Complaint decrees and consent orders against Caremark issued by 29 Attorneys General on February 14, 2008 allege that Caremark:

- Engaged in deceptive trade practices by encouraging doctors to switch patients from originally prescribed brand drugs to different brand name drugs.
- Did not inform clients that Caremark retained all the profits reaped from these drug switches; and
- Restocked and re-shipped previously dispensed drugs that had been returned to Caremark's mail order pharmacies.

Settlement:

In conjunction with the complaints, states issued a consent decree/final judgment that required Caremark to:

- Pay a collective settlement of $41 million;
- Significantly change its business practices by imposing restrictions on drug switches and creating greater transparency;
- Apply a code of ethics and professional standards; and
- Refrain from restocking and re-shipping returned drugs unless permitted by law.

5. *State Attorneys General v. Express Scripts*

Settled: May 27, 2008
Damages: $9.3 million to states, plus up to $200,000 to affected patients

States participating: Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Iowa, Louisiana, Maine, Maryland, Massachussetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington.

Claims:

State Attorneys general settled consumer protection claims alleging that Express Scripts:

- Engaged in deceptive business practices by illegally encouraging doctors to switch their patients to different brand name drugs; and
- Illegally increased their spreads and rebates from manufacturers without passing the savings on to the plans.

Settlement:

The settlement required Express Scripts to:

- pay $9.3 million to the states, plus up to $200,000 in reimbursements to affected patients.
- Accept restrictions on drug switching practices;
- Increase transparency for plans, patients and providers; and
- Adopt a certain code of professional standards.

6. *Local 153 Health Fund v. Express Scripts (In re Express Scripts, Inc. Pharmacy Benefits Management Litigation)* (Case No. 4:05-md-01672-SNL)

Case consolidated: April 29, 2005
Pending as of January 2009

Claims:

This case, filed in the Eastern District of Missouri, alleges that Express Scripts:

- Retained undisclosed rebates from manufacturers;
- Enriched itself by creating a differential in fees;
- Failed to pass on or disclose discounted drug rates and dispensing fees;
- Gained kickbacks from drug manufacturers in exchange for favoring certain drugs on the formulary;
- Circumvented "Best Pricing" rules to artificially inflate AWP; and
- Enriched itself with bulk purchase discounts that it failed to pass on to the plaintiffs.

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Senator Bettye Davis
Chairwoman
Senate Health & Social Services Committee
Alaska State Capitol Building
Juneau, Alaska 99801

RE: SB 38 - Pharmacy Benefits Managers

Dear Chairwoman Davis and Committee Members:

I am writing to express my concerns with S.B. 38, a bill to regulate and restrict the use of pharmacy benefit services.

Express Scripts, Inc. is one of the largest pharmacy benefit management (PBM) companies in North America, providing PBM services to millions of consumers. PBMs manage prescription drug benefits for thousands of client groups, including managed-care organizations, insurance carriers, third-party administrators, employers and union-sponsored benefit plans.

Pharmacy Benefit Managers employ a variety of management tools to deliver an affordable and quality drug benefit to beneficiaries. PBMs provide purchasers a variety of tools and techniques that promote quality, improve outcomes and help drive down the cost of prescription drugs. PBMs also provide clients with clinically based services that reduce medication errors, increase compliance with drug therapies and improve health outcomes. According to a study by PricewaterhouseCoopers, pharmacy management by PBMs results in savings of 29 percent of retail prices.[1]

S.B. 38 would mandate that a PBM owe a fiduciary duty to a covered entity and require public disclosure of proprietary contract terms and conditions. (Section 21.07.100 (e); Section 21.07.125; Section 21.07.145). A study of PBM management tools shows that fiduciary mandates coupled with disclosure increases pharmacy costs by 7.1 percent.[2] PBMs simply do not fit the definition of fiduciaries under the Employee Retirement Income Security Act of 1974 (ERISA) law. PBMs perform claims processing and other ministerial tasks that do not involve discretionary control of plan assets, an essential threshold requirement for fiduciary status under ERISA. In addition, the Federal Trade Commission (FTC) has warned several states that legislation requiring PBM contract disclosure could increase costs and undermine the ability of some consumers to obtain drugs at a price they can afford. [3]

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[1] PricewaterhouseCoopers Pharmacy Benefit Management Savings in Medicare and the Commercial Marketplace & the Cost of Proposed PBM Legislation 2008-2017; March 2007.
[2] IBID
[3] FTC letter to Assemblyman Greg Aghazarian, California State Assembly (Sept. 3, 2004); FTC Letter to Delegate Terry Kilgore, Commonwealth of Virginia House of Delegates (Oct. 2, 2006).

This legislation restricts many of the tools and techniques that help manage costs and assure the appropriateness and suitability of prescribed medications, including prior authorization, drug utilization review, generic substitution, negotiated rebates and the option to use mail order. (Section21.07.100; Section 21.07.105). These tools all respect the physician's prescribing authority; PBMs do not "switch" prescriptions. Only a licensed pharmacy or pharmacist with a valid physician order can change an individual's prescription. Contrary to the assertions of some, these techniques reduce quality, recent research shows that employing behavior-centric clinical programs — strategies that help manage out waste and lower costs — can simultaneously achieve better patient compliance and improve overall beneficial use of prescription drugs. [4]

S.B. 38 mandates certain pricing terms that may look favorable in the short run, but could lead to higher long-term drug costs. (Section 21.07.130; Section 21.07.145). Specifically, the bill bans certain pricing models used by plan sponsors to align PBM financial incentives with that of the plan sponsor to lower overall costs. Plan sponsors are sophisticated purchasers and currently utilize several pricing methods with full knowledge of the financial incentives built in for PBMs. They should be able to choose the pricing model that best meets their needs.

Forty-one states and the District of Columbia currently require payment between 30-60 days. Alaska requires payment of clean claims within 30 days. S.B. 38 reduces this to 7 days (Section 21.07.120). This would significantly reduce the PBMs ability to proactively monitor for fraud and abuse and interfere with the PBM's ability to perform certain drug management techniques that are essential for consumer safety.

Finally, the bill prohibits PBMs from selectively contracting with only those providers necessary to enable the organization to provide patients with adequate access to pharmacy services, and quality, cost-effective health care (Section 21.07.100). PBMs go to great lengths to assure they have enough qualified providers in their networks so patients have adequate access to needed medical services. Any willing pharmacy laws increase costs to enrollees by disallowing efficiencies based on economies of scale and undermine PBM's ability to control the quality of clinical services provided to its members.

Now more than ever, the current state of the economy requires us to look for ways to ensure patients have access to affordable quality drug coverage. S.B. 38 would drive up overall drug expenditures and risk patient safety without any evidence of clinical benefit to the consumer.

Sincerely,

Michael Harrold
Senior Director, State Government Affairs

[4] Behavioral Economics on Medication Compliance; Emily Cox; American Journal of Managed Care, December 2008.

SB 38

Senate Health & Social Services Committee

Friday, April 3, 2009

Testifiers

Calling in (1-888-295-4546):

- Gerry Purcell, Pharmacy Partners
- David Balto, American Progress

In Person:

- Dirk White, Pharmacist/Board of Pharmacy

Calling in:

- Ron Miller, Pharmacist, Carrs-Safeway
- Kim West, Pharmacist, Fred Meyer
- Jerry Brown, Pharmacist
- Barry Christensen, Pharmacist/Chair, Alaska Pharmacists Association

Bio

pharmacy PARTNERS

Achieving Optimal Pharmacy Value©

Gerry Purcell
Managing Partner

Since 1998, Gerry Purcell has become a nationally recognized heath care reformer, speaker and thought leader calling for full disclosure and transparency in health care spending. His primary focus has been in the fast growing area of Pharmacy Benefit Manager (PBM) revenues. He advocates on behalf of commercial, union and public sector plans, assisting them in managing their pharmacy programs and expenditures. He has led the charge in requiring PBMs to properly disclose, manage and account for plan assets where a fiduciary and/or a good faith duty exists.

Gerry ignited a national discussion with his 1998 article, "A Cost Effective Guide To Pharmacy Benefits", about the hidden practices PBMs have utilized for years to inflate pharmacy costs and derive excessive profits. Gerry authored the article with an insider's vantage point while serving as a sales manager for a leading public sector PBM. The article quickly gained national attention and was published in *Employee Benefit News, Benefit Solutions* and nine other health related publications.

Gerry is frequently interviewed by national news organizations to include being featured in the August 12, 2002 issue of *US News & World Report*, which exposed questionable PBM practices. He has served as a panelist in town hall debates moderated by Fox News' Chris Wallace and NBC's Forrest Sawyer.

In addition to work in the private sector, Gerry is frequently asked to offer insight to state executive and legislative entities and to testify before both federal and state legislative bodies, most recently in Georgia, New York, Oklahoma, Texas and Virginia. He has briefed Department of Justice attorneys and given confidential executive briefings to more than a dozen State Attorneys Generals on the subject of pharmacy benefits, and evaluated their respective state programs. He has worked extensively, on retainer, in support of the multi-state Attorneys Generals litigation against a major PBM regarding reimbursement of Medicaid claims; with estimated damages reported at potentially $500 million.

Gerry assists states, cities and private plans in selecting and contracting the best PBM, negotiating optimal contracts with pharmacies and drug manufacturers, selecting benefit designs, evaluating formularies, maximizing drug manufacturer rebate strategies and rebate migration, auditing, and litigation strategies. He is actively involved in assessing PBM business practices and the potential financial damages and overcharges as a result of their practices. He has evaluated hundreds of plan sponsor agreements, thousands of pages of PBM documents to include agreements with drug manufacturers and network pharmacies, and collaborated with the top PBM consultants and auditors in the United States for the purpose of developing a baseline model to determine potential overcharges, and ultimately the optimal contracting terms.

Gerry's efforts, along with other full disclosure advocates, are yielding substantial savings and recoveries for clients and are beginning to change PBM practices nationally.

Prior to working in the PBM industry and forming Pharmacy Partners, Gerry worked in the managed care industry with Kaiser Permanente. Prior to Kaiser, he served in several supervisory positions with multi-million dollar profit and loss responsibility to include Mobil Oil Corporation and six years as an Army intelligence officer. In 1980, he served as National President of the 300,000 member Vocational Industrial Clubs of America (VICA). In this capacity, he worked closely with corporate and union leaders and educators to prepare young people to enter trade and industrial industries.

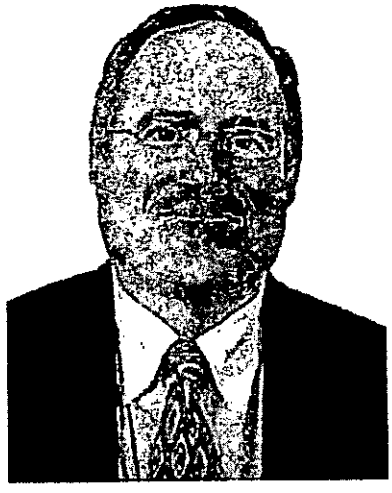
Gerry graduated with honors from the U.S. Army Intelligence Center and School and is a Distinguished Military Graduate of Chaminade University of Honolulu.

Gerry can be reached in his Atlanta office at 404.783.2020 or via email at gerrypurcell@mac.com.

Center for American Progress

David Balto

Senior Fellow



High-resolution Image

David Balto is a Senior Fellow at American Progress focusing on competition policy, intellectual property law, and health care. He has over 20 years of experience as an antitrust attorney in the private sector, the Antitrust Division of the Department of Justice, and the Federal Trade Commission. He is nationally known for his expertise in competition policy in high tech industries, semiconductors, health care, pharmaceuticals, medical devices, media, and financial services. He regularly provides advice on mergers, strategic alliances, and joint ventures.

From 1995-2001 he was the policy director of the Bureau of Competition of the Federal Trade Commission and attorney advisor to Chairman Robert Pitofsky. In these leadership roles Mr. Balto was a senior advisor in developing competition policy and identifying key enforcement initiatives. He helped draft guidelines involving intellectual property, joint ventures, and health care. He played a key role in several litigated cases, including the challenges to the Staples/Office Depot and Heinz/Beechnut mergers, the Intel monopolization case, and the challenges to anticompetitive conduct by several pharmaceutical companies. He is the only person to twice win the FTC's award for outstanding scholarship and won the FTC's award for distinguished service, the highest award given a staff attorney.

Mr. Balto has authored more than 60 articles about competition policy focusing on intellectual property, health care, pharmaceuticals, financial services, and mergers. He regularly testifies before Congress, state legislatures, the FTC, and DOJ. He has authored numerous amicus briefs for consumer groups in seminal antitrust cases.

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Articles by David Balto

- Live Nation Ticketmaster Merger Is Too Good To Be True, March 16, 2009
- A Progressive Agenda for Antitrust Enforcement at the Antitrust Division, March 10, 2009
- Processor Wars Speed into Court, February 25, 2009
- The Ticketmaster-Live Nation Merger: What Does It Mean for Consumers and the Future of the Concert Business?, February 24, 2009
- An Open Letter to the Next Federal Trade Commission Chairman, February 23, 2009
- Bringing Back Antitrust Law, February 16, 2009
- A Perfect Storm, January 16, 2009
- What Bank Mergers Mean for Credit Cards, December 16, 2008
- Merge Not: A Highmark-IBC merger would handcuff health-care reform, December 10, 2008
- Reject Pennsylvania Insurance Merger, November 26, 2008
- Reject Pa. insurance merger, November 26, 2008
- Reviving Competition in Health Care Markets, October 17, 2008

TESTIMONY OF DAVID BALTO,
ANTITRUST ATTORNEY
SENIOR FELLOW
CENTER FOR AMERICAN PROGRESS ACTION FUND
FORMER POLICY DIRECTOR, FEDERAL TRADE COMMISSION

Hearing on Senate Bill No. 38: On Health Care Provider and Patient Protection
Senate Health & Social Services Committee
Alaska Senate
April 3, 2009

Distinguished members of the Alaska Senate, thank you for this opportunity to testify today regarding the use, and misuse of Pharmaceutical Benefit Managers ("PBMs") and the need to enact legislation to protect patients and providers. My testimony today presents a brief overview based on my over 25 years as an antitrust attorney and enforcer. I conclude that: (1) there is a significant problem involving PBMs, due to the concentration in the market, deceptive practices and lack of transparency; (2) because of the market power of PBMs pharmacies are compelled to participate in pharmacy benefit networks at extremely low reimbursement rates, leading to a reduction in pharmacy services for consumers; (3) market forces alone will not correct these problems; (4) litigation will not adequately address the issues; (5) the FTC report on PBM self-dealing is critically flawed; and (6) legislation is the appropriate solution for the competitive and deceptive practices in the market. I strongly believe that Senate Bill No. 38 is an appropriate response to these competitive and consumer protection problems.

I have practiced antitrust law for over 25 years both in the government and in private practice. Prior to entering private practice, I was at the Federal Trade Commission for almost a decade in several senior positions. I was the Assistant Director of the Office of Policy and Evaluation for the Bureau of Competition of the Federal Trade Commission and attorney advisor to Chairman Robert Pitofsky. In these positions, I was a senior advisor in the FTC's merger and non-merger enforcement program. I was involved in the drafting and issuance of the FTC and

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DOJ Statements of Antitrust Enforcement Policy in Healthcare. I also assisted in the litigation of numerous monopolization cases as well as challenges to anticompetitive and exclusionary conduct by several health care companies. I am also a Senior Fellow at the Center for American Progress, where my work focuses on competition and health care reform.

During my tenure at the FTC PBMs began to arise and become a more significant competitive force. PBMs offered the potential for significant cost savings and other benefits. However, this depended upon whether market forces could function in an unimpeded fashion. In order for a market to function competitively two factors are crucial: choice and information. If either is lacking then government enforcement or regulation may be necessary. That is why the FTC acted in the 1990s to require restructuring of the Merck's acquisition of the Medco PBM, and Lilly's acquisition of the PCS PBM.

I have been in private practice for the past several years working extensively on healthcare antitrust issues. I counsel a wide variety of firms on pharmaceutical regulatory and antitrust issues. My clients include all types of participants in the PBM market including chain and independent pharmacies, plan sponsors, insurance companies and Pharmacy Benefit Managers.[1]

State legislatures around the country – as well as the U.S. Congress itself – have been searching for ways to stem dramatically rising healthcare costs. In recent years this has grown from a serious concern to a pressing crisis. Many proposals involve Pharmaceutical Benefit Managers as a promising way to increase efficiency and lower costs. PBMs provide a number of valuable services, including managing formularies and negotiating lower prices with pharmaceutical companies.

Although PBMs offer a great deal of promise in terms of controlling pharmaceutical costs, there is a pattern of conflicts of interest, self-dealing and anticompetitive conduct, which ultimately means that Alaska consumers pay far more for drugs than necessary. The dominant

[1] My views today reflect my own views and not those of any client.

PBMs have been plagued with opaque business practices, limited market competition and widespread allegations of fraud. Senator Montigny, Chair of the Board of The National Legislative Association on Prescription Drug Prices (NLARx), says "we know of no other market in which there has been such a significant number of prominent enforcement actions and investigations, *especially a market with such a significant impact on taxpayers.*"[2] The facts are clear: while PBMs may well prove a necessary expedient in lowering the cost of healthcare, measures must be taken to ensure that they operate as they are supposed to.

PBMs in their current form pose a serious financial problem for the state of Alaska and its consumers. While PBMs are in a position to negotiate low prices from pharmaceutical manufacturers, a lack of transparency makes this a dubious proposition. Even if PBMs receive significant revenue from pharmaceutical manufacturers; it is increasingly unclear the degree that these rebates reduce costs for the PBM's clients. Therefore, the very same aspect of the PBM that should create savings also contains an inherent conflict of interest. A review of the considerable federal and state litigation against PBMs reveals several recurring issues:

(1) conflicts of interest because PBMs both manage drug benefits and dispense drugs;

(2) the exercise of monopsony power harming pharmacies and reducing pharmacy services for consumers;

(3) improper prescription drug switching to a higher priced drug without medical justification and without the authorization of the prescribing physician;

(4) failing to disclose and pass on the full extent of rebates and other incentives received from drug manufacturers, and failing to pass through such discounts to pharmacies and consumers; and,

(5) price fixing.

The tremendous amount of litigation by employers, insurers, consumer groups and others against PBMs demonstrates the extent of the financial problem, fundamentally stemming from the lack of transparency. Regulation to create some sort of market transparency is crucial to the proper

[2] Letter from Senator Mark Montigny, on behalf of NLARx, to Deborah Platt Majoras, FTC Chair, May 11, 2005.

functioning of this market. The First Circuit Court of Appeals that upheld Maine's regulatory statute noted that PBMs "introduce a layer of fog to the market that prevents benefits providers from fully understanding how to best minimize their net prescription drug costs." Over the past four years, more than twenty states either have passed or are considering regulation of PBMs to address these problems. The State of Alaska should seriously consider legislation to alleviate the same opaque conditions that have already cost so much to so many.

PBMs harm consumers by using their market power to reduce compensation to pharmacies. As noted below the PBM market is highly concentrated and that enables them to exercise "monopsony" or buyer power to reduce compensation to the pharmacies that provide dispensing services. Although a reduction in compensation may appear attractive from the perspective of a buyer of PBM services, that attraction is misleading. The savings from reducing compensation is not passed on to buyers in lower prices because of the market power of PBMs. Moreover, ultimately the consumer of drugs is harmed because there are fewer pharmacies available or other forms of pharmacy services diminish.[3]

This is a particularly severe problem in largely rural states such as Alaska. Consumers value convenience and the ability to visit community pharmacies for face to face service. The interest of PBMs is to lower compensation to the minimal level (or even less) to drive pharmacies out of the market. PBMs have an inherent conflict of interest because they dispense drugs through their own mail order operations.

In Alaska, there is a chronic problem with PBMs either paying pharmacies late or manipulating the PBM claims process. Senate Bill No. 38 addresses this problem by requiring the timely payment of claims and limiting the ability of PBMs to manipulate claims processing.

Market forces and litigation are not the solution to this problem. PBMs consistently claim that market forces have taken or will take care of any problems. Clients are sophisticated, and can sufficiently ensure that their plans save money. The PBMs therefore contend that no

[3] 3] This monopsony power that PBMs enjoy is similar to that of health insurers, which have the ability to impose take-it-or-leave it contracts on physicians.

supervision is needed. Furthermore, they pretend, the litigation that has already occurred has been sufficient to iron out any difficulties with the current structure. Both of these arguments are critically flawed.

Market forces are not a complete solution. First of all, the PBM market is highly concentrated. The three largest PBMs (Caremark, Express Scripts, and Medco) control over 80% of insured prescriptions and 90% of insured mail order prescriptions... Furthermore, high barriers to entry insulate the market from potential competition. Meanwhile, the PBMs dismiss the issue by saying that clients are competent enough not to lose money. Indeed, those who have the resources for monitoring the PBMs have in some cases done so, and prosecution has been the frequent result.

Indeed, there have been market-driven reforms, such as contract negotiations which involve a degree of transparency similar to that of proposed legislation. This again relies on clients, however, to have sufficient resources for researching and sufficient leverage for negotiating such a contract. Clearly, PBMs are willing to accept transparency when necessary; though they will fight tooth and nail to avoid it whenever possible.

Litigation is not a complete solution. Proponents of PBMs may argue that if there are competitive problems or deceptive practices they will be cured by litigation. Certainly there are numerous antitrust, fraud and consumer protection cases ongoing. But as the Senate knows all too well, litigation is expensive and time-consuming. Some of these cases have been pending for several years. And the ultimate resolution of these cases will cure a single problem in the past. Litigation is too episodic, slow and expensive to be a cure all

Each of the major PBMs has been the subject of a major enforcement action brought by a coalition of state attorneys generals and in some cases by the Department of Justice. These cases have secured over $370 million of penalties and damages. And numerous settlement agreements involving varying degrees of information disclosure strongly recommend transparency as a reasonable solution to the problem. (A list of the respective cases is attached.)

For example, in September 2005, AdvancePCS (acquired by Caremark) agreed to a $137.5 million fine and a five-year injunction and settlement agreement with the United States Department of Justice. The allegations against AdvancePCS included receiving kickbacks from pharmaceutical manufacturers, improper therapeutic substitutions, as well as making false claims to the government. One key provisions of the settlement agreement was – unsurprisingly – disclosure to client plans of all information reasonably necessary to audit contract compliance.

Perhaps most importantly, recent litigation upheld a Maine law addressing these issues. In *PCMA v. Maine*, PBMs attempted to strike down a Maine statute that required them to disclose information regarding rebates from pharmaceutical manufacturers. The federal district court granted summary judgment in favor of Maine on all claims.[4] Furthermore, the First Circuit Court of Appeals upheld this decision unanimously. Judge Torruella of the First Circuit wrote, "If PBMs truly assumed that they would be free from disclosure requirements of the sort set forth in the Maine law here, this would be more wishful thinking than reasonable expectation. Whether or not the law strikes the right economic balance between competing producer and consumer interests, it is no more a taking than the requirement that public corporations disclose private corporate information about financial prospects to the public through regular SEC filings." In this context, it is easy to understand why so many states are considering saving themselves millions of dollars by demanding PBM transparency from the outset.

Senate Bill No. 38 attempts to address two problems identified in the past government enforcement actions. First, the Bill attempts to protect patients from unwarranted so-called "therapeutic substitutions." The government enforcement actions found that PBMs often compel patients to switch drugs, not because a drug is preferable or less costly, but because the PBM receives a greater rebate for the new drug. Senate Bill No. 38 requires the PBM to secure the approval of the prescriber to substitute the drug and informed the patient of the substitution and the reason for the substitution. (Section 21.07.130).

[4] Pharmaceutical Care Management Association (PCMA) v. Rowe, Civil No. 03-153-B-H (April 2005)(at 4-5)

Second, PBMs are often reluctant to provide information to covered entities on the sources and amounts of compensation and rebates they receive from pharmaceutical manufacturers. This lack of information allows the PBMs to secure new sources of revenue by failing to disclose the amount of revenue they secure or engaging in spread pricing. Transparency is essential for covered entities to make sure they receive the best price from their PBM and the provisions in the Bill will result in greater competition and cost savings.

Greater efficiency and ability to control costs are within reach. American healthcare is changing rapidly, and PBMs have become an important element in healthcare management. Legislation is absolutely necessary to ensure that this arrangement turns out to be a blessing and not a curse. If transparency and a fiduciary duty are mandated for PBMs, there will be little chance for them to defraud their clients and the state of Alaska with conflicts of interest or cryptic closed-door financial dealings. With careful legislation that actually allows market forces to work, the rising costs of pharmaceuticals can be at least in some considerable measure abated.

I appreciate the opportunity to provide this testimony and would be pleased to answer any questions.

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SB

46

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Judiciary
Finance

Don't fill in leave out

Date of 5-Day Notice: Waive Blank
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: _____

Health and Social Services Committee considered SENATE BILL NO. 46

SB 46 CHILD SUPPORT AWARDS

"An Act relating to child support awards made by a court; and repealing Rule 90.3, Alaska Rules of Civil Procedure."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB46 ~~[illegible]~~ (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[X] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

Corrected from Referral

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
Rev	2/28/10			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
J. J. Thomas	THOMAS	✓			
Joe Ellis	ELLIS	✓			
Joe Paskvan	PASKVAN	X			
Fred Dyson	DYSON	✓			
CHAIR: Bettye Davis	DAVIS	✓			

26-LS0279\P
Mischel
3/3/10

CS FOR SENATE BILL NO. 46(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR KOOKESH

A BILL

FOR AN ACT ENTITLED

"An Act relating to child support awards; and repealing Rule 90.3, Alaska Rules of Civil Procedure."

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

*** Section 1.** AS 25 is amended by adding a new chapter to read:

Chapter 28. Child Support Awards.

Sec. 25.28.010. Guidelines; primary physical custody. (a) A tribunal shall calculate a child support award in a case in which one parent is awarded primary physical custody as an amount equal to the adjusted annual income of the noncustodial parent multiplied by a percentage specified in (b) of this section.

(b) To calculate the child support award, the tribunal shall multiply the noncustodial parent's adjusted annual income by the following percentages:

(1) 20 percent for one child;

(2) 27 percent for two children;

(3) 33 percent for three children; and

New Text Underlined *[DELETED TEXT BRACKETED]*

(4) an additional three percent for each additional child.

(c) The tribunal may allow the obligor parent to reduce child support payments by up to 75 percent for a period in which the obligor parent has extended visitation of more than 27 consecutive days. The order must specify the amount of the reduction that is allowable if the extended visitation is exercised.

(d) The tribunal may calculate child support based on a determination of the potential income of a parent who voluntarily and unreasonably is unemployed or underemployed. A determination of potential income may not be made for a parent who is physically or mentally incapacitated, or who is caring for a child under two years of age to whom the parents owe a joint legal responsibility. Potential income shall be based on the parent's work history, qualifications, and job opportunities. The tribunal also may impute potential income for nonincome producing or low income producing assets.

(e) In this section, "adjusted annual income" means the parent's total income from all sources less

(1) mandatory deductions, including

(A) federal, state, and local income tax;

(B) social security tax or the equivalent contribution to an alternate plan established by a public employer, and self-employment tax;

(C) Medicare tax;

(D) mandatory union dues;

(E) mandatory contributions to a retirement or pension plan;

(2) voluntary contributions to a retirement or pension plan or account in which the earnings are tax-free or tax-deferred, except that the total amount of these voluntary contributions plus any mandatory contributions under (1)(E) of this subsection may not exceed 7.5 percent of the parent's gross wages and self-employment income;

(3) child support and alimony payments arising from previous relationships that are required by another tribunal and actually paid;

(4) child support for children from prior relationships living with the parent, calculated by using the formula under this chapter; and

(5) work-related child care expenses for the child who is the subject of the child support order.

Sec. 25.28.020. Guidelines; shared, divided, and hybrid custody awards. (a) The tribunal shall calculate shared, divided, and hybrid physical custody awards as provided in this section.

(b) The tribunal shall calculate a child support award in a case in which the parents are awarded shared physical custody by

(1) calculating the annual amount each parent would pay to the other parent under AS 25.28.010 assuming the other parent had primary custody; in this calculation, the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d) apply;

(2) multiplying the amount determined under (1) of this subsection for each parent by the percentage of time the other parent has physical custody of the child; however, if the tribunal finds that the percentage of time each parent will have physical custody does not accurately reflect the ratio of funds each parent will directly spend on supporting the child, the tribunal shall vary this percentage to reflect its findings;

(3) determining which parent has the greater amount under (2) of this subsection; the parent with the greater amount under (2) of this subsection is the obligor parent, and the annual award is equal to the difference between the two amounts under (2) of this subsection multiplied by 1.5; however, if this amount is greater than the amount of support calculated under AS 25.28.010 assuming the obligor parent has primary custody, the annual support is the amount calculated under AS 25.28.010.

(c) The child support award for shared custody under (b) of this section must be paid in 12 equal monthly installments, except that if

(1) shared custody is based on the obligor parent's having physical custody for periods of 30 consecutive days or more, the total annual award may be paid in equal installments over those months in which the obligor parent does not have physical custody; or

(2) the obligor parent's income is seasonal, the tribunal may order

unequal monthly support payments as provided in AS 25.28.030(g) and (h).

(d) The child support order must state that failure to exercise sufficient physical custody to qualify for shared physical custody under (b) or (c) of this section is grounds for modification of the child support order. Denial of visitation by the custodial parent is not cause to increase a child support award.

(e) The tribunal shall

(1) calculate a child support award in a case in which the parents are awarded divided custody by determining the amount each parent would pay to the other parent for support of a child for whom that parent has primary physical custody under AS 25.28.010, taking into account the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d), and offsetting those amounts; and

(2) consider whether the amount determined under (1) of this subsection should be varied under AS 25.28.030(b).

(f) The tribunal shall

(1) calculate a child support award in a case in which the parents are awarded hybrid custody by

(A) applying AS 25.28.010, taking into account the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d), to determine support for a child in the primary physical custody of each parent;

(B) applying (b) of this section to determine support for a child in the shared physical custody of the parents;

(C) adjusting pro rata the percentages provided in AS 25.28.010(b) based on the number of children to which each type of custody applies; and

(D) combining the amounts to determine the net obligation; and

(2) consider whether the amount determined under (1) of this subsection should be varied under AS 25.28.030(b).

Sec. 25.28.030. Exceptions to support awards. (a) Notwithstanding the requirements in AS 25.28.010 and 25.28.020, the tribunal may vary the award for the reasons stated in this section.

(b) The tribunal may vary the child support award as calculated under the other provisions of this chapter for good cause on proof by clear and convincing evidence that manifest injustice would result if the support award were not varied. The tribunal shall specify in writing the reason for the variation, the amount of support that would have been required but for the variation, and the estimated value of any property conveyed instead of support calculated under the other provisions of this chapter. Good cause may include a finding that unusual circumstances exist that require variation of the award in order to award an amount of support that is just and proper for the parties to contribute toward the nurture and education of their children. The tribunal shall consider the custodial parent's income in this determination.

(c) The calculation for primary physical custody under AS 25.28.010 does not apply to the extent that the parent has an adjusted annual income of more than ~~$105~~,000. The tribunal may make an additional award only if it is just and proper, ~~taking into account~~ the needs of the child, the standard of living of the child, and the extent to which that standard should reflect the supporting parent's ability to pay.

(d) Except as provided in AS 25.28.010(c) and 25.28.020, the minimum child support amount that may be ordered is $50 a month or $600 a year.

(e) In addition to ordering a parent to pay child support as calculated under this chapter, the tribunal may, in appropriate circumstances and when the parents are minors as described in (f) of this section, order one or more grandparents of a child to pay child support to an appropriate person in an amount determined by the tribunal to serve the best interests of the child; however, the amount may not exceed the lesser of

(1) a proportionate share of the amount required to provide care in a supervised setting to the grandchild, as determined by the tribunal; or

(2) the amount that would have been awarded if the child's parents had the incomes of the child's grandparents and AS 25.28.010 and 25.28.020 were applied.

(f) An order under (e) of this section may be issued only with respect to a child whose parents are both minors, and the order terminates when either parent becomes 18 years of age. The tribunal shall specify in writing the reasons it considers it to be appropriate to order a grandparent to pay child support under this subsection and the factors considered in setting the amount of the child support award. In this

subsection, "grandparent" means the natural or adoptive parent of the minor parent.

(g) If the noncustodial parent's income is seasonal, the tribunal may order that the annual support amount be paid in unequal monthly payments, with higher payments during the months the parent expects to receive higher income and lower payments in other months; the tribunal may not make an unequal payment order unless

(1) the tribunal finds that the burden of budgeting for periods of unequal income should be placed on the obligee rather than the obligor; and

(2) the obligee agrees.

(h) An order of the tribunal for unequal payments under (g) of this section must specify the annual support amount, the average monthly support amount, and the amount due for each month. The order must provide that variations from the average monthly amount begin with monthly payments in excess of the average monthly amount so that a deficit situation cannot occur. Until the excess payments begin, the tribunal shall order payment of the average monthly amount.

Sec. 25.28.040. Health care expenses. (a) The tribunal shall include in the order coverage of the child's health care needs and require health insurance for the child if insurance is available to either parent or both parents at a reasonable cost. The tribunal shall consider whether the child is eligible for services through the Indian Health Service, any other entity, or other insurance coverage before ordering either parent or both parents to provide health care coverage through insurance, cash medical support, or other means. A court shall find that health insurance is available only if the ~~dependent child has reasonable geographic access~~ to the covered services or the insurance includes the coverage of transportation needed for the services.

~~(b) The tribunal shall allocate equally the cost of insurance and cash~~ medical support between the parents unless the tribunal orders otherwise for good cause. An obligor's child support obligation shall be decreased by the amount of the obligee's portion of health insurance payments and cash medical support ordered by the tribunal and actually paid by the obligor. The tribunal shall increase a child support award by the obligor's portion of health insurance if the obligee is ordered to, and actually does, obtain and pay for insurance.

(c) The cost of insurance is the cost attributable to the child for whom support

is paid. If the cost to the employee of covering the employee alone is the same as the cost to the employee of covering the employee and dependents, then there is no additional cost to the employee for adding the child and no portion of the cost of coverage may be allocated to the child. If dependent coverage can be added for a single cost, rather than for each dependent, and the dependent coverage covers dependents in addition to the child subject to the order, the cost of the dependent coverage shall be allocated equally among the dependents covered. If there is reason to believe that there is an incremental cost to the employee for insuring dependents but evidence of that incremental cost is unavailable, the cost of insurance is determined by dividing the total cost of coverage by the number of family members covered and multiplying that amount by the number of children subject to the order.

(d) The tribunal shall allocate equally between the parties the cost of reasonable health care expenses not covered by insurance unless the tribunal orders otherwise for good cause. A party shall reimburse the other party for the party's share of the uncovered health care expenses within 30 days after receipt of the bill for the health care, payment verification, and, if applicable, a health insurance statement indicating what portion of the cost is uncovered. The tribunal shall allocate the reasonable, uncovered health care expenses exceeding $5,000 in a calendar year based on the parties' relative financial circumstances when the expenses occur.

(e) A court shall find that the cost of cash medical support or private health insurance is reasonable under this section if the cost to the responsible parent does not exceed five percent of the responsible parent's gross income. In calculating the percentage for purposes of health insurance coverage, the cost is the cost of adding the dependent child to the existing insurance coverage or the difference between self-only and family coverage.

(f) In this section,

(1) "cash medical support" means an amount ordered to be paid toward the cost of health insurance provided by a public entity or by another parent through employment or otherwise, or for other medical costs not covered by insurance;

(2) "health care expenses" includes medical, dental, vision, and mental health counseling expenses.

Sec. 25.28.050. Child support affidavit and documentation. (a) Subject to the confidentiality requirements of Rule 90.1(f), Alaska Rules of Civil Procedure, each parent in a proceeding of a tribunal at which child support is involved shall file a statement under oath that states the parent's adjusted annual income and the components of adjusted annual income as described in AS 25.28.010(e). This statement must be filed with a party's initial pleading in superior court, including the dissolution petition, divorce complaint or answer, motion to modify, and any response to a motion to modify, and must be accompanied by documentation verifying the income. The documents must be redacted to delete social security numbers and to provide only partial financial account information as provided in Rule 90.1(f), Alaska Rules of Civil Procedure. The statement must state whether the parent has access to health insurance for the children and, if so, the additional cost to the parent of the children's health insurance.

(b) While there is an ongoing monthly support obligation, each party shall provide to the other party, within 30 days after a written request, documents such as tax returns and pay stubs showing the party's income for the prior calendar year. The party making the request shall provide documentation of the party's annual income for the same period at the time the request is made. A request under this section may not be made more than once a year. This section does not preclude discovery under the Alaska Rules of Civil Procedure.

(c) Unless the information has already been provided to the tribunal under Rule 90.1(f), Alaska Rules of Civil Procedure, a statement under (a) of this section must be accompanied by a confidential information sheet as described in Rule 90.1, Alaska Rules of Civil Procedure. Once a complete confidential information sheet has been submitted to the tribunal listing names, dates of birth, and social security numbers as required, the parties shall omit or redact social security numbers from documents subsequently filed in the action unless otherwise ordered by the tribunal.

(d) The tribunal may withhold or assess costs or attorney fees for a violation of this section as the circumstances and discouragement of like conduct in the future may require. Costs and attorney fees may be imposed on offending attorneys or parties.

Sec. 25.28.060. Travel expenses. After determining an award of child support under this chapter, the court shall allocate between the parties reasonable travel expenses that are necessary to exercise visitation as may be just and proper for the parties to contribute.

Sec. 25.28.070. Modification; defense against arrearages. (a) A tribunal may modify a final child support award on a showing of a material change of circumstances as provided by state law. A material change of circumstances shall be presumed if support as calculated under this chapter is more than 15 percent greater or less than the outstanding support order. An award may be modified to require cash medical support regardless of whether insurance is available to either parent if neither parent has purchased health insurance. In this subsection, support includes health insurance payments ~~or cash medical~~ support made under AS 25.28.040.

(b) A court may not modify a child support arrearage retroactively, except as authorized by AS 25.27.166(d). A modification that is effective on or after the date that a motion for modification, or a notice of petition for modification by the child support services agency, is served on the opposing party is not considered a retroactive modification.

(c) The tribunal may find that a parent and a parent's assignee are precluded from collecting arrearages for support of a child that accumulated during a time period exceeding nine months for which the parent agreed or acquiesced to the obligor exercising primary custody of the child. A finding that preclusion is a defense must be based on clear and convincing evidence.

Sec. 25.28.080. Third-party custody. (a) When the state, or another third party entitled to child support, has custody of all children of a parent, the parent's support obligation to the third party is an amount equal to the adjusted annual income of the parent multiplied by the percentage specified in AS 25.28.010(b). If the third party has custody of some but not all children, the parent's support obligation to the third party is an amount equal to the adjusted annual income of the parent, multiplied by the percentage specified in AS 25.28.010(b) for the total number of the parent's children, multiplied by the number of the parent's children in third-party custody, divided by the total number of the parent's children. In this subsection, the number of

the parent's children includes only children of the parent who live with the parent, are substantially supported by the parent, or are in custody of the third party entitled to support.

(b) If, in addition to a support obligation to a third party, one or both parents retain primary or shared physical custody of at least one of their children, the support obligation between the parents is calculated under the other provisions of this chapter, without consideration of the third-party custodian or any children in the custody of the third-party custodian, except that the percentage in AS 25.28.010(b) must be adjusted pro rata for the number of children in the primary custody of a parent, or shared custody of the parents, compared to the total number of children. After that calculation is completed, any support owed may be offset with support owed to a third-party custodian under (a) of this section in order to minimize transactions.

Sec. 25.28.090. Support order forms. All orders for payment or modification of child support shall be entered on a form developed by the administrative director of the tribunal. A party may lodge a duplicate of the tribunal form produced by a laser printer or similar device. A device may also print, in a contrasting typestyle equivalent to that produced by a typewriter, text that otherwise would have been entered by a typewriter or word processor. A party or attorney who lodges a duplicate certifies by lodging the duplicate that it is identical to the current version of the court form.

Sec. 25.28.100. Dependent tax deduction. The court may allocate the dependent tax deduction for each child between the parties as is just and proper and in the child's best interests. The allocation must be consistent with AS 25.24.152 and federal law.

Sec. 25.28.300. Definitions. In this chapter,

(1) "child support" and "child support obligation" have the meaning given "duty of support" in AS 25.27.900;

(2) "divided custody" means that one parent has primary physical custody of one or more children of the relationship and the other parent has primary custody of one or more other children of the relationship, and the parents do not share physical custody of any of their children;

(3) "hybrid custody" means that at least one parent has primary

physical custody of one or more children of the relationship, and the parents have shared physical custody of at least one child of the relationship;

(4) "primary physical custody" or "primary custody" means that a child resides with the other parent for a period, specified in the custody order, of less than 30 percent of the year;

(5) "shared physical custody" or "shared custody" means that a child resides with one parent for a period, specified in writing in the custody order, of at least 30 percent but not more than 70 percent of the year, regardless of the status of legal custody;

(6) "tribunal" means the superior court or the child support services agency created in AS 25.27.010.

*** Sec. 2.** AS 47.10.120(a) is amended to read:

(a) When a child in need of aid is committed under this chapter, the court or the child support services agency created in AS 25.27.010 shall, after giving the parent a reasonable opportunity to be heard, require that the parent pay to the department in a manner that the court or the child support services agency directs a sum to cover in full or in part the maintenance and care of the child. The support obligation shall be calculated under **AS 25.28** [RULE 90.3(i) OF THE ALASKA RULES OF CIVIL PROCEDURE].

*** Sec. 3.** AS 47.12.230(a) is amended to read:

(a) When a delinquent minor is committed under this chapter, the court or the child support services agency created in AS 25.27.010 shall, after giving the parent a reasonable opportunity to be heard, require that the parent pay to the department in a manner that the court or the child support services agency directs a sum to cover in full or in part the maintenance and care of the minor. The support obligation shall be calculated under **AS 25.28** [RULE 90.3(i) OF THE ALASKA RULES OF CIVIL PROCEDURE].

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REPEAL OF COURT RULE. Rule 90.3, Alaska Rules of Civil Procedure, is repealed.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

NONAPPLICABILITY OF TWO-THIRDS VOTE REQUIREMENT. Because the rule repealed in sec. 4 of this Act is a substantive rule rather than a rule of practice or procedure, the repeal of the rule takes effect even if sec. 4 of this Act does not receive the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

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CS FOR SENATE BILL NO. 46( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR KOOKESH

A BILL

FOR AN ACT ENTITLED

"An Act relating to child support awards; and repealing Rule 90.3, Alaska Rules of Civil Procedure."

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

*** Section 1.** AS 25 is amended by adding a new chapter to read:

Chapter 28. Child Support Awards.

Sec. 25.28.010. Guidelines; primary physical custody. (a) A tribunal shall calculate a child support award in a case in which one parent is awarded primary physical custody as an amount equal to the adjusted annual income of the noncustodial parent multiplied by a percentage specified in (b) of this section.

(b) To calculate the child support award, the tribunal shall multiply the noncustodial parent's adjusted annual income by the following percentages:

(1) 20 percent for one child;

(2) 27 percent for two children;

(3) 33 percent for three children; and

(4) an additional three percent for each additional child.

(c) The tribunal may allow the obligor parent to reduce child support payments by up to 75 percent for a period in which the obligor parent has extended visitation of more than 27 consecutive days. The order must specify the amount of the reduction that is allowable if the extended visitation is exercised.

(d) The tribunal may calculate child support based on a determination of the potential income of a parent who voluntarily and unreasonably is unemployed or underemployed. A determination of potential income may not be made for a parent who is physically or mentally incapacitated, or who is caring for a child under two years of age to whom the parents owe a joint legal responsibility. Potential income shall be based on the parent's work history, qualifications, and job opportunities. The tribunal also may impute potential income for nonincome producing or low income producing assets.

(e) In this section, "adjusted annual income" means the parent's total income from all sources less

(1) mandatory deductions, including

(A) federal, state, and local income tax;

(B) social security tax or the equivalent contribution to an alternate plan established by a public employer, and self-employment tax;

(C) Medicare tax;

(D) mandatory union dues;

(E) mandatory contributions to a retirement or pension plan;

(2) voluntary contributions to a retirement or pension plan or account in which the earnings are tax-free or tax-deferred, except that the total amount of these voluntary contributions plus any mandatory contributions under (1)(E) of this subsection may not exceed 7.5 percent of the parent's gross wages and self-employment income;

(3) child support and alimony payments arising from previous relationships that are required by another tribunal and actually paid;

(4) child support for children from prior relationships living with the parent, calculated by using the formula under this chapter; and

(5) work-related child care expenses for the child who is the subject of the child support order.

Sec. 25.28.020. Guidelines; shared, divided, and hybrid custody awards. (a) The tribunal shall calculate shared, divided, and hybrid physical custody awards as provided in this section.

(b) The tribunal shall calculate a child support award in a case in which the parents are awarded shared physical custody by

(1) calculating the annual amount each parent would pay to the other parent under AS 25.28.010 assuming the other parent had primary custody; in this calculation, the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d) apply;

(2) multiplying the amount determined under (1) of this subsection for each parent by the percentage of time the other parent has physical custody of the child; however, if the tribunal finds that the percentage of time each parent will have physical custody does not accurately reflect the ratio of funds each parent will directly spend on supporting the child, the tribunal shall vary this percentage to reflect its findings;

(3) determining which parent has the greater amount under (2) of this subsection; the parent with the greater amount under (2) of this subsection is the obligor parent, and the annual award is equal to the difference between the two amounts under (2) of this subsection multiplied by 1.5; however, if this amount is greater than the amount of support calculated under AS 25.28.010 assuming the obligor parent has primary custody, the annual support is the amount calculated under AS 25.28.010.

(c) The child support award for shared custody under (b) of this section must be paid in 12 equal monthly installments, except that if

(1) shared custody is based on the obligor parent's having physical custody for periods of 30 consecutive days or more, the total annual award may be paid in equal installments over those months in which the obligor parent does not have physical custody; or

(2) the obligor parent's income is seasonal, the tribunal may order

unequal monthly support payments as provided in AS 25.28.030(g) and (h).

(d) The child support order must state that failure to exercise sufficient physical custody to qualify for shared physical custody under (b) or (c) of this section is grounds for modification of the child support order. Denial of visitation by the custodial parent is not cause to increase a child support award.

(e) The tribunal shall

(1) calculate a child support award in a case in which the parents are awarded divided custody by determining the amount each parent would pay to the other parent for support of a child for whom that parent has primary physical custody under AS 25.28.010, taking into account the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d), and offsetting those amounts; and

(2) consider whether the amount determined under (1) of this subsection should be varied under AS 25.28.030(b).

(f) The tribunal shall

(1) calculate a child support award in a case in which the parents are awarded hybrid custody by

(A) applying AS 25.28.010, taking into account the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d), to determine support for a child in the primary physical custody of each parent;

(B) applying (b) of this section to determine support for a child in the shared physical custody of the parents;

(C) adjusting pro rata the percentages provided in AS 25.28.010(b) based on the number of children to which each type of custody applies; and

(D) combining the amounts to determine the net obligation; and

(2) consider whether the amount determined under (1) of this subsection should be varied under AS 25.28.030(b).

Sec. 25.28.030. Exceptions to support awards. (a) Notwithstanding the requirements in AS 25.28.010 and 25.28.020, the tribunal may vary the award for the reasons stated in this section.

(b) The tribunal may vary the child support award as calculated under the other provisions of this chapter for good cause on proof by clear and convincing evidence that manifest injustice would result if the support award were not varied. The tribunal shall specify in writing the reason for the variation, the amount of support that would have been required but for the variation, and the estimated value of any property conveyed instead of support calculated under the other provisions of this chapter. Good cause may include a finding that unusual circumstances exist that require variation of the award in order to award an amount of support that is just and proper for the parties to contribute toward the nurture and education of their children. The tribunal shall consider the custodial parent's income in this determination.

(c) The calculation for primary physical custody under AS 25.28.010 does not apply to the extent that the parent has an adjusted annual income of more than $100,000. The tribunal may make an additional award only if it is just and proper, taking into account the needs of the child, the standard of living of the child, and the extent to which that standard should reflect the supporting parent's ability to pay.

(d) Except as provided in AS 25.28.010(c) and 25.28.020, the minimum child support amount that may be ordered is $50 a month or $600 a year.

(e) In addition to ordering a parent to pay child support as calculated under this chapter, the tribunal may, in appropriate circumstances and when the parents are minors as described in (f) of this section, order one or more grandparents of a child to pay child support to an appropriate person in an amount determined by the tribunal to serve the best interests of the child; however, the amount may not exceed the lesser of

(1) a proportionate share of the amount required to provide care in a supervised setting to the grandchild, as determined by the tribunal; or

(2) the amount that would have been awarded if the child's parents had the incomes of the child's grandparents and AS 25.28.010 and 25.28.020 were applied.

(f) An order under (e) of this section may be issued only with respect to a child whose parents are both minors, and the order terminates when either parent becomes 18 years of age. The tribunal shall specify in writing the reasons it considers it to be appropriate to order a grandparent to pay child support under this subsection and the factors considered in setting the amount of the child support award. In this

subsection, "grandparent" means the natural or adoptive parent of the minor parent.

(g) If the noncustodial parent's income is seasonal, the tribunal may order that the annual support amount be paid in unequal monthly payments, with higher payments during the months the parent expects to receive higher income and lower payments in other months; the tribunal may not make an unequal payment order unless

(1) the tribunal finds that the burden of budgeting for periods of unequal income should be placed on the obligee rather than the obligor; and

(2) the obligee agrees.

(h) An order of the tribunal for unequal payments under (g) of this section must specify the annual support amount, the average monthly support amount, and the amount due for each month. The order must provide that variations from the average monthly amount begin with monthly payments in excess of the average monthly amount so that a deficit situation cannot occur. Until the excess payments begin, the tribunal shall order payment of the average monthly amount.

Sec. 25.28.040. Health care expenses. (a) The tribunal shall include in the order coverage of the child's health care needs and require health insurance for the child if insurance is available to either parent or both parents at a reasonable cost. The tribunal shall consider whether the child is eligible for services through the Indian Health Service, any other entity, or other insurance coverage before ordering either parent or both parents to provide health care coverage through insurance, cash medical support, or other means. The tribunal shall allocate equally the cost of insurance and cash medical support between the parents unless the tribunal orders otherwise for good cause. An obligor's child support obligation shall be decreased by the amount of the obligee's portion of health insurance payments and cash medical support ordered by the tribunal and actually paid by the obligor.

(b) The tribunal shall increase a child support award by the obligor's portion of health insurance if the obligee is ordered to, and actually does, obtain and pay for insurance. The cost of insurance is the cost attributable to the child for whom support is paid. If the cost to the employee of covering the employee alone is the same as the cost to the employee of covering the employee and dependents, then there is no additional cost to the employee for adding the child and no portion of the cost of

coverage may be allocated to the child. If dependent coverage can be added for a single cost, rather than for each dependent, and the dependent coverage covers dependents in addition to the child subject to the order, the cost of the dependent coverage shall be allocated equally among the dependents covered. If there is reason to believe that there is an incremental cost to the employee for insuring dependents but evidence of that incremental cost is unavailable, the cost of insurance is determined by dividing the total cost of coverage by the number of family members covered and multiplying that amount by the number of children subject to the order.

(c) The tribunal shall allocate equally between the parties the cost of reasonable health care expenses not covered by insurance unless the tribunal orders otherwise for good cause. A party shall reimburse the other party for the party's share of the uncovered health care expenses within 30 days after receipt of the bill for the health care, payment verification, and, if applicable, a health insurance statement indicating what portion of the cost is uncovered. The tribunal shall allocate the reasonable, uncovered health care expenses exceeding $5,000 in a calendar year based on the parties' relative financial circumstances when the expenses occur.

(d) In this section, "health care expenses" means medical, dental, vision, and mental health counseling expenses.

Sec. 25.28.050. Child support affidavit and documentation. (a) Subject to the confidentiality requirements of Rule 90.1(f), Alaska Rules of Civil Procedure, each parent in a proceeding of a tribunal at which child support is involved shall file a statement under oath that states the parent's adjusted annual income and the components of adjusted annual income as described in AS 25.28.010(e). This statement must be filed with a party's initial pleading, including the dissolution petition, divorce complaint or answer, motion to modify, and any response to a motion to modify, and must be accompanied by documentation verifying the income. The documents must be redacted to delete social security numbers and to provide only partial financial account information as provided in Rule 90.1(f), Alaska Rules of Civil Procedure. The statement must state whether the parent has access to health insurance for the children and, if so, the additional cost to the parent of the children's health insurance.

(b) While there is an ongoing monthly support obligation, each party shall provide to the other party, within 30 days after a written request, documents such as tax returns and pay stubs showing the party's income for the prior calendar year. The party making the request shall provide documentation of the party's annual income for the same period at the time the request is made. A request under this section may not be made more than once a year. This section does not preclude discovery under the Alaska Rules of Civil Procedure.

(c) Unless the information has already been provided to the tribunal under Rule 90.1(f), Alaska Rules of Civil Procedure, a statement under (a) of this section must be accompanied by a confidential information sheet as described in Rule 90.1, Alaska Rules of Civil Procedure. Once a complete confidential information sheet has been submitted to the tribunal listing names, dates of birth, and social security numbers as required, the parties shall omit or redact social security numbers from documents subsequently filed in the action unless otherwise ordered by the tribunal.

(d) The tribunal may withhold or assess costs or attorney fees for a violation of this section as the circumstances and discouragement of like conduct in the future may require. Costs and attorney fees may be imposed on offending attorneys or parties.

Sec. 25.28.060. Travel expenses. After determining an award of child support under this chapter, the tribunal shall allocate between the parties reasonable travel expenses that are necessary to exercise visitation as may be just and proper for the parties to contribute.

Sec. 25.28.070. Modification; defense against arrearages. (a) A tribunal may modify a final child support award on a showing of a material change of circumstances as provided by state law. A material change of circumstances shall be presumed if support as calculated under this chapter is more than 15 percent greater or less than the outstanding support order. In this subsection, support includes health insurance payments made under AS 25.28.040.

(b) A tribunal may not modify a child support arrearage retroactively, except as authorized by AS 25.27.166(d). A modification that is effective on or after the date that a motion for modification, or a notice of petition for modification by the child

support services agency, is served on the opposing party is not considered a retroactive modification.

(c) The tribunal may find that a parent and a parent's assignee are precluded from collecting arrearages for support of a child that accumulated during a time period exceeding nine months for which the parent agreed or acquiesced to the obligor exercising primary custody of the child. A finding that preclusion is a defense must be based on clear and convincing evidence.

Sec. 25.28.080. Third-party custody. (a) When the state, or another third party entitled to child support, has custody of all children of a parent, the parent's support obligation to the third party is an amount equal to the adjusted annual income of the parent multiplied by the percentage specified in AS 25.28.010(b). If the third party has custody of some but not all children, the parent's support obligation to the third party is an amount equal to the adjusted annual income of the parent, multiplied by the percentage specified in AS 25.28.010(b) for the total number of the parent's children, multiplied by the number of the parent's children in third-party custody, divided by the total number of the parent's children. In this subsection, the number of the parent's children includes only children of the parent who live with the parent, are substantially supported by the parent, or are in custody of the third party entitled to support.

(b) If, in addition to a support obligation to a third party, one or both parents retain primary or shared physical custody of at least one of their children, the support obligation between the parents is calculated under the other provisions of this chapter, without consideration of the third-party custodian or any children in the custody of the third-party custodian, except that the percentage in AS 25.28.010(b) must be adjusted pro rata for the number of children in the primary custody of a parent, or shared custody of the parents, compared to the total number of children. After that calculation is completed, any support owed may be offset with support owed to a third-party custodian under (a) of this section in order to minimize transactions.

Sec. 25.28.090. Support order forms. All orders for payment or modification of child support shall be entered on a form developed by the administrative director of the tribunal. A party may lodge a duplicate of the tribunal form produced by a laser

printer or similar device. A device may also print, in a contrasting typestyle equivalent to that produced by a typewriter, text that otherwise would have been entered by a typewriter or word processor. A party or attorney who lodges a duplicate certifies by lodging the duplicate that it is identical to the current version of the tribunal form.

Sec. 25.28.100. Dependent tax deduction. The tribunal may allocate the dependent tax deduction for each child between the parties as is just and proper and in the child's best interests. The allocation must be consistent with AS 25.24.152 and federal law.

Sec. 25.28.300. Definitions. In this chapter,

(1) "child support" and "child support obligation" have the meaning given "duty of support" in AS 25.27.900;

(2) "divided custody" means that one parent has primary physical custody of one or more children of the relationship and the other parent has primary custody of one or more other children of the relationship, and the parents do not share physical custody of any of their children;

(3) "hybrid custody" means that at least one parent has primary physical custody of one or more children of the relationship, and the parents have shared physical custody of at least one child of the relationship;

(4) "primary physical custody" or "primary custody" means that a child resides with the other parent for a period, specified in the custody order, of less than 30 percent of the year;

(5) "shared physical custody" or "shared custody" means that a child resides with one parent for a period, specified in writing in the custody order, of at least 30 percent but not more than 70 percent of the year, regardless of the status of legal custody;

(6) "tribunal" means the superior court or the child support services agency created in AS 25.27.010.

* **Sec. 2.** AS 47.10.120(a) is amended to read:

(a) When a child in need of aid is committed under this chapter, the court or the child support services agency created in AS 25.27.010 shall, after giving the parent a reasonable opportunity to be heard, require that the parent pay to the department in a

manner that the court or the child support services agency directs a sum to cover in full or in part the maintenance and care of the child. The support obligation shall be calculated under **AS 25.28** [RULE 90.3(i) OF THE ALASKA RULES OF CIVIL PROCEDURE].

*** Sec. 3.** AS 47.12.230(a) is amended to read:

(a) When a delinquent minor is committed under this chapter, the court or the child support services agency created in AS 25.27.010 shall, after giving the parent a reasonable opportunity to be heard, require that the parent pay to the department in a manner that the court or the child support services agency directs a sum to cover in full or in part the maintenance and care of the minor. The support obligation shall be calculated under **AS 25.28** [RULE 90.3(i) OF THE ALASKA RULES OF CIVIL PROCEDURE].

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REPEAL OF COURT RULE. Rule 90.3, Alaska Rules of Civil Procedure, is repealed.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

NON-APPLICABILITY OF TWO-THIRDS VOTE REQUIREMENT. Because the rule repealed in sec. 4 of this Act is a substantive rule rather than a rule of practice or procedure, the repeal of the rule takes effect even if sec. 4 of this Act does not receive the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 46
() Publish Date:

Identifier (file name): SB46-REV-CSSD-02-28-10 updated
Dept. Affected: Revenue
Title: Child Support Awards
RDU: Revenue Programs & Services
Component: Child Support Services Division
Sponsor: Senator Kookesh
Requester: (S) Health and Social Services
Component Number: 111

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Moving the court rule to statute has no fiscal impact on the Child Support Services Division.

The fiscal impact of zero is based on the assumption that the Legislature will assume the responsibility of the four year review including the costs of the program review.

Prepared by: John Mallonee, Director — Phone 269-2801
Division: Child Support Services Division — Date/Time 02-24-10; 1.02pm
Approved by: Ginger Blaisdell, Director — Date 02-28-10; 4:16pm
Administrative Services Division

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 46
() Publish Date:

Identifier (file name): SB46-REV-CSSD-02-24-10
Dept. Affected: Revenue
Title: Child Support Awards
RDU: Revenue Programs & Services
Component: Child Support Services Division
Sponsor: Senator Kookesh
Requester: (S) Health and Social Services
Component Number: 111

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation has no fiscal impact on the Child Support Services Division.

Prepared by: John Mallonee, Director — Phone 269-2801
Division: Child Support Services Division — Date/Time 02-24-10; 1:02pm
Approved by: Ginger Blaisdell, Director — Date 02-24-10; 4:16pm
Administrative Services Division

(Revised 11/5/2009 OMB)

3543

Celeste Hodge

From: Dorothy Shockley
Sent: Monday, March 01, 2010 10:42 AM
To: Celeste Hodge
Subject: SB 46 Child Support Awards--legal comments

Hi Celeste....here's Ken's letter (I just got it!) thanks, ~D

Ms. Shockley: Here is a copy of Mr. Kirk's letter to you of 2/22/10.

February 22, 2010

Office of Senator Albert Kookesh

Attn: Dorothy J. Shockley

State Capitol, Room 11

Juneau, AK 99801

Re: SB 46

Dear Senator:

I am writing to express my support for the proposed SB 46, which, if passed, would finally enact a child support guideline into statute.

The lack of a child support guideline has been a blot on our constitutional system for over 20 years. In 1987 the Alaska Supreme Court adopted Civil Rule 90.3, which I am sure they intended to be only a short-term solution to avoid loss of federal benefits until the legislature replaced the rule with an actual statute. Unfortunately the justices, who predictably do not have a very good collective ear for political realities, did not realize that when you take a hot potato away from the legislature, you tend to get stuck with the hot potato for life. And so in 23 years, no legislator (until now) has even introduced a bill to enact a specific guideline. In the meantime the Supreme Court, with its typical inability to admit when it is wrong, has whitewashed the fact that this is a substantive law enacted by the judiciary, by trying to claim that it is "merely a guideline" even though its own cases require that the guideline be followed.

The Alaska Constitution gives the judiciary the authority to enact administrative and procedural rules, and to decide individual cases. It has no right or ability to enact substantive laws. For the judiciary to enact a substantive law, is a terrible precedent which threatens the structure of separation of powers. And so I implore you to remedy this embarrassment by enacting a substantive child-support law to replace 90.3.

That said, if this bill gets a committee hearing you will be provided with a lot of options, some of them probably better than what you have here. SB 46 essentially adopts the present system of child support guidelines, which is generally referred to as a "percentage of income" system. It does have the advantage of being consistent with the way we have done this in Alaska for the past 23 years, so that the many people who have to apply these rules (judges, attorneys, and CSSD workers) do not have to start all over again. On the other hand most states have adopted the "income shares" system, under which both parents' incomes are taken into account. Our system takes into account, in most cases, only the income of the noncustodial parent. There are good arguments on both sides, and you may want to consider using the income shares system instead. Likewise, there are many desirable changes which could be made to the guidelines, even if the basic structure is kept intact.

Please consider the many changes which are likely to be presented, and keep an open mind to them, but at the end of the day please pass something. Under the current system, the people who are affected by this substantive law can never talk to the people who can change it, because the justices who actually decide on changes do not talk to people. Every four years, the justices appointed a review committee, a group of lawyers who then solicit comments for change, and hold public hearings. However the review committee does not make the final decision, and the justices have been anything but a rubber stamp for the committee's recommendations. I have been on two of the review committees over the years, and many of the changes we proposed were either rejected, or dramatically revised, by the Supreme Court.

The current system is undemocratic. You have the option of changing it into a system which is democratic, in which people can petition their legislators if they believe further changes should be made. Please take some such action. The exact details of how child support is calculated, is less important than that our system of democratic government is able to continue operating the way it should.

Please feel free to contact me if there are any other questions you, or any of your fellow legislators, have for me.

Sincerely,

Kenneth Kirk

SB 47

Senator Hollis French

Capitol Room 417
465-3892
465-6595 fax

MEMORANDUM

Date: 1/29/2009

To: Senator Bettye Davis, Chair
Senate Health and Social Services Committee

From: Senator Hollis French HKF

RE: Request for Hearing – SB 47 Statute of Limitations for Sexual Offenses

---

This is a request that you schedule a hearing on SB 47 "Statute of Limitations for Sexual Offenses" at the earliest possible date.

I have attached a copy of the bill, a sponsor statement, and a sectional analysis for your use. I appreciate your consideration.

Attachments

3548

Lynda Zaugg

From: Cindy Smith
Sent: Thursday, February 26, 2009 8:32 AM
To: Lynda Zaugg
Subject: tomorrow's hearing

I had this lame notion that I'd catch up with you yesterday but that did not really account for the Key Campaign's arrival!

For tomorrow's hearing we will have 3 in-person witnesses and one person on-line -- all adult survivors of child sexual abuse, and all originally from villages, so I wanted to let you know that if Senator Davis is willing, right after the basic bill presentation we'd like these folks to testify just because it's hard testimony to give, so that way they can get it done and not sit and be terrified any longer than they need to be.

In person witnesses are: Florence Penny, from Juneau (originally from Holy Cross)
Elsie Boudreau (I can't remember where Elsie was originally from but she went to school in Nome)
Henry Napoleon, Hooper Bay

On line will be Delbert Ackerman from Stebbins. He is using the offnet number.

Finally, I'd expect in-person testimony testimony from a woman named Joelle Castix, who will talk about how this kind of bill worked in California, and the Alaska Women's Lobby and the Network on Domestic Violence may be there and may offer brief testimony in support.

Let me know if you need anything else from me. I will be bringing one brief handout for the committee and will bring an adequate number for them and for handouts. :)

Cindy Smith
Office of Senator Hollis French
(907) 465-3892
www.aksenate.org

Lynda Zaugg

From: Cindy Smith
Sent: Wednesday, February 04, 2009 8:32 AM
To: Lynda Zaugg
Subject: SB47

Hi!

I will be carrying SB47 for Hollis and I wanted to let you know that we will need some time to put together witnesses for this bill hearing (it's kind of complicated because we need to get witnesses in from some rural communities and I also want an attorney on line who can speak to the provisions of the bill), --- so although I know Andy dropped off a hearing request, we actually will not be ready to have it heard for a week or so.

Please don't schedule us next week and I'll let you know sometime next week if we've been able to get everybody organized for the week of the 16th or after that.

Thanks!

Cindy Smith
Office of Senator Hollis French
(907) 465-3892
www.aksenate.org

Alaska State Legislature

Senator Hollis French

SB 47 - Statute of Limitations for Sexual Offenses

Senate Bill 47 creates a one year period in which civil action may be brought in felony sexual assault cases that have been time barred by the formerly restrictive statute of limitation laws in Alaska. During the 2001 legislative session, both the House and Senate voted unanimously to remove the statute of limitations for felony sexual offenses that were still open to prosecution at that time. For instances of felony sexual assault where the statute of limitations had expired, no recourse was given to the victims of the crime.

SB 47 allows the victims of felony sexual assault to have their day in court. Experts have found there are several reasons that a victim, especially a child, will not report sexual abuse for years after it occurred. Multiple studies have shown:

- Victims of childhood sexual assault are often extremely embarrassed by the abuse, and may not disclose the crime against them until adulthood.
- Children who are victims will often fail to report sexual abuse due to fear of the consequences; a child may also feel guilty for reporting the perpetrator or fear retaliation from his or her abuser.
- It can take years for a victim to understand the connection between the problems they are experiencing as an adult and the abuse they experienced as a child.
- Among victims of sexual assault, an inability to trust is common. This inability can prevent many victims from disclosing abuse.
- Many victims of childhood sexual abuse have repressed all memory of the abuse for years; it is often only under the guidance of professional counseling or therapy that the victim may come to realize that a crime against them took place.

SB 47 allows past victims of sexual abuse the same rights they would have under today's law - the right to file charges against their perpetrators no matter when the abuse occurred. I urge your support for this important bill that provides closure for victims of sexual assault, while holding the perpetrators for these crimes accountable.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB47-DOC-OC-02-20-09
() Publish Date:

Identifier (file name): SB47-DOC-OC-02-20-09
Dept. Affected: DOC
Title "Act relating to the statute of limitations for certain sexual offenses and permitting causes of actions otherwise barred by statute ...."
RDU Adminstration & Support
Component Office of the Commissioner
Sponsor Senator French
Requester Governor
Component Number 694

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Passage of this legislation will should have no impact to the Department of Corrections.

Prepared by: Leslie Houston, Director
Phone (907) 465-3339
Division Administration and Support
Date/Time 2/20/2009 17:33:00 PM
Approved by: Dwayne Peeples, Deputy Commissioner
Date 2/20/2009
Department of Corrections

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB047
() Publish Date:

Identifier (file name): SB047-LAW-CIV-2-27-09
Dept. Affected: LAW
Title: An Act relating to the statute of limitations for certain sexual offenses.
RDU: Civil
Component: Torts & Workers Compensation
Sponsor: SENATOR(S) FRENCH
Requester: Health & Social Services
Component Number: 2719

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The bill would amend the statute of limitations for civil actions involving certain sexual offenses, so that actions that are pending in court on the effective date or are filed within one year after the effective date of the bill would be considered timely. Enactment of the bill is not anticipated to fiscally impact the Department of Law.

Prepared by: Robert Meiners, Deputy Director — Phone 907-465-5427
Division: Administrative Services Division — Date/Time 2/27/09 10:15 AM
Approved by: Richard Svobodny, Acting Attorney General — Date 2/27/2009
Department of Law

(Revised 9/10/2008 OMB)

LEGISLATIVE RESEARCH REPORT

MARCH 13, 2007

REPORT NUMBER 07.156

HISTORY OF ALASKA STATUTES OF LIMITATIONS FOR CIVIL ACTIONS RELATED TO SEXUAL OFFENSES

PREPARED FOR SENATOR HOLLIS FRENCH

BY CHUCK BURNHAM, LEGISLATIVE ANALYST

You asked about Alaska statutes of limitations. Specifically, you wanted a history of statutes involving time limitations for bringing civil actions related to sexual offenses.

As you know, pursuant to AS § 09.10.065, there currently exists no statutory time limitation on bringing a civil action resulting from the crimes of felony sexual abuse of a minor, felony sexual assault, or unlawful exploitation of a minor.[1] Other statutes that currently impact time limitations on civil actions for sexual offenses are provided in AS § 09.10.140 and AS § 09.55.650. We provide a review of the legislative histories of each of the three aforementioned statutes as follows.[2]

The state's general statute of limitations for civil actions related to "assault" contained in AS § 09.10.070 was enacted as § 1.07 ch 101 SLA 1962; however § 1.14 of the same chapter provided that the general limitation did not apply to a plaintiff who was under age 19 at the time of the cause for the action.[3] This section, currently AS § 09.10.140, recognized "minority," that is, being under age 19, as a "disability" with regard to an individual's ability to bring civil action. The legislature therefore determined that the time spent in "disability," or the time period between the subject of the civil action and the date the plaintiff reaches age 19, should not be considered as part of the time limitation on the commencement of a civil action. In effect, this section implemented a two-year limit beginning on the plaintiff's 19th birthday. In 1979, the age clause of AS § 09.10.140 was changed from "19 years of age" to the age of "majority," which is currently age 18 (AS § 25.20.010).

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[1] These crimes are enumerated in statute as follows: felony sexual abuse of a minor—AS §§ 11.41.434-438; felony sexual assault—AS §§ 11.41.410-425; unlawful exploitation of a minor—AS § 11.41.455.

[2] We include copies of AS § 09.10.65, AS § 09.10.140, and AS § 09.55.650 as Attachment A.

[3] We include a copy of each of the session laws mentioned in this report as Attachment B.

907-465-3991
907-465-3908 (fax)

Alaska Legislature
Legislative Research Services
w3.legis.state.ak.us/Research/research_home.htm

State Capitol
Juneau, AK 99801

With the enactment of §§ 1-4 ch 4 SLA 1990, the legislature expanded time limitations for civil actions for most serious sexual offenses, particularly offenses involving minors. Section 1 added a new subsection to what is currently AS § 09.10.065 to provide that a victim of sexual assault or sexual abuse of a minor may not maintain an action for damages against a perpetrator unless the action is commenced within three years of the act or knowledge of the act. This section alone extended the time limitation by just one year; however, § 4 added AS § 09.55.650 to provide that a victim who was under sixteen years of age at the time of the abuse may "maintain an action for recovery of damages" for an injury or condition that is the result of the abuse. This new section also provided that if more than one act of abuse has occurred, the plaintiff need not prove which act caused the damage or injury. Finally, §§ 2-3 amended AS § 09.10.140 to provide that a victim whose abuse is subject to AS § 09.55.650 (under age sixteen at the time of abuse) is exempt from the three-year limitation under AS § 09.10.065 if an action is commenced within three years of the time the plaintiff "discovered" or should have reasonably discovered that an act, or series of acts, of abuse caused the injury or condition underlying the action.

The intent of the 1990 legislation was to maintain a general limitation on bringing civil actions—three years—but to provide a mechanism by which individuals who, as adults, discovered that they were sexually abused as children could pursue civil remedies for damages and injuries resulting from that abuse. Testimony on the enacting legislation before the House Judiciary Committee wide acceptance that many victims of sexual abuse "block-out" memories, or are otherwise unaware, of the abuse until they discover the negative impacts resulting from that abuse years later. Legislators, therefore, determined that the period of time limitation on civil actions stemming from the impacts of sexual abuse should commence at the point of a plaintiff's "discovery" of the abuse rather than from the time of the offense or the age of majority.[4]

The legislature removed time limitations for bringing a civil action for felony sexual abuse of a minor and felony sexual assault with the enactment of § 1 ch 86 SLA 2001, which repealed and reenacted AS § 09.10.065. This statute was further amended by § 2 ch 40 SLA 2003 by removing time limitations on actions for unlawful exploitation and adding subsection (b) to provide a three-year limitation on bringing actions for misdemeanor sexual offenses, incest, and felony indecent exposure. This new language was also referenced in AS § 09.10.140(b). The result was the exemption of misdemeanor sexual offenses against victims who were under age sixteen at the time of the abuse from the three-year limitation provided in AS § 09.10.065(b), permitted that action for those offenses is commenced within three years of the time the plaintiff "discovered" or should have reasonably discovered that an act, or series of acts, of abuse caused injury or damage.

The attached table provides a brief summary of the history of statutes related to time limitations for bringing civil actions related to sexual offenses.

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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[4] Testimony before the House Judiciary Committee, April 6 and 19, 1989.

History of Statutes of Limitation for Civil Actions Related to Sexual Offenses

Session Law	AS § 09.10.140		
§ 1.14 ch 101 SLA 1962	Provided that the general limitation of two years for bringing action for an "assault" (as established in § 1.07) did not apply to a victim under age 19; however, the exemption was limited to not more than two years following the 19th birthday.		
§ 1 ch 46 SLA 1979	Changed the age clause from "19 years" to the age of "majority."		
	AS § 09.10.065	**AS § 09.10.140**	**AS § 09.55.650**
§§ 1-4 ch 4 SLA 1990	Added subsection (c) to provide that a victim of sexual assault or sexual abuse of a minor may not maintain an action for damages against a perpetrator unless the action is commenced within three years of the act or knowledge of the act.	Provided that a victim whose abuse is subject to AS § 09.55.650 (under age sixteen at the time of abuse) is exempt from the three-year limitation under AS § 09.10.065 if an action is commenced within three years of the time the plaintiff "discovered" or should have reasonably discovered that an act, or series of acts, of abuse caused the injury or condition underlying the action.	Added section to provide that a victim who was under sixteen years of age at the time of the abuse may "maintain an action for recovery of damages" for an injury or condition that is the result of the abuse. Also provides that if more than one act of abuse has occurred, the plaintiff need not prove which act caused the damage or injury.
§§ 1-2 ch 81 SLA 1998	Added the crime of indecent exposure in the first degree [provided by § 3] to the crimes to which subsection (c) applies.	Section not amended.	Added the crime of indecent exposure in the first degree to the definitions of the "sexual abuse" crimes to which the section applies.
§ 1 ch 86 SLA 2001	Removed time limitations on bringing actions for felony sexual abuse of a minor and felony sexual assault.	Section not amended.	Section not amended.
§§ 1-3 ch 40 SLA 2003	Removed time limitations on bringing action for unlawful exploitation of a minor. Added subsection (b) to provide a three-year limitation on bringing an action for misdemeanor sexual offenses, incest, and felony indecent exposure.	Referenced AS § 09.10.065(b) in subsection (b), to provide that a victim who was under age sixteen at the time of a sexual abuse misdemeanor or felony indecent exposure is exempt from the three-year limitation under subsection (a) if an action is commenced within three years of the time the plaintiff "discovered" or should have reasonably discovered that an act, or series of acts, of abuse caused the injury or condition underlying the action.	Section not amended.

Sources: Session Laws of Alaska and Alaska Statutes.

adn.com
Anchorage Daily News

Judge says sex suit filed too late -
DISMISSED: Victim claimed priest got her pregnant in 1977.
Anchorage Daily News (AK)
February 22, 2006
Author: SHEILA TOOMEY
Anchorage Daily News

A Nome judge on Tuesday dismissed a sex abuse lawsuit against the Jesuits and the Fairbanks Catholic diocese, ruling that a woman who says former Nome priest James Poole got her pregnant when she was 14 waited too long to take legal action.

Superior Court Judge Ben Esch said the woman, known as Jane Doe 2, should have known when Poole told her to get an abortion that he and the church had done something wrong to her. In legal terms, that knowledge triggered her "duty to inquire" and set in motion the civil statute of limitations, which required her to file suit no more than two years after she turned 18.

"This will be seen as unjust by many people," Esch wrote in his dismissal, "but is, I believe, required by the laws of the State of Alaska." The decision came less than a week before trial was scheduled to begin.

Both sides reacted to the dismissal as might be expected. In a written statement, the Jesuits -- formally the Society of Jesus, Oregon Province -- said the ruling confirms "the justice of our position" but vowed to seek healing for "those who have suffered from abuse."

"(W)e still hope to find a path to reconciliation," the statement said.

"We do not celebrate today's decision."

Attorney Ken Roosa, who represents Jane Doe 2 and dozens of other litigants reporting childhood abuse by Alaska-based priests, said he will appeal the dismissal to the Alaska Supreme Court.

"I think Judge Each is a fine judge, but I think he called it wrong here," Roosa said. The decision is based on the facts of this case and does not imperil other pending cases, he said.

"This is just one skirmish in a long battle."

In her 2004 lawsuit, Jane Doe 2 said Poole abused her in the late 1970s and got her pregnant in 1977. She said she had an abortion in 1978 at Poole's urging.

Roosa said the woman reported the abuse to two different local priests within the

allowed time period and was told to do penance.

Both religious organizations have said they knew nothing of such accusations at the time.

In 2001, the Alaska Legislature eliminated the statute of limitation for child sex abuse cases. That means anyone abused after that date has no deadline for filing suit.

Roosa claims, and is arguing in another case before the state Supreme Court, that the law is retroactive and covers people like Jane Doe 2. Esch apparently did not agree.

In December, he removed Poole as a defendant in the case, saying Jane Doe 2 should have known something wrong was done to her and needed to take action within two years of her 18th birthday.

He left the Jesuits and the Fairbanks diocese as defendants, saying it was not clear she should have known she had a case against the two organizations, according to Roosa.

The case was scheduled to go to trial in Nome next week. In the meantime, the Alaska Supreme Court in an unrelated case ruled that judges, not juries, must decide statute-of-limitation questions, Roosa said.

Forced to decide, Esch concluded Jane Doe 2 should also have taken timely action against the two organizations.

On Tuesday, Roosa seemed bitter that the church even raised the timing question. "Would Christ assert the statute of limitations against a victim who had been sexually abused by a priest?" he said. " I just don't think so."

In their statement, the Jesuits spoke of a resolution better than a "legal dispensation."

"There remains, at this time, a woman whose suffering and story deserve our respect and our pastoral care. ... we continue to pray that we will find together a deeper justice, based not on adversarial strife but on our shared concern for the well-being and healing of all those involved."

In addition to the dismissed case, two other suits against Poole have been settled and two remain.

The Associated Press and the Fairbanks Daily News-Miner contributed to this story. Sheila Toomey can be reached at 907-257-5341 or stoomey@adn.com.

adn.com
Anchorage Daily News

28 men allege abuse by monk -
1965 TO 1975: Western Alaska men sue Fairbanks Catholic Diocese, Jesuits.
Anchorage Daily News (AK)
November 12, 2004
Author: RICHARD MAUER
Anchorage Daily News
Staff
Estimated printed pages: 4

Twenty-eight Alaska men say that when they were children, a religious brother who served several Western Alaska villages bought sexual favors from them with candy, better grades, sacramental wine and coins from collection plates.
The men, now mostly in their 40s, say in a lawsuit filed in Bethel that the former Trappist monk, Joseph Lundowski, abused their trust as deacon and religious instructor and engaged them in sexual misconduct, including oral sex. One man said he was also raped.

The men's identities are not disclosed in the lawsuit, which seeks monetary damages from the Fairbanks Catholic Diocese and the Jesuit province in Oregon, which has a historical affiliation with the Fairbanks diocese. At the time of the alleged abuse, from 1965 to 1975, the victims ranged in age from 6 to 24, with most of them in their adolescence.

The lawsuit says that Lundowski was forced from Alaska by church authorities in 1975. He is believed to have died. He was born in 1918.

A spokeswoman for the Fairbanks diocese said it had not received a copy of the suit and couldn't comment on the allegations.

"From the best I can figure, he left in the mid-'70s," said Ronnie Rosenberg, the director of human resources. "There are not many people here now who even remember him. As for the victims, all them are 'James Doe,' and we don't know who they are now. We do pray for healing for anyone who may have been injured."

In a prepared statement, the Jesuits denied any direct connection to Lundowski.

"The Society of Jesus learned this morning about the filing of litigation alleging multiple instances of sexual misconduct several years ago by Mr. Joseph Lundowski. As we have been committed to healing in the Church, we are saddened by these new allegations, and keep all who have suffered in our prayers. However, the Society wishes to clarify that Mr. Joseph Lundowski was at no time a member of the Society of Jesus nor in any way subject to the authority of any Jesuit superior or Provincial," it said.

According to the lawsuit, Lundowski was kicked out of his monastery "because of his

inability to withstand the rigors of monastic life." The lawsuit asserted that the language was code for "his improper and illegal sexual involvement with young boys."

Lundowski was recruited to Alaska by The Rev. George Endal for the Holy Rosary Mission School in Dillingham around 1949. Endal put Lundowski in charge of the boys' dormitory.

In 1963, when Endal went to the Western Alaska village of Nulato, Lundowski followed, the lawsuit said. It was there that Lundowski was "involved in a scandal with a person 'who is not a woman,' " the lawsuit said, quoting from a 1965 letter written to another priest in Western Alaska by his superior. The letter, discovered by the plaintiffs' attorney, Ken Roosa of Anchorage, in another abuse case, suggested that Lundowski's behavior was already established and known, though nothing was done about it other than complaining.

"Rather," the lawsuit continued, "he was transferred to Hooper Bay with Father Endal in 1965, where he continued to molest and sexually assault boys and young men."

Lundowski was deacon and religious instructor over the next 10 years at parishes in Hooper Bay, Stebbins and St. Michael. He also left a trail of abuse, according to the suit. Six of the victims were from Little Flower of Jesus parish at Hooper Bay; 11 attended St. Michael's parish at St. Michael; and 11 were from St. Bernard's parish in Stebbins.

His "sexual predation accelerated" when he was transferred to St. Michael and Stebbins in 1968, the lawsuit said. "He continued to serve as a deacon and catechist, often molesting boys after Mass or catechism."

The suit charged he engaged in oral copulation with each of the victims, "and forced many to submit to anal sodomy and required them to masturbate him." The boys were rewarded with candy, money stolen from collection plates, cooked and baked foods, beer, sacramental wine "and better grades on their catechism assignments."

He also warned them against telling. He said "no one would believe them because he worked for God," the suit said.

His abuse finally came to an end when a resident of St. Michael, Martha Abochook, caught him in the act with the 24-year-old, the suit said. Abochook, who is now dead, "raised a fuss" that resulted in the Fairbanks diocese removing Lundowski from Alaska.

Each of the men still lives in Western Alaska. Until other lawsuits against priests in the area became known, the men didn't understand their depression, anxiety, self-blame, shame and guilt were caused by Lundowski, the suit said. "They didn't know they had the right to sue the diocese until they heard of the others."

Church officials should have stopped the abuse and reported Lundowski's felonies to authorities, but failed, the lawsuit said.

Senator Hollis French

Capitol Room 417
465-3892
465-6595 fax

MEMORANDUM

Date: February 12, 2008

To: All Senators

From: Senator Hollis French HSF

RE: SB 112

I would like to draw your attention to the following court decision.

The case was one of many involving alleged abuse committed by a priest against young Alaskans. The case was dismissed by the court after defendants in the case successfully used the statute of limitations as a defense. If the abuse had happened under today's laws, no statute of limitations would apply – the victim could bring suit at any time in the future.

The judge in the case was aware of the unfairness of the old statute of limitations. In reaching his decision, he wrote:

"The court believes that a legislative remedy to the conundrum these cases present might be fair and reasonable. Perhaps something akin to SB 112, presented in the most recent legislative session, will allow individuals who have been victimized to obtain fair redress these many years later."

I urge you to support SB 112.

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

SECOND JUDICIAL DISTRICT AT NOME

JANE DOE 3,

Plaintiff,

vs.

JAMES E. POOLE, S.J.; CATHOLIC BISHOP OF NORTHERN ALASKA; THE SOCIETY OF JESUS, OREGON PROVENCE; and THE SOCIETY OF JESUS, ALASKA,

Defendants.

Case No. 2NO-05- 56 CI

RULING ON STATUTE OF LIMITATIONS

The defendants have moved to dismiss this action based upon the statute of limitations and the motion was opposed by the plaintiff. The plaintiff has also cross-moved for summary judgment on the claim that fraudulent concealment precludes the Catholic Bishop and the Jesuits from relying on the statute. The parties have briefed the issues and an evidentiary hearing was held. The court considered the arguments of counsel and the testimony presented at the hearing, the exhibits offered and admitted, and the deposition testimony filed with the court.

FACTS:

The circumstances giving rise to the plaintiff's claims begin in the 1960s. Ms. Doe lived in Nome. Her life, at that time, was impacted by emotional and sexual abuse perpetrated by others. Her first direct contact with Fr. Poole arose at a junior high dance at which he was a chaperone. Fr. Poole was an ordained priest and member of the Society of Jesus working under their supervision. He was employed by the Bishop of Northern Alaska to establish a radio station in Nome. Ms. Doe was fourteen years old. He asked her to dance and she testified that during the dance he had an erection and rubbed against her. This same conduct occurred at another dance later

in the school year. On another occasion during that school year, Poole invited Doe to participate in a musical group. When she arrived at Poole's office, there were none of her contemporaries present. She described events that transpired as Poole sitting close to her and then rubbing his groin area through his clothing. The incident was interrupted when Poole's mother entered the room and asked Ms. Doe to leave. Finally, some months later, after a man who had been sexually abusing her murdered her aunt, she met Poole on the street. Doe had witnessed the murder and was despondent. Poole offered her solace at the Catholic church. Doe testified that when the two arrived at the Church, they went to his office and spoke for some time. She said that he then took her to a nearby dark hallway, pulled up her shirt, pulled down her pants and sexually penetrated her with his penis. This attack was interrupted by the sound of some men approaching the hallway. This incident occurred in 1969, when Doe was fifteen. Doe had no further direct contact with Poole.

Ms. Doe graduated from high school in Nome, attended college in Fairbanks for two years, and then married. She and her husband lived in Nome from their marriage in about 1975 until the late 1980s. They then moved to Florida for about two years and over the next few years moved between Florida and Anchorage at least twice. They have been residents of Anchorage since the mid-1990s.

Ms. Doe testified that while she and her husband lived in Nome, she worked for Kawarek, Inc. and for Norton Sound Health Corporation. In these jobs she provided training for village counselors on mental health issues, was an alcoholism counselor and provided training to members of various tribal councils. Doe became involved in issues of child abuse from very early in her career with Kawarek. She attended workshops on the issue and got intensive on-the-job training from psychologists and other professional. As part of her job, she wrote articles which were published in the Nome paper on the subject of child abuse. A number of these articles discussed the

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SEP-13-2007

emotional and physical consequences of sexual abuse. On one occasion, she reported sexual abuse by a foster parent. On another occasion, in the early 1980s, Ms. Doe learned that her brother was sexually abusing her daughter. She reported the abuse, got her children involved in individual counseling, she and her husband got couples counseling, and all participated in family counseling. At another time, after she moved to Anchorage, she was fired for trying to report sexual abuse by a superior on a young girl.

By 2000, Ms. Doe began to see mental health counselors on a regular basis. Shortly thereafter she was hospitalized at Alaska Psychiatric Institute. There were other hospitalizations subsequently. She received initial therapy from Joelle Werner, transferred to Tim Mannen and then returned to Ms. Werner in 2003. Her initial therapy focused on the death of her aunt and the sexual abuse that her aunt's murder had perpetrated upon her. In May 2004 she reported Poole's alleged abuse to Anchorage Police after reading an article about allegations of abuse by Poole asserted by another woman. This suit followed thereafter.

LEGAL STANDARD:

First, the plaintiff suggests that AS 09.10.065 is the statute of limitations to be applied in this case. However, in *Catholic Bishop Of Northern Alaska v. Does 1-6*, 141 P.3d 719 (Alaska 2006) our Supreme Court concluded that AS 09.10.065 does not revive civil claims that were time-barred before the effective date of the statute, October 1, 2001. Consequently, that argument has no merit.[1]

The plaintiff argues that the discovery rule excuses her delay in filing the complaint. The defendants argue the discovery rule cannot operate to extend the statute for the more than thirty

[1] At oral argument, the plaintiff withdrew the claim that AS 09.10.130 tolled the statute for the time that Fr. Poole was outside the state of Alaska.

years that passed between the abuse and when the complaint was filed.

The Alaska Supreme Court has formulated the discovery rule in three possible ways:

> (1) a cause of action accrues when a person discovers, or reasonably should have discovered, the existence of all elements essential to the cause of action; (2) a person reasonably should know of his cause of action when he has sufficient information to prompt an inquiry into the cause of action, if all of the essential elements of the cause of action may reasonably be discovered within the statutory period at a point when a reasonable time remains within which to file suit.

Cameron v. State, 822 P.2d 1362, 1366 (Alaska 1991).

> (3) where a person makes a reasonable inquiry which does not reveal the elements of the cause of action within the statutory period at a point where there remains a reasonable time within which to file suit, the limitations period is tolled until a reasonable person discovers actual knowledge of, or would again be prompted to inquire into, the cause of action.

Pedersen v. Zielski, 822 P.2d 903, 908 (Alaska 1991).[2]

The plaintiff offers an additional way in which a discovery rule could delay the filing deadline. Alaska Statute 09.10.140(b) states:

> An action based on a claim of sexual abuse under AS 09.55.650 that is subject to AS 09.10.065(b) may be brought more than three years after the plaintiff reaches the age of majority if it is brought under the following circumstances:
>
> (1) if the claim asserts that the defendant committed one act of sexual abuse on the plaintiff, the plaintiff shall commence the action within three years after the plaintiff discovered or through use of reasonable diligence should have discovered that the act caused the injury or condition;
>
> (2) if the claim asserts that the defendant committed more than one act of sexual abuse on the plaintiff, the plaintiff shall

---

[2] No evidence exists in this case that Ms. Doe made any inquiry into the existence of a claim, let alone a reasonable inquiry. Consequently, the third method for extending the deadline of the statute of limitations has no application in this case.

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SEP-13-2007 14:04

> commence the action within three years after the plaintiff discovered or through use of reasonable diligence should have discovered the effect of the injury or condition attributable to the series of acts; a claim based on an assertion of more than one act of sexual abuse is not limited to plaintiff's first discovery of the relationship between any one of those acts and the injury or condition, but may be based on plaintiff's discovery of the effect of the series of acts.

This statutory formulation of the discovery rule was adopted in 1990, but was specifically made fully retroactive. Alaska Statute 09.55.650 states that an individual who "as a minor under 16 years of age, was the victim of a sexual abuse may maintain an action for recovery of damages against the perpetrator of the act or acts of sexual abuse based on the perpetrator's intentional conduct for an injury or condition suffered as a result of the sexual abuse."

However formulated, the discovery rule allows an individual to maintain an action on a claim that would otherwise be barred.

> Where the plaintiff does not actually know of the existence of elements essential to her cause of action, under the "discovery rule," the limitations period does not begin to run until "a reasonable person [in like circumstances would have] enough information to alert that person that he or she has a potential cause of action or should begin an inquiry to protect his or her rights."

Alaska Tae Woong Venture, Inc. v. Westward Seafoods, Inc., 963 P.2d 1055, 1065 (Alaska 1998). The discovery rule is measured by an objective not subjective standard, requiring the court to determine what a reasonable person in Ms. Doe's circumstances would have known. None of the legislative history submitted by the plaintiff regarding the operation of the statutory formulation of the rule suggests that a subjective standard should be used in its operation.

The determination of which of the various formulations of the discovery rule should be used and how it operates in the particular case is an issue that must be resolved by the court. In

Cikan v. ARCO Alaska, Inc., 125 P.3d 335, 342 (Alaska 2005) our Supreme Court stated:

> disputes concerning the statute of limitations raise preliminary questions of fact that should ordinarily be decided by the court after conducting an evidentiary hearing. In the present case, then, the superior court should conduct a pretrial evidentiary hearing on remand to resolve ARCO's statute-of-limitations defense.

In determining these preliminary evidentiary issues, the court will use the preponderance of evidence standard.

The cross-motion for summary judgement on fraudulent concealment seeks to prevent reliance on the statute of limitations due to the active concealment of facts that would prevent the plaintiff from being aware of her cause of action.

> "A party who fraudulently conceals from a plaintiff the existence of a cause of action may be estopped to plead the statute of limitation if the plaintiff's delay in bringing suit was occasioned by reliance on the false or fraudulent representation." To establish equitable estoppel, the plaintiff must show (1) fraudulent conduct, which may take the form of either an affirmative misrepresentation or a failure to disclose facts where there is a duty to do so; (2) justifiable reliance; and (3) damage.

Williams v. Williams, 129 P.3d 428, 432 (Alaska 2006).

Summary judgment may be entered for a party under Civil Rule 56 when there is no genuine issue as to any material fact and ... [the] party is entitled to judgment as a matter of law. All reasonable inferences of fact are drawn in favor of the party opposing the motion [for summary judgment] and against the moving party. *Kaiser v. Umialik Ins.*, 108 P.3d 876, 879 (Alaska 2005)(citations omitted).

ANALYSIS:

The plaintiff asks the court to use the date of Ms. Doe's psychological counseling with Ms. Werner when she disclosed Poole's conduct as the discovery date. It was only then that

she asserts that she learned that the sexual abuse she suffered at the hands of Poole was a cause of her ongoing mental injuries. Ms. Doe testified that she failed to discuss her abuse by Poole in her initial counseling with Mr. Mannen because he was Irish and Catholic. She also stated that her initial counseling with Ms. Werner was focused on crisis management and she did not consider disclosing about Poole. The plaintiff argues that the legislative history of AS 09.10.140 discloses that many people only connect their later life problems with earlier sexual abuse when in counseling. The testimony of Dr. Sperbeck at the evidentiary hearing was equivocal and not overly helpful regarding the issue of when a person in similar straits as Ms. Doe would objectively know that she had been injured by the sort of abuse that Poole allegedly visited upon her.

In his direct examination, the doctor discussed his opinion that Ms. Doe was suffering from serious psychological problems and that Poole's abuse was a cause of those problems. The doctor did testify at one point that Ms. Doe "couldn't connect the dots" to really understand the relationship between Poole's abuse and why she developed as she did. However, in response to the court's question he indicated that she may have understood the effect of the abuse but couldn't come forward to disclose it. He testified on several other occasions that the sexual abuse she suffered made it difficult or impossible to come forward and disclose what had happened. He also testified that is normal or common for adult victims of childhood sexual abuse to disclose in adulthood, often in the context of therapy, what had happened to them. He conceded that therapy is not a necessary prerequisite to disclosure. However, the court finds this testimony to be unhelpful to resolving the issue of the statute of limitations. The testimony concerning Ms. Doe's individual issues is directed to her subjective ability to discover the claims against the defendants. The testimony about the circumstances that objectively allow others to disclose abuse is likewise of little concern. The issue is not the time that an individual discloses abuse, but rather the time a victim objectively understands

that injury flows from the abuse that triggers the duty to inquire.

An individual has a duty to investigate when they are aware that another has wrongfully visited injury upon them. That duty to inquire does not await full recognition of the extent of the injury. *Sopko v. Dowell Schlumberger, Inc.*, 21 P.3d 1265, 1272 (Alaska 2001). Here, the plaintiff makes no assertion that she believed that Poole's action in sexually penetrating her was not wrong. Doe stated in her deposition that she knew what he did was wrong. Her action in avoiding even walking by him on the street demonstrates that she was aware that he had injured her. The court believes that any victim of such abuse would objectively feel these emotions. The central question of whether a victim would know that the abuse would cause psychological injuries that would manifest themselves years later is not so clear.

In Ms. Doe's case, however, the answer is clearer. She later, in adulthood, received training in the issue of child abuse. She authored articles that specifically noted:

> It is estimated that at least 50% of all sexually abused children never tell anyone about their abuse. . . . Many are later identified as having serious problems that interfere with their ability to cope with to [sic] pressures of adult life. Other victims, who lead normal, healthy lives are at risk for a number of other problems that interfere with personal happiness. Many suffer form low self-esteem, social skills and problems in trusting others, distorted attitudes toward sex resulting in poor sexual adjustment, problems with independence and mature judgment, and difficulties in providing proper parenting to their own children. More extreme problems may include mental illness, drug and alcohol abuse, suicide, physical abuse of children or partners, and sexual abuse of children or adults.

Evidentiary Hearing Exhibit AN (dated 2/16/89).

The court believes it must consider and attempt to determine if a reasonable person in a situation similar to Ms. Doe would have appreciated that the sexual abuse she experienced would have serious

long-standing consequences. By the time Ms. Doe wrote these things, she had graduated from high school, attended college, received extensive on-the-job training in child abuse, and worked in the field of child abuse prevention for years. That she could author articles like the one cited above demonstrates that she was aware of the problem of sexual abuse and its likely consequences. Dr. Sperbeck opined that these articles were merely unconscious "warning flags" raised for others, not evidence that she appreciated that these things were happening to her. The court believes, however, that a reasonable person who had received such training and worked in a similar job would be aware of the consequences of abuse. Perhaps not aware of the full extent of such consequences, but that knowledge is not necessary to trigger the duty to investigate.

However, in Ms. Doe's case, additional factors demonstrate that she subjectively knew that sexual abuse would likely result in psychological damage. In the early 1980s she discovered that her brother had sexually abused her daughter. Upon learning this, she reported his abuse to the authorities. She then arranged individual counseling for both of her children, enrolled in couples counseling with her husband and arranged counseling for the entire family. This seems to be evidence that Ms. Doe was aware of the potential for psychological injury from one or more instances of sexual abuse.

Ms. Doe asserts that the doctrine of fraudulent concealment prevents the assertion of the statute by the Catholic Bishop and the Jesuits. She argues that both the defendants were aware of conduct by Poole that suggested he was disposed to engage in sexual misconduct. The plaintiff asserts that the defendants were under a duty to disclose this information and their failure to do so is the sort of fraud by inaction that justifies application of the doctrine. The defendants deny a duty to disclose and the court fails to find such a duty exists. Additionally, a party generally cannot invoke estoppel "unless [they have] exercised due diligence in attempting to uncover the concealed

facts." *Waage v. Cutter Biological Div. of Miles Labs., Inc.*, 926 P.2d 1145, 1151 (Alaska 1996). Here, the allegedly concealed fact is that Poole presented an unreasonable threat of perpetrating sexual assault against individuals similar to Ms. Doe. However, by 1990, Ms. Doe knew that Fr. Poole presented more than a threat. It would have been utterly unreasonable for her not to be aware of this because she had been abused. Because Ms. Doe is not entitled to judgment as a matter of law on the issue of fraudulent concealment, her motion for summary judgment will be denied.

The court will find that by 1990 Ms. Doe had sufficient information to prompt an inquiry into the existence of a claim of sexual abuse against Fr. Poole. The court will further find that had she used reasonable diligence by that time, she would have discovered the effect of Poole's injury and the condition attributable to the series of acts he perpetrated. Because Doe took another fifteen years to file this suit, the court finds that the claims of Count I are time-barred and will dismiss them.

Similarly, Ms. Doe knew that Fr. Poole was associated with the Catholic Church and KNOM radio. Tom Busch testified that it was common knowledge in the community that Poole was a member of the Jesuit order. Consequently, Ms. Doe was on inquiry notice as to those entities responsibility under theories of vicarious liability, by that time as well. Therefore, the court will dismiss the plaintiff's claims against defendants Catholic Bishop and the Jesuits set out in Counts II, III and IV. Finally, the plaintiff has indicated she has no opposition to the dismissal of the claims in Count VI and IX against Fr. Poole.

CONCLUSION:

The court believes that application of the facts of this case to the binding authority it is required to follow mandates the decision reached here. Had Ms. Doe's background and life experiences been different, another result would have been reached. That the court is taking the

actions it has is in no way a decision condoning the actions of Fr. Poole, assuming they occurred. The court believes that a legislative remedy to the conundrum these cases present might be fair and reasonable. Perhaps something akin to SB 112, introduced in the most recent legislative session, will allow individuals who have been victimized to obtain fair redress these many years later.

For the reasons set out herein, the defendants' motions to dismiss are GRANTED. The plaintiff's motion for summary judgement on fraudulent concealment is DENIED. And the claims against Fr. Poole set out in Counts VI and IX are DISMISSED. Since these are the last theories of liability asserted against Poole, the claim for punitive damages against him, asserted in Count V, is also DISMISSED.

DATED AT NOME, ALASKA This 12th Day of September, 2007.

BEN ESCH
Superior Court Judge

I certify that on 9/13/07
a copy of the foregoing was mailed/given to: BY FAX EXCEPT THOMAS (CCT TRAN)
ROSA GROSECLOSE LYNCH
GORSKI, MANLY, THOMAS, HANSEN
Clerk EMP

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Judiciary

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/27/09

Health and Social Services Committee considered SENATE BILL NO. 47

SB 47 STATUTE OF LIMITATION FOR SEXUAL OFFENSES

"An Act relating to the statute of limitations for certain sexual offenses and permitting causes of action for certain sexual offenses that would otherwise be barred by the statute of limitations to be brought during a certain one-year period."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DOC	2/20			✓	
LAW	2/27			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	THOMAS	✓			
	PASKVAN				X
	DYSON	✓			
	[illegible]				
CHAIR:	DAVIS	X			

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130 Seward St #214
Juneau, Alaska 99801
Phone: (907) 586-3650
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www.andvsa.org

ANDVSA
Alaska Network on Domestic Violence & Sexual Assault

Pro Bono Office
PO Box 6631
Sitka, Alaska 99835
Phone: (907) 747-7545
Fax: (907)747-7547

February 26, 2009

Dear Senator French:

On behalf of the eighteen member domestic violence and sexual assault programs throughout the state that comprise the Alaska Network on Domestic Violence & Sexual Assault, we thank you for bringing forth SB 47.

As state-wide advocates for victims of sexual assault, we strongly support the right of all victims of sexual assault to pursue justice in our courts of law. SB 47 will allow past victims of sexual abuse, previously excluded by a statute of limitations, the right to file charges against their perpetrators no matter when the abuse occurred. This is the same right they would have today under current law.

The Network believes that this is a commonsense approach to ensure justice for all victims of sexual assault equally and in a timely manner. The Network is in full support of SB 47. Thank you for advocating for victims of sexual assault in our state, and if I may be of any assistance or provide you any information, please let me know.

Sincerely,

Peggy Brown
Executive Director

Cc: Lisa Mariotti, Policy Associate

ALASKA WOMEN'S LOBBY
AWL Mission: To defend and advance the rights and needs of Women, Children and Families in Alaska

P.O. Box 20891
Juneau, Alaska 99802-0891
www.akwomenslobby.org

2009
AWL Steering
Committee
Members

Caren Robinson
Lobbyist

Geran Tarr,
Chair

Jayne Andreen

Nancy Courtney

Grace Danborn

Torie Foote

Cady Lister

Patricia Macklin

Rebecca Madison

Lauree Morton

Jorden Nigro

Taber Rehbaum

Nancy Scheetz-
Freymiller

Libby Silberling

Rose Wysocki

Letter of Support
SB 47: Statute of Limitations for Sexual Offenses

The Alaska Women's Lobby, a statewide group defending and advancing the rights and needs of women, children and families, supports SB 47. It gives an important window of time to certain victims of felony sexual assault.

The statute of limitations for felony sexual assault was eliminated in 2001 for cases that were open at the time and for sexual assault that occurred after the passage of the bill. Unfortunately, the limitation was not lifted for those victims who were assaulted and the statute of limitations had already run. We applaud Senator French for introducing SB 47 which allows a one year period of time in which those victims may bring a civil action against the perpetrators who committed the sexual assault.

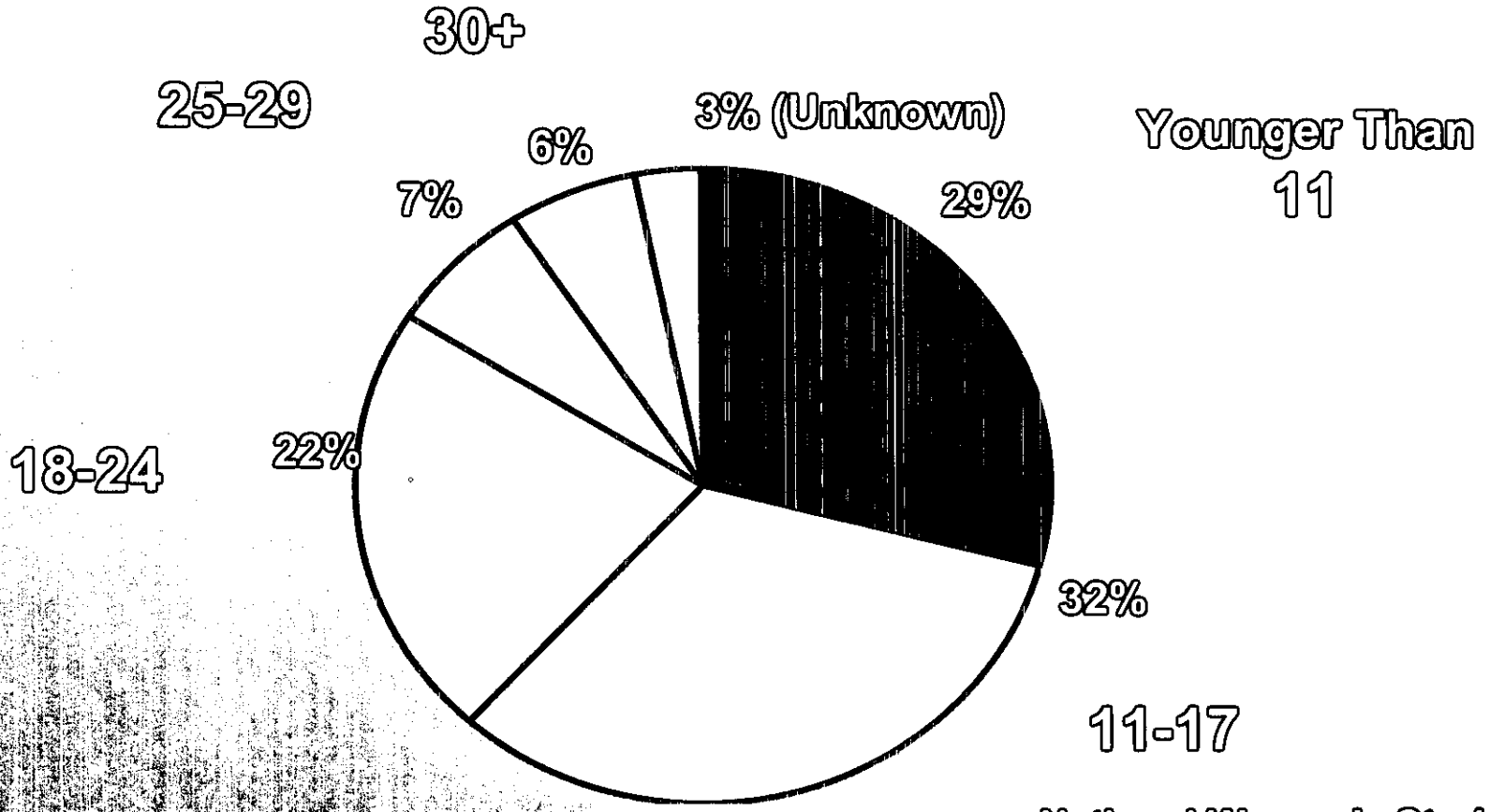
Sometimes civil actions are the only legal means to recover some measure of personal loss caused by the trauma of sexual assault and its emotional effects. The perpetrator or those responsible for an assault can be held accountable. The victim has a chance to tell her/his story and confront the perpetrator. The case can put the community on notice about the perpetrator. Having the perpetrator formally held accountable for his/her actions may provide relief to the victim and restore a sense of balance that has been missing for too long.

Creating this window of opportunity for justice and closure is the least we can do for those who continue to suffer in silence without a recourse that is available to anyone who has been assaulted since 2001. Please pass SB 47 this session.

Most Victims Are Young

61% of rapes victims are 17 years old or younger

Age at Time of Rape



National Women's Study (n=714)

Most Victims Know the Perpetrator

- Children
  - Fear of being disbelieved, punished or unprotected (Lawson & Chaffin, 1992)
  - Fear or experience of being blamed for break up of family
    - Often the outcome is more devastating to the child than to the perpetrator
    - Child is held responsible for the father's absence from the family
    - Almost 100% of children said they would not report the incident if they were molested again

(William Marshal presentation, Ass. Of the TX of Sex Abusers 1995)

Lag Time for Detection

Study	Type of Offender	# of Years
Freeman-Longo(1985)	Rapist	6
	Child Molester	13
Elliot (1986)	Paraphiliacs	10
Ahlmeyer et al.(2000)	Rapists and Child Molesters	16

PERSONAL & SOCIAL COSTS

- More than half of victims have been raped more than once
- Victims of sexual assault are:
  - 6x more likely to develop Post-Traumatic Stress Disorder
  - 3x more likely to develop major depression
  - 13x more likely to attempt suicide
  - 25 - 50% of rape and child sexual abuse victims receive some sort of mental health treatment as a result of the victimization (Miller, 1996)

Kilpatrick et al., 1992, Rape in America: Report to the Nation 1992

Senate Bill 47

SB 47

Brad Thomson, Director
Alaska Department of Administration
Division of Risk Management
~~645-5723~~ 465-5723

What is the financial exposure to the State of Alaska and it's political subdivisions?

to State issue would be my argument

Matt Kelly
Rep Carl P.

2/24 T.C. & Mr. Thomson - 235 - he does not plan to testify. - does not see impact on State - will be listening -

POSITION STATEMENT IN OPPOSITION TO SB 47

The Society of Jesus, Oregon Province

Senate Bill 47 seeks to make a retroactive change to the statute of limitations for certain civil claims alleging felony sexual abuse. Sexual abuse is a serious crime which must be eradicated from our society. SB 47, however, does not assist with that goal. SB 47 does not deter or prevent sexual abuse. Instead, it seeks to create a retroactive suspension of the statute of limitations to allow lawsuits to be filed to collect monetary damages for acts that took place many decades ago on claims which have already expired under existing law.

The Society of Jesus, Oregon Province ("Province") has been dealing with claims arising out of alleged sexual abuse of minors; claims date back to the 1940s and continue through the early 1990s. The vast majority of the claims are from 30-40 years ago. Alaska law has a series of statutes of limitations which have been interpreted by our courts so as to strike a balance between insuring claimants have enough time to file a claim and protecting persons from due process concerns that arise when subjected to stale claims.

Courts (and common sense) long have recognized that adjudications become less reliable with the passage of time; both our Alaska Supreme Court and the United States Supreme Court have said so. Over time, the risk grows that evidence may be lost or that key witnesses may disappear or die. The testimony of available witnesses also becomes less reliable over time as memories fade and recollections of events are colored by intervening experiences.

What SB 47 does is create a one year period of time where no statute of limitations whatsoever would apply. If this bill were to become law, it would pose serious problems for the State of Alaska, as well as public and private organizations within the state. The problems generally are as follows:

- Retroactively suspending the statute of limitations would impair the integrity of Alaska's judicial system for dispute resolution. Retroactive suspension would allow plaintiffs to make allegations of past wrongdoing without any consideration to how long ago the alleged wrongdoing occurred. As a result, the State of Alaska, public entities (such as, schools, correctional facilities foster care programs, municipalities—any government program where adults work with minors under age 18) and non-profit entities that work with children (such as the Boy and Girl Scouts, Boys and Girls Clubs, sports and religious organizations) will be subjected to defending claims alleging misconduct many decades ago.

- SB 47 would significantly increase the risk of inaccurate adjudications or potentially fraudulent claims. Although a plaintiff making an allegation necessarily would be alive and available to testify, the passage of time makes it likely that other key witnesses and evidence would be unavailable to disprove plaintiff's allegations. Documents about supervision and attendance (or potential insurance) are regularly discarded over time. Our system of justice works only when witnesses on both sides can be heard and one party is not deprived of important evidence. Reviving decades-old claims where an important witness or party has died or is unable to testify as to the allegations is inherently unfair.

- Strong arguments exist that SB 47 is unconstitutional. Due process and other constitutional considerations weigh against, and sometimes prohibit, retroactive revival of time-barred claims.

The primary beneficiaries of SB 47 are not necessarily real victims of abuse. It is public knowledge that in the 2008 settlement the Province made with more than 100 plaintiffs in Northern Alaska, $20 million of the $50 million settlement went to two private law firms. Moreover, in testimony before the Alaska Senate Judiciary Committee in 2007, the Executive Director of a victim's advocacy group testified that the normal recovery to victims of sexual abuse is approximately 30% on every dollar.

The Alaska legislature previously modified the statute of limitations to allow claims for felony sexual abuse to be initiated at any time for any claim arising after October 1, 2001. In addition, under the current state of the law (and as the Province is well aware), access to the courts for child sexual abuse is still possible with the understanding that claimants are required to demonstrate why their claims are timely under the law as it presently exists.

While the Province has recently filed for protection under Chapter 11 of the Bankruptcy Code, the fact remains that numerous claims are outstanding and remain to be decided and ultimately handled through the legal processes available under the law. The full impact of SB 47 is being evaluated, but at this point in time, the Province believes, as it did in years past, that SB 47 does not serve the public good of state, private and public institutions, as well as religious institutions. Thus, the Province believes that SB 47 is a bill that should not be passed into law.

SB

52

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Judiciary
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/23/09

Health and Social Services Committee considered SENATE BILL NO. 52

SB 52 SALVIA DIVINORUM AS CONTROLLED SUBSTANCE

"An Act relating to scheduling Salvia divinorum and Salvinorin A as controlled substances."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
COR	2/9			✓	1
DPS	2/9		✓		2
LAW	2/6		✓		3
ADM/OPA	2/9		✓		4
ADM/PDA	2/9		✓		5

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC.	AMEND
	ELLIS			X	
	THOMAS				✓
	PASKVAN			X	
	DYSON	✓			
CHAIR: Bettye Davis	DAVIS			X	

Committee Minutes
Apr 27, 2007

SB 38-SALVIA DIVINORUM AS CONTROLLED SUBSTANCE

2:32:44 PM
CHAIR FRENCH announced the consideration of SB 38.

SENATOR THERRIAULT, sponsor of SB 38, said Mr. Stancliff would introduce the bill.

DAVE STANCLIFF, Staff to Senator Therriault, said the bill will add Salvia divinorum, the most potent naturally occurring hallucinogenic substance on the planet, to the state's list of controlled substances. He cited cautionary testimony from users and said that young people in particular are being targeted. The problem law enforcement has with this substance is that it can't be detected in the bloodstream. Another problem is that it's readily available over the Internet and Alaska is considered to be a "green-light" state for shipping the substance. In fact it's being sold down the street and in other places around the state as incense. Indications are that shipments stop or are much reduced when an area becomes "red-light." Simply because the substance can't be identified in the bloodstream should not be an impediment to saying that Alaska is not a place to sell Salvia divinorum.

SB 38 simply places Salvia divinorum on same schedule II list as peyote, mescaline and LSD. This is not a safe drug, he concluded.

2:39:26 PM
CHAIR FRENCH recalled the bill coming through judiciary last year but he didn't recall its presence in local head shops. He asked if this is a new phenomena.

MR. STANCLIFF replied he discovered one shop in Anchorage and one in Fairbanks. Since that time a number of other locations have the substance including one down the street here in Juneau. It's a fairly good source of revenue. You can buy the leaf, the plant, or the extract. Use is proliferating and youths are being targeted. Many experienced "mind travelers" warn against its use, particularly for youths. But there is support for allowing people over age 18 to use the substance. That's a policy call you have to think about, he said.

2:41:38 PM
SENATOR McGUIRE asked if the problem is that law enforcement can't stop sales because there's nothing on the books about the substance.

MR. STANCLIFF said that is the problem; currently there is nothing that would allow interdiction.

SENATOR McGUIRE suggested it might be time to consider an ability for the Department of Public Safety to use something like the emergency regulation process before going to the legislature for a full vetting.

MR. STANCLIFF said an advantage to law enforcement is that it is very difficult to grow Salvia divinorum in places that it doesn't occur naturally. If Alaska were to become a "red-light" state it would be easier to control than a substance that readily grows here.

2:44:56 PM
CHAIR FRENCH questioned why the federal government hasn't taken any action on this substance.

MR. STANCLIFF answered it is on the Drug Enforcement Administration (DEA) watch list and federal legislation is being considered. Also, the Navy bans this substance as part of its administrative code. "I think they're just lagging behind the states and the states aren't waiting," he added.

CHAIR FRENCH pointed out that the substance is legal today. Passing this law means that in 90 days it would be a B felony to

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possess and an A felony to sell or distribute. It seems as though we've either severely under reacted on one side or we're about to severely over react on the other, he said.

MR. STANCLIFF said he isn't sure what happened with regard to transition periods when other psychotropic substances were made illegal. There is an increased awareness and he knows that Internet sites warn that Alaska is looking at outlawing the substance. Currently someone could argue that they thought the substance was sage and they'd have a good shot at a successful defense because the best chemists at the state lab can't identify the psychotropic substance from the plant.

CHAIR FRENCH clarified that the penalty for a C felony is 0-5 years with no presumptive sentence. The penalty for a B felony is 0-10 years with no presumptive sentence, but there's a guideline for serving. Referring to the statement that the lab can't identify the substance, he questioned how the crime could be prosecuted.

MR. STANCLIFF said a lab can identify the substance that causes the psychotropic reaction. The chemical and botanical difficulty is to identify that particular plant among thousands in the sage family.

2:49:08 PM
SENATOR WIELECHOWSKI referred to an article that says that Salvia divinorum has medical and research value. Noting that it's potentially being used as a non-addictive painkiller, for Alzheimer's disease, and mental illness he asked if this bill would ban medical use or research.

MR. STANCLIFF said no. In fact this is the only substance of its kind that promises to help people who have addictions to more serious substances. On the other side there's evidence that it exacerbates depression. It is an unpredictable substance and very little is known about it. Error on the side of caution, but keep the door open for medical and scientific purposes, he said.

SENATOR McGUIRE added there is nothing in the substance schedule that prohibits prescription. The bill says the penalties come into play unless the substance is prescribed. I don't see a problem as long as research and prescription by a licensed physician aren't prohibited.

CHAIR FRENCH observed that if the state makes the substance illegal, head shops will stop carrying it and the market will evaporate.

SENATOR McGUIRE suggested the committee consider an effective date to allow the public time to learn about the change in law. Intent language could also be added to make folks as aware as possible.

CHAIR FRENCH brought up the topic of an effective date.

SENATOR THERRIAULT said his sense is that a limited number of sites within the state are selling the substance so a long period isn't necessary.

CHAIR FRENCH agreed that 90-days would do it.

2:53:39 PM
SENATOR THERRIAULT noted that the poison quarterly newsletter warns against using Salvia divinorum. "There's a lot of alarming information about this and the power of this drug so I think it's advisable that we do take the step that is suggested in the legislation today," he stated.

CHAIR FRENCH said he supported the bill in a previous session. Finding no further questions or testimony he closed public testimony.

SENATOR McGUIRE motioned to report SB 38 from committee with individual recommendations and attached fiscal note(s). There being no objection, it was so ordered.

Committee Minutes
Mar 19, 2007

SB 38-SALVIA DIVINORUM AS CONTROLLED SUBSTANCE

2:51:04 PM
CHAIR BETTYE DAVIS announced SB 38 to be up for consideration.

DAVE STANCLIFF, staff to Senator Therriault, sponsor of SB 38, said that the bill would add Salvia divinorum to the state's list of controlled substances. It's the most potent naturally occurring hallucinogenic substance on the planet; there are groups on both sides of the issue of classification, and Mr. Stancliff cited testimony from users. Alaska is considered to be a "green-light" state for shipping of the substance, meaning it can be easily obtained over the internet without legal ramifications. It has gained popularity as a legal alternative to marijuana, and many young people have access to it. Studies indicate that the use of it is rising, while the internet is making it very easy to find. The state crime lab is in the process of creating a way to identify the presence of the drug in a user's system. SB 38 will send a message to all using the drug that it's a substance that is unpredictable, powerful, and dangerous, while allowing it to remain prescribeable for medical reasons. He added that the drug is currently available in Juneau and online; he showed print-outs from the internet showing the prevalence of Salvia divinorum information on the internet.

2:59:21 PM

SENATOR COWDERY asked if the drug is a plant.

MR. STANCLIFF said that it's a plant grown in Mexico, and a member of the sage genus; there's no blood or breath test available for the drug. The main purpose of the bill is to act as a disincentive to people shipping it to Alaska.

SENATOR COWDERY asked about the effects of the drug.

MR. STANCLIFF said that according to online research, the drug causes hallucinations and a state of uncontrolled delirium. It would be dangerous to operate a motor vehicle under the influence.

3:02:03 PM

JACK HURD, analyst for the Alaska Scientific Crime Detection Laboratory, said that he was available for questions on the bill.

SENATOR DYSON asked if people are victimized under the influence of the drug.

MR. STANCLIFF said that that would be possible.

SENATOR DYSON asked how many other states have criminalized the drug.

MR. STANCLIFF said that four states have banned it, and at least seven countries have banned it or control it heavily.

3:03:25 PM

SENATOR ELTON asked if the state crime laboratory is currently developing tests for identification in a person's body, and asked if there are costs incurred by the process.

MR. HURD said that the costs would be negligible.

SENATOR ELTON asked if the drug is federally banned.

MR. STANCLIFF said that the DEA has not placed it on its controlled substance list, although there have been several measures before Congress to begin that action.

3:05:06 PM

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JACK DEGENSTEIN, with the Alaskan Libertarian Party, said that he's studied the plant for the last four years, and the information in the sponsor statement is skewed. He said that the news on the drug has changed to become more pejorative over time, and that facts often cited about the case of a kid who committed suicide under the influence were not clearly used.

He explained that Salvia divinorum is not a similar substance to LSD or marijuana. The bill proposes to keep children from accessing the plant, but since it's federally legal it can't ever become totally illegal in Alaska. Other substances are more dangerous than Salvia divinorum, which doesn't cause brain damage. If Salvia is made illegal, it will simply be replaced by something else. It will only make criminals out of law-abiding citizens, and people using it irresponsibly will continue to do so. Vendors have said that they will continue sending it to Alaska despite a state ban, so the bill will be pointless.

He explained how the drug has been found to relieve depression where other substances have failed. Recent studies have shown that it relieves cocaine and opium addiction in rats; if the plant is made illegal in the state, research possibilities will be limited. The drug is non-toxic even with prolonged exposure, and shows promise in addiction help; the bill would be harmful to those wishing to cease their addictions. The bill could be altered to allow for older individuals to receive the plant; Maine is attempting to make it legal for those 18 and older, but a felony for provision to underage kids. The people who want to use the plant responsibly shouldn't be punished.

SENATOR COWDERY asked if the testifier had used the drug.

MR. DEGENSTEIN said that he had, 4 months previously.

SENATOR COWDERY asked how he found the plant.

MR. DEGENSTEIN replied that he ordered a live plant over the internet.

DAVIS said that there were some concerns about the bill but she thought it should be allowed to move through the system. She then asked the will of the body.

SENATOR COWDERY moved to report SB 38 from committee with individual recommendations and attached fiscal note(s). There being no objection, the motion carried.

CHAIR DAVIS, seeing no further business before the committee, adjourned the meeting at 3:16:47 PM.

Thank you Sue. SB 52

From: Stancliff, Sue M (DPS) [mailto:sue.stancliff@alaska.gov]
Sent: Tuesday, February 10, 2009 4:55 PM
To: Lynda Zaugg
Subject: SB 52 - Salvia
Importance: High

Linda,

If the committee needs information and assistance from the Department of Public Safety regarding SB 52 – Salvia, we will have the folks listed below available on teleconference:

Captain Keith Mallard, Commander, Alaska Bureau of Alcohol and Drug Enforcement
Location: Anchorage

David Schade, Director, Division of Statewide Services
Orin Dym, Forensic Laboratory Manager
Jack Hurd, Forensic Scientist
Location: Anchorage

If you need to reach me please feel free to call either number below. Thanks for your help.

Sue Stancliff
Special Assistant to the Commissioner
Legislative Liaison
Department of Public Safety
465-2649 desk
351-2722 cell

will be on line @ 2:30

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB 52**
() Publish Date:

Identifier (file name): SB052-DPS-LAB-02-09-09
Dept. Affected: Public Safety
Title "An Act relating to scheduling Salvia divinorum and Salvinorin A as controlled substances."
RDU Statewide Support
Component Laboratory Services
Sponsor Senator Therriault
Requester Senate Health & Social Services Committee
Component Number 527

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	***		***	***	***	***	***
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	***		***	***	***	***	***

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The controlling of Salvia divinorum (Salvinorin A) will impact the Controlled Substance and Evidence sections of the Alaska Scientific Crime Detection Laboratory; however, what this will look like and what the actual fiscal impact of this legislation will be cannot be accurately determined at this time.

Prepared by: Orin Dym, Forensic Laboratory Manager
Phone (907) 269-5743
Division Scientific Crime Detection Laboratory
Date/Time 2/10/09 9:00 AM
Approved by: Joe Masters, Commissioner
Date 2/10/2009

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: SB52-DOC-OC-02-09-09
Bill Version:
() Publish Date:

Identifier (file name): SB52-DOC-OC-02-09-09
Dept. Affected: DOC
Title: An Act Relating to Scheduling Salvia Divinorum and Salvinorin A
RDU: Administration & Support
Component: Office of the Commissioner
Sponsor: Therriault
Requester: Governor
Component Number: 694

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Passage of this legislation should not have a fiscal impact on the Department of Corrections.

Prepared by: Leslie Houston, Director
Phone 465-3339
Division: Administrative Services
Date/Time 2/9/2009 1600 hrs
Approved by: Dwayne Peeples
Date 2/9/2009
Deputy Commissioner

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 52
() Publish Date:

Identifier (file name): SB052-LAW-CRIM-02-04-09
Dept. Affected: Law
Title
RDU Criminal
An Act relating to scheduling Salvia divinorum and Salvinorin A as controlled substances.
Component Criminal Justice Litigation
Sponsor Senator Therriault
Requester Health and Social Services
Component Number 2202

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	***	***	***	***	***	***	***
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	***	***	***	***	***	***	***

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 52 adds a new substance – salvia divinorum and salvinorin A to schedule IIA of Alaska's schedules of controlled substances. The fiscal impact of this legislation connot be accurately determined at this time.

Prepared by: Dave Blaisdell, Director — Phone 465-3673
Division: Administrative Services Division — Date/Time 2/6/09 12:00 AM
Approved by: Talis Colberg — Date 2/6/2009
Attorney General

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB52
() Publish Date:

Identifier (file name): SB52-DOA-OPA-2-9-09
Dept. Affected: Administration
Title: An Act relating to scheduling Salvia divinorum and Salvinorin A as controlled substances
RDU: Legal and Advocacy Services
Component: Office of Public Advocacy
Sponsor: Senator Therriault
Requester: Senate Health and Social Services Committee
Component Number: 43

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	***	0.0	***	***	***	***	***
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	***	0.0	***	***	***	***	***

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation will add Salvia Divinorum to the list of controlled substances. Since Salvia Divinorum is not currently classified as a controlled substance and because the number criminal prosecutions this may generate is unknown, the agency cannot accurately predict the fiscal impact. Accordingly, OPA submits an indeterminate fiscal note.

Prepared by: Rachel Levitt, Director — Phone 907 269-3504
Division: Office of Pubic Advocacy — Date/Time 2/9/09, 11:00 a.m.
Approved by: Rachael Petro, Deputy Commissioner — Date 2/9/2009
Department of Administration

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB52
() Publish Date:

Identifier (file name): SB52-DOA-PDA-2-9-09
Dept. Affected: Administration
Title: An Act relating to scheduling Salvia divinorum and Salvinorin A as controlled substances
RDU: Legal and Advocacy Services
Component: Public Defender Agency
Sponsor: Senator Therriault
Requester: Senate Health and Social Services Committee
Component Number: 1631

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	***	0.0	***	***	***	***	***
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	***	0.0	***	***	***	***	***

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill adds Salvia Divinorum to the list of controlled substances. Because this substance has not previously been listed as a controlled substance, it is not possible to determine the potential fiscal impact. The Agency, therefore, submits an indeterminate fiscal note.

Prepared by: Quinlan Steiner, Director — Phone 907 334-4414
Division: Public Defender Agency — Date/Time 2/9/2009, 10:00 AM
Approved by: Rachael Petro, Deputy Commissioner — Date 2/9/2009
Department of Administration

(Revised 9/10/2008 OMB)

SENATOR
GENE THERRIAULT
Mailing Address:
292 Sadler Way, Suite 308
Fairbanks, Alaska 99701
(907) 488-0857
Fax: (907) 488-4271

Alaska State Legislature

Senate

While in session
State Capitol
Juneau, Alaska
99801-1182
(907) 465-4797
Fax: (907) 465-3884
Senate District F

Memorandum

To: Senator Bettye Davis / Chair of Senate HESS Committee

From: Senator Gene Therriault

Date: January 27, 2009

Re: Senate Bill 52 / Listing as a controlled substance, Salvia Divinorum

I respectfully request a hearing on Senate Bill 52. It is a bill your committee took up last session and passed out with strong support.

Unfortunately, it failed to clear the Finance Committee prior to adjournment so I have brought it back before the legislature this session.

Thank you for your cooperation and assistance in helping to get this dangerous hallucinogenic listed along with LSD, Mescaline and other similar substances.

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Email: Senator_Gene_Therriault@legis.state.ak.us

SENATOR
GENE THERRIAULT
Mailing Address:
292 Sadler Way, Suite 308
Fairbanks, Alaska 99701
(907) 488-0857
Fax: (907) 488-4271

Alaska State Legislature

Senate

While in session
State Capitol
Juneau, Alaska
99801-1182
(907) 465-4797
Fax: (907) 465-3884
SENATE DISTRICT F

Sponsor Statement

Senate Bill 52

Salvia Divinorum (pronounced Div-i-nor-um) is very powerful a hallucinogenic substance primarily grown in the mountainous regions of Mexico. It has a history of use as a vision inducing substance by the Mazatec Indians of the region. Because it is so easy to misuse and can produce long-lasting psychological effects, it is banned in several countries and an ever growing number of states.

The leaves of this perennial herb, once processed can be eaten, drunk as a tea, or inhaled. Salvia is presently available to persons in Alaska who choose to order it over the Internet. Although purchasers of this substance are asked to certify they are over the age of 18, we know such restrictions are loosely applied. Sellers and their web sites promise mind-altering experiences, but experts warn that depression and schizophrenia are very real risks with this drug. (www.intheknowzone.com)

As with all items that enter the pop drug culture, Salvia Divinorum is enjoying a rise in use due to the lack of restrictions. We have an opportunity to get ahead of this powerful substance and reduce the risk to our young people by following the lead of other states and countries in declaring Salvia a dangerous substance and adding it to our Schedule II list of illegal drugs. Such action would place it in the same category as mescaline and Peyote.

I urge your support for this important action.

Email: Senator_Gene_Therriault@legis.state.ak.us

delawareonline The News Journal

http://www.delawareonline.com/apps/pbcs.dll/article?AID=/20060226/NEWS/602260356/1006

Legal high new worry for parents

LSD-like herb blamed in Delaware teen's suicide

BY MIKE CHALMERS
THE NEWS JOURNAL
02/26/2006

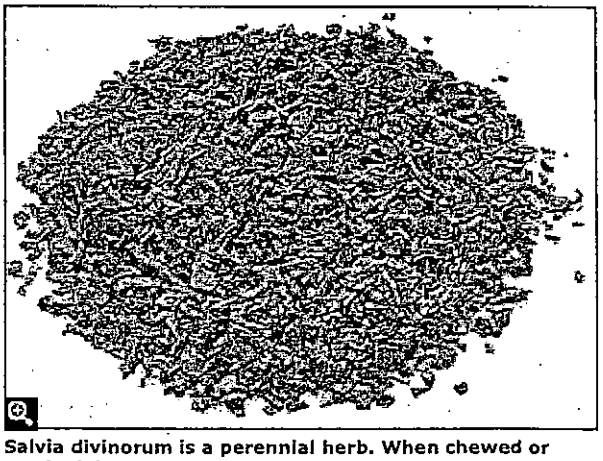
In the daily search for reasons behind their 17-year-old son's suicide, Dennis and Kathy Chidester keep coming back to the same answer: salvia divinorum.

The herb, a cousin of the flowering sages enjoyed by backyard gardeners, contains the world's most potent natural hallucinogen, as strong as LSD. The drug is legal in most states, including Delaware, and easily available through hundreds of Internet sites, including eBay.

That aura of legitimacy lulled Brett Chidester, a straight-A senior at Salesianum School, into thinking smoking salvia leaves was safe, even while convincing himself that he had gained incredible insights into the universe, his parents said.

COURTESY OF THE CHIDESTER FAMILY

Bret Chidester's parents are certain that smoking salvia divinorum led him to take his own life.



Salvia divinorum is a perennial herb. When chewed or smoked, it produces LSD-type hallucinations.

"Salvia allows us to give up our senses and wander in the interdimensional time and space," Brett wrote in an essay his parents found after his death. "Also, and this is probably hard for most to accept, our existence in general is pointless. Final point: Us earthly humans are nothing."

Brett acted on that belief Jan. 23.

Dennis Chidester had been trying to call Brett all day with no luck. He came home at 5 p.m., opened the garage door and saw a tent pitched inside -- an odd sight that he didn't process right away.

"I just ran upstairs calling his name," Chidester remembered. "Now my heart's pounding. He's not in his room. I go downstairs, I go into the garage and I open up that tent.

"That's the one thing I didn't want to do," he said, his voice cracking. "I found him in there, dead. He had taken a charcoal grill and ... carbon monoxide poisoning."

About the time Brett Chidester started smoking salvia, his parents say, he began falling into moods of anger or melancholy.

Brett's essay, suicide note and actions before his death still

leave his parents with more questions than answers.

"We just won't have any answers, and we have to learn to accept that," Kathy Chidester said. "But my gut feeling is it was the salvia. It's the only thing that can explain it."

Abuse concerns DEA

Mazatec Indians have used salvia divinorum to divine spiritual truths for hundreds or thousands of years, experts said. Outsiders discovered it in the 1960s, but it remained a relatively obscure drug until popularized on the Internet, beginning in the 1990s. It's now sold as live plants that can be grown indoors, dried leaves or liquid extracts, from tiny bags costing a few dollars to wholesale shipments for hundreds of dollars.

"You type 'salvia divinorum' in a search engine and you get 10,000 hits, most of which are head shops on the Internet," said Thomas E. Prisinzano, a medical researcher at the University of Iowa. "That's not good. People are going to abuse it."

Experts and users say when the leaves are chewed or smoked, they produce powerful visions that make users believe they're in an alternate place and time. Despite its growing popularity online, law enforcement and health officials, as well as several teenagers and their parents, said salvia is not a common drug in Delaware.

Since 2003, the federal Drug Enforcement Agency has considered salvia divinorum a "drug of concern" because of its wide availability, potential for abuse and unknown long-term effects. Louisiana, Missouri and several countries have outlawed it, but congressional attempts to control it in the United States have failed, in part because of a reluctance to infringe on the religious freedoms of American Indians.

"It's dangerous," DEA spokeswoman Rogene Waite said. "Just because it's not a controlled substance, people shouldn't think it's OK to use it."

Dennis and Kathy Chidester, who divorced when Brett was 3, are uncomfortable talking publicly about their son's salvia use and suicide. But, they said, they are more uncomfortable remaining silent and letting other parents learn through tragedy.

"If other states can [regulate] it, why do we have to wait for a nationwide law?" Dennis Chidester said. "States should act on their own."

Delaware should consider outlawing salvia, two state legislators said. Sen. Karen E. Peterson, chairwoman of the Senate Combat Drug Abuse Committee, and Rep. Pamela S. Maier, chairwoman of the House Health and Human Development Committee, had not heard of the herb but said they would look at the laws in Louisiana and Missouri.

COURTESY OF THE CHIDESTER FAMILY

SALVIA Q&A

Is it legal?

It is not a controlled substance, so it is legal to own, use and distribute salvia divinorum in Delaware and most states. Louisiana, Missouri and several countries have outlawed salvia.

What are the effects?

The DEA considers salvia divinorum a "drug of concern" because its full effects are not known. Researchers said they do not know the long-term effects of using salvia.

Is it addictive?

Researchers and users said salvia is not addictive.

Who uses it?

Mazatec Indians have chewed salvia divinorum for ritual divination and healing for hundreds of years. Westerners discovered it in the 1960s, and its popularity has grown among teenagers and young adults since the 1990s because of availability over the Internet.

Does it have other uses?

Medical researchers are interested in the herb's potential to treat pain without addiction and to better understand Alzheimer's, Parkinson's and other diseases that alter a patient's perception of reality.

How is it sold?

Web sites and Internet vendors sell salvia divinorum as live plants, dried leaves, crushed leaves and a liquid extract.

Legislators in those states banned salvia last year over concerns about teenagers' abuse of it and other hallucinogenic plants.

"It was being marketed to high school kids," said Scott Lipke, a Missouri state representative. "It's not a widespread problem, but we were trying to be out in front on it."

Delaware police said they know little about salvia. "I don't think we'd even know what it is," said Sgt. William Wells, Wilmington police spokesman.

Health officials said it hasn't hit their radar screen, either.

"If it's not an FDA-regulated drug, we couldn't track it any more than we could track someone using ginkgo biloba," said Heidi Truschel-Light, spokeswoman for the Delaware Division of Public Health.

Local merchants who sell glass pipes and other smoking supplies said they don't sell salvia, even though customers ask for it and wholesalers have urged them carry it.

"Kids come in here all the time and ask for it," said Randy Neil, a cashier at Frolic in Newark. "But we don't mess with it. As far as I know, the only place you can get it is the Internet. Probably the reason it's legal now is most people don't know about it."

'Getting deep'

Dennis and Kathy Chidester had never heard of salvia until Brett's cousin told them last summer that she was worried about his salvia use.

About the same time, a friend showed Kathy Chidester Brett's site on MySpace.com, an Internet service where teenagers can chat and share pictures and music. Brett's site contained a video of him and a friend smoking salvia. She confronted him.

"He kept saying, 'Mom, it's legal. It's just an herb. The Indians used to use it to divine knowledge of the universe,' " she remembered. He told them he stopped using salvia, and they believed him.

Still, when Brett was out with friends, his parents would stay up until he came home.

"I thought, if he's doing this stuff or he's drinking, I'm going to know," Kathy Chidester said. "And when he came home, he would be normal, always normal."

Experts said salvia's effects last from a few minutes to an hour or two, with no hangover or other symptoms. Daniel Siebert, a California botanist who sells the herb online and promotes its "responsible" use, described the experience as similar to a vivid

dream. "It's like your mind is on autopilot," Siebert said. "Your brain is generating images that have some kind of narrative line to them. It puts your mind in a very introspective place. It's a way of getting deep inside yourself."

Siebert said crowds and loud music make a salvia-induced trip unpleasant, so it's unlikely people would use it as a "party drug" more than once or twice. He supports some regulations on salvia, such as age restrictions and penalties for driving under the influence of salvia.

"People take their experiences way too literally and read too many things into it," Siebert said. "If you take it literally, you really believe you've traveled to other dimensions and met other beings that told you things. Minors are particularly prone to not understanding that."

That doesn't stop some Internet merchants from billing salvia as a legal, albeit more expensive, alternative to illicit recreational drugs.

The site where Brett Chidester got at least one batch sells it in packages dubbed "mind bender," "mood mix" and "freshman selection." It sells a "party pack" of three different strengths of extract, plus four ounces of leaves, for $207.90.

Promising medical use

Salvia does have legitimate research value.

Prisinzano, who earned a bachelor's degree in chemistry from the University of Delaware in 1995, is studying whether salvia's main ingredient, salvinorin A, could be used to create a nonaddictive painkiller. Also, he said, understanding the way salvia creates hallucinations could help scientists better understand Alzheimer's disease and mental illnesses that alter patients' perceptions of reality.

"It's actually become a hot area of research," said Bryan Roth, a leading salvia researcher at Case Western Reserve University in Cleveland. In 2002, he discovered how salvinorin A travels through the brain.

One salvia user described watching a mountain lake turn into a desert, Roth said. Another said she found herself in a room with an alternate future behind each door. She picked one door and saw the death of her child, he said.

"Depending on the dose, it can cause a mild sense of distortion," Roth said. "In the extreme, people are basically shot out into another reality, another place and time."

A changed son

Dennis and Kathy Chidester think that's what happened to Brett.

About the time Brett began using salvia, he became more melancholy and had trouble sleeping, his parents said. He was sometimes angry for no reason. Because Brett had never displayed typical teenager moodiness, they thought he was just catching up to his peers.

"He definitely changed," Kathy Chidester said. "It wasn't a drastic change. I just figured well, this is the other shoe dropping. This is what teenagers are like and we haven't experienced it."

The week before Brett's suicide, Kathy Chidester called him from Austria, where she was leading an annual ski trip for the Wilmington Ski Club. Brett said he was fine and probably was going to make the Salesianum honor roll again.

The next Saturday night, Jan. 21, Brett went to his girlfriend's homecoming dance. In the few months they had been dating, the relationship had become serious, his parents said. Brett noted in his daily planner that he was going to buy her flowers and take her to dinner for Valentine's Day.

Brett spent much of the weekend writing college application essays, hoping to become an architect. Brett was off work Monday, Jan. 23, from his job in the dining room of Cokesbury Village, an assisted living facility.

He was still sleeping when his father left the house that morning.

"Mom and Dad, don't worry about me," Brett wrote in his suicide note. "Please don't cry. I love you guys so much. I always have. Take a vacation. You deserve it. Please do not be sad. I want you to carry on your lives. Remember me and be happy when you think of me, not sad. Tell yourselves I'm in a better place, because I am. I'm sorry I didn't get to say goodbye before this, but I love you."

Contact Mike Chalmers at 324-2790 or mchalmers@delawareonline.com.

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SALVIA DIVINORUM

(Hallucinogenic) sage, Salvia divinorum, salvia, the matrix

Salvia is derived from the American plant *Salvia divinorum*, a member of the mint family. It is used by the Mazatecs and others in Meso America. It is marketed in the UK under many guises. In head and sex shops it is often sold as herbal ecstasy, using names such as Eclipse. It is also sold as a dried natural high, intended for smoking (in variable amounts) or as a herbal remedy under its botanical name, or as the matrix or 'hallucinogenic sage'.

"Salvinorin A" the active component of Salvia Divinorum, is most effective when vaporized and inhaled, but the most common way to take it is by swallowing or smoking. Its effects are more hallucinatory than other legal highs - though high doses of the raw plant are usually needed to achieve these effects.

A dose of 200-500 mcg produces profound hallucinations that last from 30 minutes to an hour or two, while doses over 2mg are effective for much longer. According to the literature, doses greater than 500 mcg can cause the user to become completely unaware of their surroundings and enter a state of uncontrollable delerium during which they must be watched carefully. [1]

[1] *Salvia Divinorum and the Unique Diterpene Hallucinogen Salvinorin (Divinorin) A.*, Valdes, L.J., From: Journal of Psychoactive Drugs, vol.26 (3), 1994. p.277-283.

Updated October 2003

Powerful but legal, hallucinogenic under scrutiny

USA Today

A little-known hallucinogenic leaf that is legal in most of the USA is the target of new calls for a ban after the suicide of a teenager who smoked it.

Salvia, a relative of flowering sages enjoyed by many gardeners, is the most powerful natural hallucinogen known — almost as strong as LSD, experts say. Known as "diviner's sage," salvia has been used for centuries by the Mazatec Indians in Mexico. In the USA it is sold in leaf and liquid form by websites and head shops and is available to anyone at any age.

"Kids fall into a false sense of security because it's legal," says state Sen. Karen Peterson, a Delaware Democrat. "We control LSD, and we should control this."

Peterson has filed a bill to make Delaware the third state to designate *Salvia divinorum* a banned substance like marijuana and heroin. Louisiana and Missouri have already taken such action.

Her action came in response to the suicide of Brett Chidester, 17, of Wilmington, Del., whose family blames the drug.

Brett was a straight-A student who ranked top in his state in Spanish and was making plans for college and to buy his girlfriend roses for Valentine's Day, his family says. On Jan. 23 he put a charcoal grill inside a tent in his father's garage, lit the grill and crawled inside the tent.

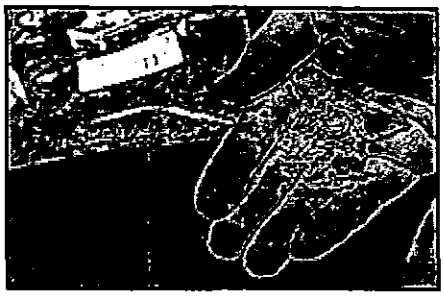
A suicide note described revelations that echoed descriptions of salvia experiences posted by users to various salvia-related websites. "How can I go on living after I learned the secrets of life," he wrote. "It took me 17 years, but I finally figured it out. I can't tell you that here because that kind of information can cause chaos."

His mother, Kathleen Chidester, says her son bought salvia on a website. His father, Dennis, says police took salvia from his room. Kathleen Chidester says she believes Brett was depressed and used salvia because it was legal. His suicide note left no doubt in her mind that salvia had something to do with his death.

Despite salvia's powerful nature, the Drug Enforcement Administration has not recommended that it be banned as a dangerous drug. The DEA has been collecting information for years on the leaf, says Rogene Waite, a spokeswoman for DEA. The process involves measuring its availability, potential for abuse and medical uses.

November 13, 2005

Salvia: It's intense, it's dangerous, it's inexpensive ... and it's legal



Salvia is a powerful, legal herb from Mexico that produces vivid, often terrifying hallucinations. The drug is sold in Magic Man in various strengths.

Mail Tribune / Bob Pennell

By JOHN DARLING
for the Mail Tribune

Few police, teachers or counselors have even heard of it, but the drug salvia — a powerful psychedelic herb from Mexico — is legal in the U.S. and easily purchased over the counter in Medford or on eBay.

Also known as Diviner's Sage or Sally-D, salvia divinorum is extremely intense, say those who have tried it. They say it is as powerful or more so than LSD and produces vivid, often terrifying hallucinations and out-of-body experiences lasting five to 10 minutes. Effects vary widely; a few users report little or no effect.

The herb is sold at Magic Man in the Bear Creek Shopping Center in various strengths for $11.95 to $44.95. In Ashland, Zen Den doesn't sell it and Puff's used to but stopped.

Theresa Jermain of Medford called police when a 17-year-old high school student, for whom she is guardian, bought salvia at Magic Man and, after smoking it, told her he "got real high" and it was "way too strong."

After checking out the shop, police reported back to Jermain that the drug was not illegal and there was nothing they could do, she said.

The student, "Chris," who asked not to be identified by his full name, said he smoked it with 15 fellow South Medford High School students and that only three of them had a "good trip" – the rest being "very bad." Students, he added, are little aware of the drug and it's not being much used there.

He described his experience as an "out-of-body experience in a totally different world" followed by a bad "body high," in which he felt sick and awkward and couldn't move. With a cell phone, he videoed another student on salvia hallucinating and trying to crawl out the back window of a car, he said.

Sheriff's Lt. Dewey Patten, commander of the Jackson County Narcotics Enforcement Team, said he wasn't aware of the drug. "I don't know what we'd do if we found someone whacked on it, because it's not illegal," he said.

Jan Janssen, community outreach officer with Ashland Police, said she'd never encountered it, but after consulting the drug Web site erowid.org, said it's surprising that it's legal, considering that most users report unfavorable experiences. Ashland officers trained as drug recognition experts do know the drug and can spot its effects, she said.

Patten consulted a comprehensive drug reference, "Uppers, Downers and All-Arounders," co-written by Ashlander William Cohen, who also lectures and makes films about psychoactive drugs.

Salvia, wrote Cohen, is similar to PCP and originates among the Mazatec Indians of Oaxaca, Mexico, who use it to induce dreamlike hallucinations, delirium and out-of-body experiences, so as to seek out the causes of illness.

The effects, or "trip," last up to 10 minutes, tapering off over half an hour, with the nature of the trip dependent on the person's mind-set and surroundings.

"Cliff," a 19-year-old from Ashland who asked not to be identified, called salvia an "anti-drug drug" because his trip was so intense that it turned him off alcohol and drugs.

"In my first trip, my legs turned to a waterfall of tears," said Cliff. "The second time, I thought, seriously, that I had died and that my soul was being sucked out of me. It was the most intense thing I've ever done. Coming off it, I felt needles were coming out of my body. It definitely had teaching value because I was abusing (alcohol and drugs) and it gave me a lot of insight about what I was doing."

Magic Man owner John Hopf said salvia is sold as an incense or meditative aid like sage — and that customers learn about it on the Internet and come in to buy it. Although Hopf said he knows of no psychedelic properties for the plant, his store had a stack of printouts from a government Web site warning that salvia is a powerful hallucinogen.

"Pete," 27, another Medford resident who used salvia and asked not to be identified, said he had bought salvia from Magic Man seven or eight times. He described it as "a meditative thing that helps you feel a reality outside the ordinary reality and become one with yourself, as a unity."

He added, "It's very personal, not smoke-a-bowl-and-relax."

"Max," an 18-year-old senior at North Medford High School who bought salvia last week at Magic Man and declined to be identified, said friends suggested he try it. "I'm curious. I'll probably feel good for a while and hallucinate. They said it was worth the money for the feeling you get."

The federal Drug Enforcement Administration has the plant under review based on its potential abuse, availability and effects on users, said DEA public affairs officer Lauren Alder in Washington, D.C.

"The DEA lists it as 'of concern,' but just because it's not listed as a controlled substance doesn't mean it's healthy or safe," said Alder. "The medical profession stresses the danger of it."

The DEA Web page on salvia — www.usdoj.gov/dea/pubs/states/newsrel/newark_intel_bulletin_salvia.html — classifies it as a psychoactive terpenoid, a family that includes marijuana. It produces "profound hallucinations," with effects similar to mescaline, the DEA bulletin said.

The DEA welcomes comments at its Drug and Chemical Evaluation Section: 202-307-8570 (fax) or 202-307-7183 (phone).

Three years ago, staff Oregonian columnist Margie Boule branded salvia "the most powerful natural hallucinogen known on earth."

"Salvia divinorum is a wild ride," wrote Boule. "This is not a drug that simply makes people play Beatles' records backward. It induces powerful hallucinations that sometimes are terrifying."

Salvia is illegal in Australia, Italy, Denmark, Norway and South Korea. California Rep. Joe Baca in

2002 introduced a bill to ban it in the U.S., but, says erowid.org, it is chemically different from schedule I and II drugs, so it is not covered by the federal law used to ban drugs.

SALVIA

salvia divinorum

- **Other names**: Diviner's Sage, Sally-D
- **Cost**: Sold in various strengths for from $11.95 to $44.95 a bag
- **Use**: Similar to PCP, intense hallucinations lasting for 5-10 minutes when the drug is smoked
- **Legal use**: An incense or meditative aid, akin to sage
- **Federal position**: The U.S. Drug Enforcement Administration has the plant under review. The government classifies it as a psychoactive terpenoid, with effects similar to mescaline
- **Why is it still legal?** Chemically differences from schedule I and II drugs mean it is not covered by the federal law used to ban drug
- **Where is it banned?** Australia, Italy, Denmark, Norway and South Korea
- **Salvia web site**: erowid.org
- **DEA information**: www.usdoj.gov/dea/pubs/states/newsrel/newark_intel_bulletin_salvia.html
- **Comments**: The DEA welcomes comments at its Drug and Chemical Evaluation Section: 202-307-8570 (fax) or 202-307-7183 (phone).

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You can find this story online at:
http://www.mailtribune.com/archive/2005/1113/local/stories/11local.htm

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The Legal Hallucinogen Targeted to Teens

By Laura Dawn Lewis

Salvia Divinorum (Salvia) or *Salvinorin A*, street names *Salvia, Divine Sage* and *Magic Mint* is a legal, powerful natural hallucinogen marketed to and easily accessed by teens on the web and at times, health and spirituality stores. Health care and law enforcement officials described Salvia as the organic hallucinogen as potent as LSD. Users dispute the comparing of Salvia to LSD and insist that it is a mild, harmless perception and spirituality enhancer.

Generally it takes science a few years to catch up with new herbal remedies that create potentially harmful reactions. This may be why even the DEA cannot respond to many questions regarding *Salvia Divinorum*. Though the DEA may not be able to junior high, high school and college students can.

Salvia Divinorum is currently legal in every country but Australia. The Australian government banned Salvia effective as of June 2002. Salvia is a member of the sage family and a common garden plant. To date, the Divinorum species of Salvia seems to be the only member of this family with perception-altering or intoxicating capabilities. Divinorum seeds are rare.

NEW Salvia Divinorum Special

IN STOCK!!!!
Get the best of both worlds with 1/2 oz. of Prime Salvia Leaves & 1 gm Salvia standardized 5x Extract
For a limited time $36

Salvia Divinorum Leaves -Prime Oaxacan Harvest Leaves

The leaves are harvested fresh in the high mountains of Oaxacan by the native people of that region, then dried, cured & blessed. Oaxacan salvia leaves are known to be 50% more potent than Hawaiian or other grown salvia leaves. These are the highest potency and quality leaves you can get anywhere.

$20 for 1/2 oz. (14 g) of Prime Salvia Divinorum Leaves
$35 for 1 oz. (28 g) of Prime Salvia Divinorum Leaves

Actual Sales Copy from a Salvia Dealers Web site

Salvia Divinorum is not a new drug or plant. Classified in the sage/mint family the Mazatec Indians of Northern Mountains in Oaxaca, Mexico have been using the leafy plant in healing and in religious ceremonies for centuries. The drug itself provides a trip for the user that can range from mild to extreme. Cases have been documented of users falling asleep while driving and walking through glass walls while under its influence.

Referring to the above cases, a 23-year-old Salvia defender in Pittsburgh, PA commented, *"You state things like, it could cause a user to fall asleep while driving. What idiot would use this while trying to drive a car?"*

Users argue that the effect lasts only about five minutes. One responded to this article by stating, *"When salvia is smoked the "trip" only lasts about 3 minutes."* The few medical sources we were able to find with some

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> background on Salvia placed intoxication closer to thirty to forty minutes. Several aficionados also insist that the effects *"Aren't much more "intense" than smoking tobacco"*.

User sites dispute our reader's assertion that Salvia highs are no more intense than smoking tobacco. Search and you will see notations referring the 5th and 6th levels of intoxication, called immaterial and amnesiac. These notations dispute what many of the users are stating and do warn of the potential hazards and need for supervision. These are stressed for the highest level, Amnesiac.

"User remains conscious but loses accurate perception of actual surroundings. At this point the person should not be left alone and must have a sober person in the room. The user is in an altered reality, will wander and encounter brief periods of unconsciousness and blackouts."

The DEA's limited information on Salvia describes its use as follows: "*Salvia is being smoked to induce hallucinations, the diversity of which are described by its users to be similar to those induced by ketamine, mescaline, or psilocybin. It is being widely touted on internet sites aimed at young adults and adolescents eager to experiment with these types of substances.*"

Access

Obtaining this drug is as simple as entering a store or visiting eBay. Users adamantly defend its virtues and their right to partake in its pleasures. The following came in to Couples Company from a reader. We found this letter interesting because unlike the others it wasn't angry but it does illustrate the allure. The writer is also mature and in his mid-thirties, showing the appeal to this drug transcends generations.

> Dear Couples Company.
>
> Thank you for bringing this subject to parents' attention. I wonder, why would the parents be the last to know about this plant? In answer to my own question, I say the parents are too comfortable in their lives and they don't want to know. Answering your question - I do know what salvia is. My first experience took place last December. Even though I had been reading what other people posted about their encounters with salvia for a few months before I got enough courage to try it myself (unfortunately, I am not a teenager any more). It was so unexpected, so moving, so out-of-this-world that you wouldn't believe. That experience that lasted no more than 5 minutes of Earth time changed my outlook on life in general and my life in particular. I set up a site to collect any salvia related posts that were ever published online - SalviaDivinorumCorps.org, started a discussion group "SalviaD Alliance" on Yahoo and recently formed "Salvia Buyers Club" to provide good quality salvia at wholesale prices to salvia community. My advice to the parents - take it into your hands, "say once to salvia" and be the judges what is good for your children.

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Sincerely,
Slava M 37,
Potomac Falls, VA

Salvia is not just an intercity drug issue; like crack or ecstasy it is in small towns and the big cities. This legal consciousness-altering drug is being used in small towns and major cities around the world. The Internet makes it accessible by overnight delivery to anyone with a credit card, checking account or money order. About half of the 30 web sites we visited selling this drug were based in Germany. The rest are US based.

"Some drugs alter reality in such a way that you come face to face with thoughts that which you have been afraid to confront. There is a reason these substances have been (some still are) researched for psychiatric application," states an anonymous reader of Couples Company.

"This is an escape drug? You are totally wrong, unless you consider 3 minutes of calm an escape. No, alcohol is an escape drug," comments another reader.

Though users argue the drug does not offer an escape from reality, their web sites, comments and culture contradict this through the act of assigning varying descriptions to levels of intoxication or the exaltation of the trips; the creation of a special language for the drug and its altered states of reality. The documentation of experiences under the influence of the drug as exceptional, extraordinary and life-changing. These actions dispute and disprove claims of non-escapism or of a drug with little impact on the user.

Targeting Teens

The target market for Salvia is teens and twenty-something's and it taps into the issues, insecurities and confusion this age group struggles with and identifies with. Salvia ads promise to deliver spiritual enlightenment and bliss to the user. Testimonials from other users further convince and persuade potential users of the benefits of using the product. Many Salvia sales web sites includes step-by-step instructions for smoking the product, while enthusiastically showcasing the results through affirming statements, user trip reports and other personal accounts of the experiences. The following is the introduction from one of the largest legal Salvia dealers on the web:

General FAQ's

A typical ounce usually contains 100 – 200
One ounce = 4 to 12 doses

To achieve moderately strong effects from 1/2 gram of average potency leaf, or 1/4 gram of stronger material.

Salvinorin A is the fortified leaf

"Salvia Divinorum has been steadily growing in popularity over the last few years due to the incredible visionary mystical experiences people are having. Many People are discovering Salvia Divinorum as a powerful tool for soul searching, exploration of consciousness and pure bliss."

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From this copy it is easy to see why many people refer to Salvia as the legal LSD Travel back in time to the 1960's and this same statement, nearly verbatim could be heard emanating from the lips of those enjoying or promoting LSD. Many *Salvia Trip Reports* are also eerily similar to the trip descriptions recorded by those on LSD.

> *"There were beautiful closed eye visuals: a dome composed of ribs of light forming arched groining like that of a Gothic cathedral. The colors were the iridescent rainbow in a peacock's tail. This "reality" opened into another one: a narrow red rock canyon with a fast moving river plunging over rocks.*
>
> *I then felt that I was no longer a specific individual, but was an awareness that opened into every individual's consciousness everywhere, forever. I had the feeling that there was a lesson to be learned."*
>
> Salvia Trip Report

Also like LSD, Salvia users have created their own language, logic and culture based around the experiences and consumption of the drug.

Salvia & Health

Salvia is endorsed and marketed by dealers as healthy with spiritual significance. Spirituality is empowered through the action of blessing the dried and cured leaves by an Indian Shaman. Then the leaves are consumed by smoking or chewing.

The health claims are easily disproved by the fact that the leaves are smoked. To date no scientific evidence exists to prove a medicinal purpose for this drug. It also must be noted that scientists have been unable to determine how it works. It does not appear to alter the nervous system and scientists speculate its effects can range from hormonal to affecting a gland yet to be studied. It is possible at a later date a medical purpose may be discovered. Claiming health benefits at this time has no foundation and is simply marketing.

Salvia is also marketed in high-potency drops referred to as Emerald Essence. The drops enter blood stream through the cells in the mouth where it is held for a period of time. Users insist the drops have no effect if ingested or added to food. Currently no scientific research or evidence exists to either prove or disprove this statement.

Salvia & Spirituality

The faith claim for Salvia is stronger than the health claims. As one reader points out, *"For countless millennia, Shamanic traditions have used plant medicines and plant teachers for ceremonial and spiritual use."*

Ancient Indian religions may use Salvia as part of their worship, but the majority of people using the drug today do not subscribe to Shamanic traditions and are not using it

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for religious purposes. Cocaine, peyote, opium and other drugs have also been used in religious observances in the past. To claim and use the drug as a religious necessity, users would need to convert and practice the Mazatec Indian's faith and then only use it for ceremonial purposes.

What Salvia Does:

Salvia Divinorum provides the user with an escape, or as users prefer, an enhancement of his or her reality. The drug creates a sense of well being within the user when the experience is positive. Negative experiences can be living nightmares and cause blackouts.

The 3 Degrees of Use

- **General inebriation, (a few hits):** Similar to mushrooms with brighter colors and increased sexual desire.
- **Increased Potency:** Users fall into Trances
- **Further Increased Potency:** User remains conscious but loses accurate perception of actual surroundings. At this point the person should not be left alone and must have a sober person in the room. The user is in an altered reality, will wander and encounter brief periods of unconsciousness and blackouts.

Salvia users rate trips on a 6-tiered scale based upon the name of the drug:

- **S = SUBTLE effects**
- **A = ALTERED perception**
- **L = LIGHT visionary state**
- **V = VIVID visionary state**
- **I = IMMATERIAL existence**
- **A = AMNESIC effects**

As a parent, what can you do and how do you know if your child is using this?

Going through the Salvia sites one thing stood out, vocabulary. The users speak about Trip Reports. These are retellings of their drug-induced experiences. The words "visionary, spiritual enhancement, soul, altered-consciousness, sage." There is an official Salvia dictionary for proper trip descriptions and these includes:

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Salvia User's Vocabulary, *Partial List*

- accepting
- afterglow
- besaged
- dissociadelic
- dream people
- endoreality
- fantasia
- floating
- goofy
- healing
- magic casements
- mind tunnels
- sound of silence
- strange attractor
- teacher
- tranSalviaimensional
- visions
- weird
- wiSalviaom

For More information on Salvia:

- DEA
- Sage Group FAQ
- Trip Reports
- Group for Cognitive Liberty and Ethics

Many of these words are not common in the English language or have been created specifically for this drug's culture. The use of such vocabulary may be your only clue as a parent that your child is involved in the Salvia culture. Symptoms of use are vague appear like those experienced under LSD, mushrooms and PCP.

The reason Salvia is not illegal is that scientist can't figure out how it works. This also means there is no documentation on the long-term ramifications of this drug, good or bad. The only professional consensus on Salvia at this time is that it is a hallucinogen. Unlike other hallucinogens, the active ingredient in Salvia, *Salvinorin A* does not attach itself to the neurotransmitters, a requirement for illegal classification. Unless the definitions for controlled substances are changed or process of intoxication is discovered, the drug can and will remain legal.

A group called the Group for Cognitive Liberty and Ethics is currently working a grassroots effort to keep Salvia Divinorum legal and easily accessible to the masses. Their stance is that drug use enhances creativity and brainpower and should be encouraged rather than prohibited.

This article was inspired by the October 20, 2002 Portland Oregonian Article by staff reporter Margie Boulé entitled: Meet the most potent natural hallucinogen—And it's legal!

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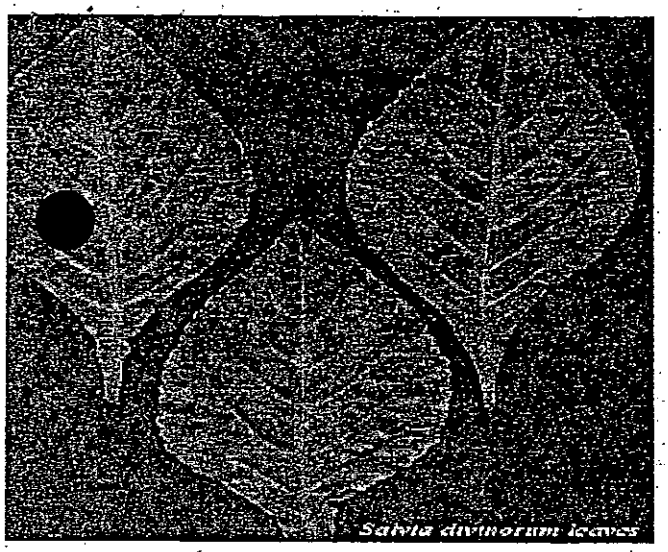


Drug Enforcement Administration
Newark Division

Michael Pasterchick, Jr.
Special Agent in Charge

Salvia Divinorum, ska Maria Pastora, Salvia (Salvinorin A, Divinorin A)

Introduction

Salvia Divinorum is a perenial herb in the mint family native to certain areas of the Sierra Mazateca region of Oaxaca, Mexico. It is one of 500 species of Salvia in the New World is in similar to the sage plant. The plant grows in large groupings to well over 3 feet in height. It's large green leaves, hollow square stems and flowers are it's characteristic features. S. Divinorum is one of several vision-inducing plants employed by the Mazatec Indians

There has been a recent interest among young adults and adolescents to re-discover ethnobotanical plants that can induce changes in perception, hallucinations, or other psychologically-induced changes. Since S. Divinorum, or any of its active ingredients are not specifically listed in the Controlled Substances Act, some on-line botanical companies and drug promotional sites have advertised Salvia as a legal alternative to other plant hallucinogens like mescaline. The plant material is smoked for the induction of "mystical" or hallucinogenic experiences.

Chemistry/Pharmacology

"Salvinorin A" the active component of S. Divinorum, is most effective when vaporized and inhaled. Chemically, Salvinorin A is a neoclerodane diterpene, a psychotropic terpenoid. The grouping of psychoactive plants containing terpenoid essential oils includes Salvia Divinorum, Wormwood (Absinth), and Cannabis Sativa (tetrahydrocannabinols, THC). Divinorin A was chemically characterized by Valdes et al., in 1984, however Ortega et al., (1982) had previously characterized the same substance and called it Salvinorin A and thus, out of convention, the psychoactive substance should be called Salvinorin A. A dose of 200 to 500 micrograms produces profound hallucinations when smoked. Its' effects in the open field test in mice and locomotor activity tests in rats are similar to mescaline. Salvinorin A's action in the brain are not

well elucidated. However, recent tissue testing (in vitro assays) have suggested that Salvinorin A may act at the kappa opiate receptor site, but functional assays are lacking to determine the exact mechanism of action of this drug substance.

Illicit Uses

Salvia is being smoked to induce hallucinations, the diversity of which are described by its users to be similar to those induced by ketamine, mescaline, or psilocybin. It is being widely touted on internet sites aimed at young adults and adolescents eager to experiment with these types of substances.

User Population

The user populations, thus far, seems limited to younger adults and adolescents influenced by the promotion of the drug on internet sites

Illicit distributed

Salvia Divinorum is grown domestically and imported from Mexico, and Central and South America.

Control status

Salvia Divinorum, Salvinorin A, and Divinorin A are not listed in the Controlled Substances Act.

Comments and additional information are welcomed by the Drug and Chemical Evaluation Section, FAX 202-307-8570 or telephone 202-307-7183.

September, 2002

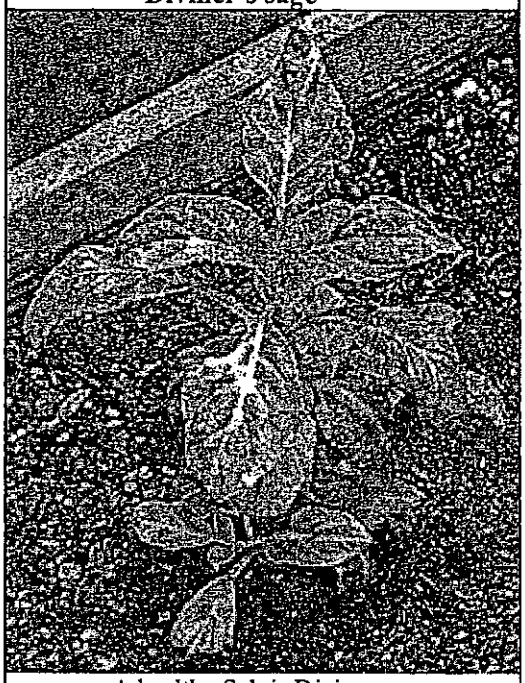
Salvia divinorum

From Wikipedia, the free encyclopedia

Salvia divinorum (also known as **Diviner's sage**, ***María Pastora*** or simply **Salvia**, although the genus name is shared among many plants) is a psychoactive plant, a member of the sage genus and the Lamiaceae (mint) family. The plant is grown by the Mazatec indigenous people of the Oaxaca mountains of southern Mexico in isolated, moist, and secret plots. It has been used as an entheogen by their shamans for centuries for healing during spirit journeys. It is thought to be a cultigen. No definitively wild populations have been found. The Latin name *Salvia divinorum* literally translates to "sage of the diviners".

The primary psychoactive constituent is trans-neoclerodane diterpenoid known as *salvinorin A*. Salvia also contains the closely related compounds salvinorins B-G, divinatorins A-E, salvinicins A and B, and hardwickiic acid. Salvinorin A is the most potent naturally-occurring hallucinogen known. It is active at doses as low as 100 μg [1] (http://www.erowid.org/plants/salvia/salvia_faq.shtml). Recent research has shown that salvinorin A is a remarkably potent and selective kappa opioid receptor agonist. It has been demonstrated that the effects of salvinorin A are blocked by kappa opioid receptor antagonists. This indicates that the effects of *S. divinorum* can be largely, if not entirely, attributed to kappa agonism. Salvinorin A is unique in that it is the only naturally occurring substance known to induce a visionary state *via* this mechanism of action.

Diviner's sage



A healthy Salvia Divinorum.

Scientific classification	
Kingdom:	Plantae
Division:	Magnoliophyta
Class:	Magnoliopsida
Order:	Lamiales
Family:	Lamiaceae
Genus:	*Salvia*
Species:	***S. divinorum***

Binomial name

Salvia divinorum

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- 1 History
- 2 Usage and effects
  - 2.1 Methods of ingestion
    - 2.1.1 Traditional Methods
    - 2.1.2 Nontraditional Methods
  - 2.2 Subjective effects
  - 2.3 Duration and after-effects
- 3 Chemistry
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History

In 1939 Salvia was first recorded in print by Jean Basset Johnston. He was studying the psilocybin mushroom use

of the Mazatecs in Mexico when he encountered this entheogen. R. Gordon Wasson documented its use a decade later and reported its effects through his own testimonials. Historical data at this point is largely unresearched, but it is likely to date back into the early history of Central America. It was not until the 1990s that it become more widely known through the experiments of Daniel Siebert.

As is often the case with cultigens, it is likely that the history of this plant dates back a number of generations. Cultigens require a long historical relationship with human cultures, and salvia is no exception. Perhaps the decline of its widespread use began with the Spanish Conquest, or this phenomenon may have been already underway, either due to religious or political reasons.

Gordon Wasson theorized that this plant was the mythological pipilzintzintli, the "Noble Prince" of the Aztec codices. This theory would explain why a cultigen of such extraordinary power was not otherwise known to the Aztecs, but this theory is not without dispute. The Aztecs were extremely knowledgeable in plant identification, and in their records report that *pipilzintzintli* has both male and female varieties. Salvia divinorum is lacking sexes, meaning there are no male or female flowers, as its flowers contain both sexes. The skeptics of this theory report that the Aztecs would have known the difference between male flowers and female flowers. Wasson, still, may have been correct in his hypothesis, in that there are a number of historical accounts of gendered properties being assigned to plants in a metaphorical manner, not in a botanically anatomical one.

Usage and effects

Methods of ingestion

Traditional Methods

Mazatec shamans use two methods of ingestion. Often, they simply eat the fresh leaves by chewing and swallowing them. Sometimes, they crush the leaves to extract the leaf juices, which they then drink (usually mixed with water). Reportedly, dosages vary from as few as 6 leaves to as many as 120, when using these methods.

Nontraditional Methods

Dry leaves can be smoked in a pipe but most users prefer the use of a bong to cool the smoke. The temperature required to release salvinorin-A from the plant material is quite high (about 240°C). A regular flame will work, but the direct application of something more intense, such as the flame produced from a butane torch lighter, is often preferred.

Many people find that smoking the unprocessed dried salvia leaf produces only light or unnoticable effects, perhaps due to the large volume of plant material that must be smoked to produce psychoactive effects. However, responses vary widely. A concentrated preparation of salvia leaf called salvia extract, with relative strength suggested by terms such as 5x, 10x, and 20x, may be smoked in place of natural strength leaves; this reduces the total amount of smoke inhaled for a given dosage of salvinorin overall, and facilitates more powerful experiences. One cone of 5X strength extract should be enough to produce the desired effect.

Sublingually ingested tinctures constitute another form of prepared salvia. A tincture is made from salvia leaf that has had the psychoactive components extracted, often using high-proof ethanol. Once produced, the liquid can either be used as a tincture or infused into salvia leaf, creating smokable salvia extract.

The traditional Mazatec method can also be employed; however, Salvinorin-A is generally considered to be inactive when ingested, because the chemical is inefficiently absorbed in the gastrointestinal tract unless

thoroughly emulsified; therefore, emphasis is often placed on holding the leaves (and also the saliva secreted during chewing) in the mouth as long as possible, to facilitate absorption through the oral mucosa. This consumes much more of the drug than smoking, but also produces a longer-lasting experience.

Subjective effects

Most users find that the effects of salvinorin are not conducive to socializing. People given Salvia often feel as though a trick has been played on them; in fact, while under the influence, most people tend to find any external stimuli distracting. Most people under the influence of salvia will remain in place although some users may move around. This can be especially dangerous as the user is in an altered state of consciousness and is therefore at a greater risk of unintended bodily injury. It is advisable to have a sober trip sitter present.

The effects of salvia are found by many to be highly spiritual entheogenic experience. Others find salvia useful for meditation. Consciousness is retained until the highest doses, but body control, awareness of externalities, and individual personality can disappear with even modest amounts. Even experienced drug users may feel totally out of control and confused.

At lower doses the user may experience spontaneous laughter, mild closed-eye visuals, stuttering or strobing visual effects, changes in depth perception, and a heightened sense of color and texture.

Moderate doses appear trance-like. Time distortion and open-eye visuals become increasingly apparent. Fractal patterns and geometric shapes may be noticeable with eyes open, and can be very confusing. Many people experience sensations of falling, similar to what is occasionally felt at the onset of sleep. The user may experience fully formed visions of other places, people, and events, especially with eyes closed.

At high doses, the effects become more powerful and may additionally include out-of-body experiences, perceptions of gravitational distortion, vertigo, sensations of wind or physical pressure, hearing voices, flanging of sound, significant open and closed-eye visuals, experiencing alternate realities, contact with beings or entities, dissolution of one's ego, and dissociation. It is also typical that, while under the effects of salvia, a person will not realize they have used the drug. The salvia experience is quite different from that of most other hallucinogenic drugs and may be overwhelming, even with the correct set and setting. Most users recommend darkness and silence as the best environment, however, minimal, ambient or relaxing music can be helpful.

According to experience reports at Erowid (http://www.erowid.org/experiences/subs/exp_Salvia_divinorum.shtml) and elsewhere, Salvia seems to produce visual hallucinations which have a somewhat higher level of consistency than other substances. Reports of contact with an entity supposedly associated with the plant, ("the Shepherdess") again with fairly consistent characteristics, are also common.

Many salvia users, during high-dose out-of-body experiences, may suddenly "merge" with objects. With the significant time distortion typical of salvia, users may live a lifetime as another person, or as an inanimate object, such as a wall or a piece of furniture. The experiences can be extremely pleasant, or very frightening and confusing.

People often fail to achieve the effects the first time they try the plant, possibly due to problems in the administration of the drug. With repeated use, anecdotal evidence suggests that decreased dosage may be possible for the same level experience. Due to the lack of scientific studies on Salvia, if true it is unknown whether this is due to learning proper techniques of administration or a sensitization factor, sometimes colloquially referred to as "reverse-tolerance".

Some people who try Salvia find it difficult or impossible to achieve the desired effects. This may be due to an

insufficient flame. However, sometimes the results are unpredictable. For example, a user may smoke a large amount and feel no effect, but the next day may smoke a small amount and experience a strong trip.

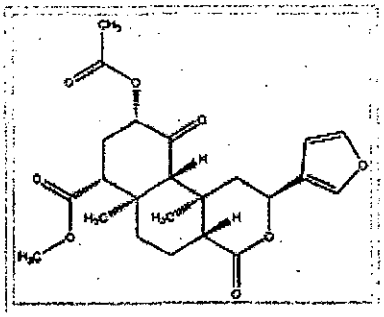
Duration and after-effects

If inhaled, the effects do not last very long, with the peak reached within one minute and then a slow descent back to one's self after about five minutes and back to baseline within 15 to 20 minutes. Chewing the leaf (in a 'quid') makes the effects come on more slowly and be experienced for longer. The first 5 minutes after smoking extract are very intense, and should be experienced lying or sitting down, eyes closed.

Most users report no hangover or negative after-effects. Some users report a pleasing "afterglow," or pleasant sensation and state of mind persisting after the experience has ended. Others, however, claim that Salvia has a depressing effect. Salvia has not been found to be either physically or psychologically addictive. There are no proven health risks associated with the psychoactive chemicals, although the long-term effects on the human body are not well documented. However, smoking any substance is generally regarded as unhealthy by medical professionals.

Chemistry

The primary active constituent is ***Salvinorin A***, sum formula $C_{23}H_{28}O_8$. Unlike most other known psychoactive compounds, Salvinorin A is not an amine—meaning it contains no nitrogen functional group. The Salvinorin group of compounds (including Salvinorin A, Salvinorin B and Salvinorin C) are called neoclerodane diterpenoids.



Salvinorin A

Extraction and purification of Salvinorin A has been documented but should only be attempted by qualified researchers with experience in chemistry and the proper laboratory equipment. Measurement of safe dosages is difficult and requires a sophisticated analytical balance, due to the extreme quantitative potency of Salvinorin A.

Legal status, Controversy

Until the late 1980s, not many people knew about salvia. The heavy commercialization of the Internet in the mid-1990s and the realization that the plant was not legally controlled engendered numerous Internet mail-order businesses which sold dried salvia leaves and other preparations, sometimes for exorbitant prices.

The general public became increasingly aware of salvia in 2002. As of June 1, 2002, Australia became the first country to ban salvia and salvinorin [2] (http://www.cognitiveliberty.org/news/salvia_australia.htm), [3] (http://www.thecouriermail.news.com.au/common/story_page/0,5936,5717251%5E3102,00.html). In late 2002, Rep. Joe Baca (D-California) introduced a bill in the United States House of Representatives to schedule salvia as a controlled substance, and the DEA has indicated on its website that it is aware of salvia and is evaluating the plant for possible scheduling.

Press accounts of efforts to ban salvia often quote law enforcement and government officials who exhibit an inaccurate knowledge of the drug's effects, and frequently characterize the "high" as "chewable marijuana", or as identical to LSD and PCP (two drugs with quite dissimilar effects to *each other*, as well as to salvia).

Under Louisiana Act № 159, 40 plants, including *Salvia divinorum*, have become illegal if sold for human consumption. It is still legal to own the plants. More laws regarding *S. divinorum* can be found at Erowid's Salvia

Law vault (http://www.erowid.org/plants/salvia/salvia_law.shtml).

Salvia divinorum was outlawed in Missouri in fall 2005. New York is considering a bill that would place heavy civil penalties on the sale of the plant. Illinois is also considering regulating Salvia divinorum.

In January 2006, the Swedish government declared their intention on making salvinorin A and all plants containing the chemical illegal. This law has been in effect since 1 March 2006.

In Delaware on January 23 2006, teen Bret Chidester (http://www.delawareonline.com/apps/pbcs.dll/article?AID=/20060226/NEWS/602260356/-1/NEWS01) committed suicide. His suicide note referred to the drug. In an essay found after his death, he wrote "*Salvia allows us to give up our senses and wander in the interdimensional time and space,... Also, and this is probably hard for most to accept, our existence in general is pointless. Final point: Us earthly humans are nothing.*" Because his use of the drug is considered to have contributed to his suicide, the Delaware State Legislature is rapidly moving to pass legislation (http://www.delawareonline.com/apps/pbcs.dll/article?AID=/20060323/NEWS/603230360/-1/NEWS01) that would make the drug illegal there.

Unlike marijuana, salvia has a nondescript appearance (being in the same genus as cooking sage), can be grown in a small space, has no odor and requires no elaborate lighting set-up, criminalization is likely to affect only the commercial sale of the plant, and not its private cultivation, which would be impossible to police. For most regular users growing the plant is considered to be an integral part of establishing a relationship with it.

Botany

Unlike other sages, *Salvia divinorum* produces very few seeds, and the seeds it does produce seldom germinate. It appears to have very little histocompatibility variation, so the pollen from a plant genetically identical to the style fails to reach the ovule. It is propagated by cuttings and by falling over and growing new roots. Although reportedly (Valdez, et al) isolated stands of *S. divinorum* exist in its native range, these are thought to be purposely created and tended by the people of the region. Therefore it is considered a true cultivar and thus does not occur naturally in the wild anywhere.

For the most part, the fate of the species lies with a very small number of clone plants. Of these few clones, there are only two that are in any kind of public circulation; the Wasson/Hofmann strain, and the Blosser ("Palatable") strain. The former is a strain discovered by those whose name the plant bears, when on a visit to the Mazatecs. The latter is the same case, in regards to name, and was discovered in Oaxaca; it is called "Palatable" as well, as it is said to have more palatable leaves when ingested orally than those of the Wasson/Hofmann strain, though other reports state that there is little difference between the taste of the plants. Other varieties are also grown, including the Luna strain which is a strange offshoot of the Hofmann/Wasson line. A few other strains exist, but they are mostly quite similar, in potency, effect, and growth.

References

1. Chavkin C, Sud S, Jin W, Stewart J, Zjawiony JK, Siebert DJ, Toth BA, Hufeisen SJ, & Roth BL. Salvinorin A, an active component of the hallucinogenic sage salvia divinorum is a highly efficacious kappa-opioid receptor agonist: structural and functional considerations (http://jpet.aspetjournals.org/cgi/content/abstract/308/3/1197). *J. Pharmacol. Exp. Ther.* 2004 Mar. 308 (3): 1197-1203.
2. Roth BL, Baner K, Westkaemper R, Siebert D, Rice KC, Steinberg S, Ernsberger P, Rothman RB. Salvinorin A: a potent naturally occurring nonnitrogenous kappa opioid selective agonist (http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=12192085). *Proc. Natl. Acad. Sci. U.S.A.* 2002 Sep 3, 99 (18): 11934-11939.

External links

- The Salvia divinorum Research and Information Center (http://sagewisdom.org/) - Daniel Siebert's site
- Erowid Salvia Divinorum Vault (http://www.erowid.org/plants/salvia/salvia.shtml) - Salvia section from Erowid's vast reference site
- Lycaeum page on Salvia divinorum (http://leda.lycaeum.org/?ID=269) - another large reference site for psychoactives
- The Salvia Center (http://www.salviacenter.com/) - a hub for Salvia information on the web
- Salvia Divinorum Scotland (http://www.salvia-divinorum-scotland.co.uk/) - information and advice on cultivation etc.
- International section of the "Salvia Community" (http://www.salvia-community.net/International-f16.html) - discussions with Salvia experts from all over the world
- SpiritPlants Salvia Forum (http://www.spiritplants.org/)
- SalviaD Alliance Forum (http://groups.yahoo.com/group/SalviaD_Alliance)
- The Entheogen Forum (http://www.entheology.org/)
- The Australian Salvia Crusaders (http://www.geocities.com/salviacrusaders/) - Issues Regarding Australian Law and Salvia Divinorum

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Categories: Dissociatives | Entheogens | Herbal and fungal hallucinogens | Lamiaceae

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Salvia

How To Smoke Salvia Divinorum

by MSS

After numerous attempts I finally came upon what I call the Secret of Smoked Salvia divinorum. I will not discuss the subjective effects except in a limited sense, but what I do wish to discuss is how one might better feel these effects.

Find a comfortable position, preferably sitting down in a quiet environment. Load a water pipe with a full hit of Salvia, light and inhale as deeply, and hold as long, as possible.

While holding in the hit it may be advantageous to poke out the left over ash/foliage and reload. Upon exhalation take a couple deep breathes of fresh air then inhale a second hit as above.

Before taking another hit you may want to empty the water pipe of the left over smoke from the previous hit since the smoke stales quickly and make the next hit more difficult to inhale and hold for a length of time.

Depending on unknown factors, or insufficient inhalations, one may find it necessary to do a hit or two more. Two deep hits has always been good for me, but I have unusually large lung capacity.

Those who are used to smoking are more likely to feel the effects of Salvia simply due to the fact that their lungs are much better prepared to inhale a large amount of smoke. One technique to use to bring in large volumes of smoke is to take a few deep breathes, exhale all the air in the lungs and then inhale from the water pipe.

One other technique is to continue loading and smoking until you no longer have the coordination to load anymore. I've tried this last technique before and it is really great for open eye visuals.

Most people don't feel anything the first time they try Salvia. If you do not get any results after several attempts, try using a high temperature lighter (or torch) and water pipe. The high temperature flame will vaporize more of the active ingredient than a standard lighter.

If you use a torch, don't do it alone. Make sure someone is there to turn off the torch. If the Salvia hits in the middle of a toke, you might loose control of the torch.

After taking the necessary hits close your eyes, lay your head back on a comfortable support, and get your arms and legs in a comfortable open position that won't require you to move after the effects have begun. When the effects begin one might have a strong desire to open ones eyes or change ones position to reestablish an equilibrium. It is important that you not do this. Lay perfectly still with eyes closed for the duration.

If you desire to attempt the experiment with eyes open I highly recommend staying still as possible, having no moving objects in sight, and fixing ones eyes upon a motionless object for the duration. The initial peak last for no more than three to five minutes while residual effects may carry on for ten.

With continued usage over time one becomes more adept at both noticing the effects of Salvia and at exploring the new landscape. As I continued using Salvia I reached a peak experience and now the visions are rather mundane, failing in their once spectacular glory.

The three most important factors in feeling the Salvia experience are appropriate silence, lack of movement, and closed eyes. I have found that a lack of dialog, either from other participants, or from TV is of primary importance, but that instrumental music makes for a quite intriguing experience, especially if 4 speakers are properly placed surrounding ones head.

Since silence is such an integral part of the experience I've conducted sessions with only one person experimenting at a time. The participation of others during ones Salvia

experience can at times be a hindrance.

If others are present when you are experimenting it is important that they be as quiet as possible, both vocally and in their physical movements (no creaking in chairs or traversing hardwood floors, heavy breathing, or, the hardest thing for an observer to hold back, laughter).

I've always required of other participants/observers that they be completely still so as to cause absolutely no noise. During the experience a new landscape is opened up, one without borders, and space can appear to go on infinitely.

Usually this landscape is one that can shift from one scene to the next without apparent provocation and which resembles a rapid succession of unconscious material forcefully trying to push itself into conscious awareness. If someone makes a noise or speaks the vision may be lost or altered since the noise, and where it is located in space, can still be comprehended by the conscious and rational mind.

This causes the mind of the experimenter, which can be quite conscious of two realities at once, to become aware of the inconsistency between these realities, and this can, and in my case usually does, disrupt the experience.

What the motionless body allows the mind to do is to slip deeper into the 3 dimensional nature of the vision. If the body is moved the vision will often alter or slip away. In some way the physical body defines the inner landscapes of the vision. My only way to explain this is to say that the conscious rational mind retains awareness of consensus reality while under the influence of Salvia.

Since Salvia creates a non-consensus reality body movement causes a dichotomy of awareness which can cause the mind to attempt a reconciliation between these realities. Consensus reality often wins, causing the vision to dissipate, or at least lose its convincing nature.

This sort of dual awareness is also played out with sight, which may be why many who attempt to feel the effects of Salvia, and have failed to try closing their eyes, cannot. By having ones eyes open the mind appears to be unconsciously forced to recognize one reality over the next and therefore cannot fall deeply into the full Salvia experience.

Of course this dichotomy of forces appears to be overcome

depending on how much is smoked, and obviously extracted Salvinorin-A forces consensus reality to the wayside.

The main physical effects that I have noticed are a feeling of a rise of body temperature and a slight tightening of the muscles, especially in the hands. I found that if I consciously focus on relaxing my body during this tensioning that I would be pulled further into the vision. This fits into my theory of dichotomy.

I've also found that after the main effects have worn off short term memory may be slightly impaired. For example, I kept forgetting about my lit cigarette in the ashtray. I would lay it down and then, in what appeared a couple minutes, it would be completely burned down to the filter.

One may also notice an inability to recall many of the aspects of the vision and may suffer from incoherent speech. The incoherent speech is very important in attempting to interpret the experience. Just as in Freudian dream psychoanalysis the mind make attempts to fill in the blanks of the vision with coherent structure, basically by adding material to make the vision make sense. But the visions in themselves are unconscious material coming up to a conscious level and this is very difficult to fully interpret.

When a participant comes down from the experience with me I remain completely silent, allowing the partaker to speak freely without my interjections or my attempts to make sense of what is being said. Let them freely speak, without the criticism of the all to common laughter, and try to form a new mental picture from remembered material. Let them have enough quiet time to digest what has happened so that they might come to their own personal understanding.

The main psychological effects seem to be a dissociation from ones physical surroundings. One becomes aware of other surroundings and of communication with alien, though not necessarily extraterrestrial or spiritual, beings. One of the more interesting factors I have found with Salvia is its ability to cause laughter, sometimes even uncontrollably so. Rarely have I seen fear from smoked foliage, but with Salvinorin-A I understand it is common.

Of course these are only my own observations and I make no guarantees of the same effects for others. Two last, though not thoroughly tested observations are that marijuana smoked beforehand interferes with the effects of Salvia and

that the effects of Salvia plateau, thereby requiring a rapid succession of hits.

I have yet to see if any other entheogen limits Salvia's effects. I look forward to testing and hearing about others' experiments with smoked Salvia during Mescaline, Psilocybin, Ayahuasca, and LSD excursions. It might also be interesting to try Salvia (masticated or smoked) in conjunction with smoked DMT. I have personally tried a smoked Salvia/5-MeO-DMT combination with highly dissociative effect on the ego (due to Id influences) while keeping a sense of superego awareness.

I became my superego aware of my ego as it was being affected and effected by my id. You could also say I became my super consciousness aware of my conscious mind being affected and effected by my unconscious mind. Quite a spectacular feeling. Tripartite Being recognized as one.

You should be aware that Salvia suitable for smoking purposes is available in different strengths and forms, for the sake of your own health always get standardized extract when possible, see below for more info.

--- ***Normal Salvia Leaves*** are just that, leaves that have been harvested and dried.

--- ***High Grade Salvia Leaves*** come from premium plants, similar to high grade marijuana compared to a standard strain.

--- ***Crude Extract*** is prepared by mixing crude extract with Salvia divinorum leaves. This concentrates tars and other harmful components of the leaf. It is usually described by a number followed by an x (such as "5x," "10x," etc). The number indicates the ratio of extract to leaf. For example 'Salvia Divinorum 10X Organic Extract', is prepared by mixing one unit of leaf with the tar-like crude extract obtained from nine units of leaf. The resulting product is ten times as potent as the leaves used to produce it. This type of product can vary tremendously in potency because the potency of the leaves used to produce it varies. It has a somewhat sticky feel and inferior burning characteristics due to the impure quality of the extract.

--- ***Standardized Extract*** is prepared by extracting pure salvinorin A (the active principal of the plant), then adding a measured quantity back onto Salvia divinorum leaves to bring them up to a specific, reliable, and consistent level of

potency. This type of product is time consuming to prepare, but is far superior to crude-extract enhanced leaf. Products that have been prepared in this manner have particularly good burning characteristics because they do not contain the tar-like, gummy chemicals found in crude extracts. Since the impurities have been removed during the extraction process, they won't end up in your lungs.

Salvia has been available legally in most areas of the world but it is being made illegal in more countries as time passes. Louisiana made it illegal to use Salvia as a drug in 2005. It used to be easy to buy Salvia online, it is becoming harder to find.

If you find a source, don't pay more than
$50 for a gram of 20x standardized extract
$25 for a gram of 10x standardized extract
$15 for a gram of 5x standardized extract

When smoked (in the ways described), the effects of Salvia can be overpowering and overwhelming. If it is your first time trying Salvia use the table below to find the dosage you should start at.

Normal Salvia Leaves: 1/2 - 1 gram
High grade Salvia Leaves: 1/4 - 1/2 gram
Salvia Extract 5x: 1/10 - 1/3 gram
Salvia Extract 10x: 1/10 gram
Salvia Extract 15x: 1/20 gram
Salvia Extract 20x: 1/20 gram

The bouncing bear company sells salvia, that is ideal for smoking purposes, in the Salvia divinorum section of their site. They ship from the US to most areas of the world.

Liquid Salvia Extracts

I have seen liquid Salvia extracts (tinctures) available in the past but do not know if they are still available. They are recommended for people who don't like smoking or would prefer to ingest a liquid for a milder Salvia experience. Follow the manufacturers recommendations about how much to use and how to use it.

Using a liquid Salvia extract will not be as powerful as smoking Salvia, but the Salvia experience lasts longer when taken in liquid form than it does when smoked.

See talking with god for another persons idea of what the

Salvia experience is like.

Books

The Salvia Divinorum Grower's Guide

This book is dedicated to growing Salvia Divinorum only. There are other books that about dozens or hundreds of types of salvia, but this is the book to get if you want to grow the mind altering Salvia Divinorum plant.

It's an informative book that tells you everything you need to know about the special growing conditions of this unusual plant. It is only 64 pages, but the information it contains will help anyone start and maintain a Salvia Divinorum garden with ease.

The Salvia Divinorum Grower's Guide

A Book of Salvias:
Sages for Every Garden

Salvias constitute the largest genus in the mint family, valued for their medicinal and culinary qualities. The name is derived from the Latin word salvare, to heal, and salvia provides a beneficial addition to any garden.

More than 900 species of Salvia exist, with more than half occurring in North and South America. In this book, the author has selected over 100 beautiful, garden worthy species and dozens of commercially significant hybrids and arranged them alphabetically with documentation providing the scientific name and native habitat of each, including elevation ranges and temperature tolerance, as well as historical background.

The author describes the leaves and flowers of each species, its blooming cycle, and its light, watering, fertilizing, and pruning requirements. Also suggests companion plants and offers data on propagation. The book includes a list of where to see and buy salvias, a flowering guide by seasons, and cold and shade tolerance guides. There are 96 color photographs and 40 line drawings.

A Book of Salvias

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Salvinorin A: Notes of Caution

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by Daniel J. Siebert. From "The Entheogen Review" Vol. 3, No.4: Winter Solstice, 1994.

Salvinorin A (the major active principal of the plant Salvia divinorum) is an extremely powerful consciousness altering compound. In fact it is the most potent naturally occurring hallucinogen thus far isolated. But before would-be experimenters get too worked-up about it, it should be made clear that the effects are often extremely unnerving and there is a very real potential for physical danger with its use.

When the herb Salvia divinorum is consumed either by smoking the dried leaf or chewing the fresh leaves the effects are usually (but not always) pleasant and interesting, this is because when used this way the amount of salvinorin A absorbed into the blood stream is usually very small and in the case of the chewed leaves it is absorbed into the blood stream very gradually.

The pure compound salvinorin A is active at 200 - 500 mcg when vaporized and inhaled. Since very few people have the costly equipment necessary to accurately weigh anything close to this small an amount, it is inevitable that people will try to visually estimate the dose. Unfortunately there is little room for error before the effects become potentially dangerous. When the dose goes above 500 - 1000 mcg the effects can be very alarming, I have seen several people get up and lunge around the room falling over furniture, babbling incomprehensible nonsense and knocking their heads into walls. Several people have tried to wander out of the house. When the experience is over they have no memory of any of this. In fact they usually remember very different events. To an outside observer people in this condition have a blank look in their eyes as if no one is present (and perhaps no one is). It is also common for people to have a facial expression which is probably best described as being like that of a frighten ed animal. It appears that at these "larger" doses one completely loses awareness of, and control over, the physical body and for some reason part of the brain causes the body to get up and move about recklessly while the individual has no awareness of where their physical body is or what it is doing. It seems inevitable that one of these days some careless person will do too large a dose without a sitter and will wander out in the street, or hurt themselves in some way.

Because the dose is so small and insignificant looking, there is a tendency for people to think they need more than what they are told is a safe dose. Another problem is that the technique of vaporizing and inhaling the compound can be a bit tricky. Salvinorin A has a relatively high boiling point and people often don't get it hot enough to remain a gas all the way down into the lungs. Another problem is that so little is used that the vapor often disperses before it gets inhaled. Sometimes people just don't hold the vapor in their lungs long enough for thorough absorption. Several people after trying a dose in the recommended safe range and not getting an effect assumed that they needed a larger dose, when in fact the problem was that they did not vaporize the material efficiently the first time. I have already seen more than one intelligent, careful and experienced person accidentally do too large a dose because of this. Fortunately they had sitters and managed to get through the experience safely.

It is also important to understand that there have been no toxicological studies of

this compound in humans. It is true that the Mazatecs have used the plant for a very long time and don't seem to have problems with it, but when the pure compound is used it would be a simple matter to consume a dose hundreds of times greater than anything ever encountered by the Mazatecs.

Not only is salvinorin A chemically different from other hallucinogens (it is a diterpene not an alkaloid) but its effects are quite different as well. Many people consider the effects less manageable and harder to work with than other entheogens. The majority of people who have had a full blown experience with salvinorin A are reluctant to ever do it again. Anyone choosing to experiment with this compound should always have an alert, clear-thinking sitter present to prevent them from injuring themselves or others.

Salvia divinorum as an herb can be used quite safely and many people claim that it has proved beneficial to them. Hopefully there will not be a rush to isolate the pure compound as it is almost inevitable that it will cause problems, people will get hurt, the compound and possibly the plant will get negative attention and it will become scheduled. We will just be adding one more potentially valuable plant ally to the list of species which are already feared and condemned in our society.

If you choose to pursue a relationship with this plant please treat it with respect and care. Perhaps if people can use the plant safely and responsibly it will be able to grow and thrive freely into the future.

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Leda version 1.4.3

SB

61

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Labor and Commerce
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/16/09

Health and Social Services Committee considered SENATE BILL NO. 61

SB 61 MANDATORY UNIVERSAL HEALTH INSURANCE

"An Act establishing an Alaska health care program to ensure insurance coverage for essential health services for residents of the state, the Alaska Health Care Board to administer the Alaska health care program and the Alaska health care fund, the Alaska health care clearinghouse to administer the Alaska health care program under the direction of the Alaska Health Care Board, and eligibility standards and premium assistance for health care coverage of persons with low incomes; creating the Alaska health care fund; providing for review of actions and reporting requirements related to the health care program; and providing for an effective date."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 61 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[✓] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
CED	3/2	✓			1
DHS/PAFS	2/28	✓			2
DHS/BHMS	2/28	✓			3
DHS/MS	3/6	✓			4

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
Joe Ellis	ELLIS	X			
Lyda J. Thomas	THOMAS				✓
Fred Dyson	DYSON		✓		
Joe Paskvan	PASKVAN				X
CHAIR: Bettye Davis	DAVIS	X			

Senator Hollis French

Anchorage LIO
269-0234
269-0238 fax

MEMORANDUM

Date: March 10, 2009

To: Senator Bettye Davis, Chair
Senate Health and Social Services committee

From: Senator Hollis French
Senate Bill 61 Prime Sponsor

RE: Background information for SB 61 Senate HSS subcommittee

On March 2 the Senate Health and Social Services committee formed a subcommittee to consider several issues related to Senate Bill 61 that were brought up during the legislation's first hearing. In an effort to assist the subcommittee discussion on these questions, this memo provides background information from the bill sponsor for use during the March 10 subcommittee meeting.

The AARP letter of support for Senate Bill 61 noted a particular concern about health coverage for Alaskans between the ages of 50-64. The subcommittee has expressed an interest in determining how Senate Bill 61 will impact this group of Alaskans.

AARP's Public Policy Institute[1] goes into detail about the difficulty Americans between the ages of 50-64 have when they attempt to access, and afford, health care. While Medicare kicks in at 65, many people retire before they become eligible for those benefits, and often standard individual market offerings are withheld, forcing older Alaskans into ACHIA plans which can cost up to 50% more than the price of standard risk premium rates[2].

Senate Bill 61 will ensure that all Alaskans have access to affordable, quality health coverage by putting the price of a plan within reach. Like most Americans who lack health coverage, a majority of individuals who lack benefits between the ages of 50-64 are still members of the workforce[3]. The bill will assist these

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[1] AARP Public Policy Institute, "Health Coverage among 50- to 64-Year-Olds," Data Digest #155, May 2007
[2] AS 21.55.150 (c)
[3] AARP Public Policy Institute, "Health Coverage among 50- to 64-Year-Olds," Data Digest #155, May 2007

working, uninsured individuals in the same way that it will work for all other Alaskans.

In addition, there are some elements of the legislation that should be of particular interest to Alaskans between the ages of 50-64:

Guaranteed Issue, Credible Coverage and Preexisting Condition Exclusions:

Medical underwriting in Alaska's individual market can result in denial of standard coverage by private insurers, particularly when an applicant has less than perfect health. Since the need for medical attention often increases with age, this trend is particularly worrisome for older Alaskans, who are more likely to have identified medical needs than 20 year olds. And while the state's high risk pool cannot reject an individual, these plans are often too expensive for applicants. Senate Bill 61 requires that health insurance plans for sale through the health care clearinghouse offer coverage to any applicant, preventing a scenario where the only course of action is purchasing a plan through ACHIA.

The legislation also requires that plans sold through the clearinghouse give credit for prior coverage, and that preexisting condition exclusions be reduced by any length of "continuous credible coverage" that an individual had before they applied for coverage. For Alaskans that are leaving the workforce who aren't provided benefits through a retirement package, these protections will ensure a more seamless transition into retirement.

The final element that will assist individuals acquiring coverage for the first time through Senate Bill 61 is the provision that prohibits preexisting condition limitations from extending for over one year. By capping limitations at one year, Alaskans will still be discouraged from buying coverage only when it is medically necessary, but it will also ensure that health coverage sold through the clearinghouse is a quality product for those who haven't been able to buy coverage in the past, due to cost or other circumstances.

The three consumer protections listed above – guarantee issue, credit for continuous coverage, and preexisting condition limitation caps - are currently required elements of small group, employer based plans available in Alaska. Extending these protections to individual plans sold in the clearinghouse will level the playing field for all Alaskans, both young and old.

What is the structure of the clearinghouse, and how will it take into account Alaska's unique geographic and technological situation when attempting to reach all Alaskans?

The health care clearinghouse is the entity that is charged with administering the program, under the direction of the health care board. In particular, the bill specifies that the clearinghouse will disseminate information about health care insurance products, and provide assistance in the enrollment process for businesses or individuals[4].

[4] Senate Bill 61 – Sec. 21.54.230

During the Senate Health and Social Services committee hearing on March 2, 2009, the clearinghouse was characterized as an electronic web-based 'place' where health plans can be compared and purchased. This concept, taken from Massachusetts and the Federal Employee Health Benefits program, is an innovative model that has proven successful in both instances. That being said, nothing in the bill confines how the board can structure the clearinghouse, despite the recent successes of an electronic, web based solutions.

In Massachusetts, a variety of means have been used to implement health reform. The Commonwealth Connector website touts advertizing efforts, along with partnerships, mailings, employer education and grassroots initiatives as successful elements to educating the public[5]. As one example, 'Connect to Health' events were held throughout the state to educate and enroll residents in health insurance plans through the connector. A press release noted that these forums were made possible through the involvement of public officials, community health centers, hospitals, business groups, public school districts and health care advocates[6].

Customer service centers were also created to help implement the legislation, and toll free call centers are open daily to answer questions and provide enrollment assistance.

As currently drafted, the bill leaves all options open for the health care board to determine how to communicate with and enroll eligible Alaskans. Given the broad composition of the board - which includes consumer advocates, insurance representatives, business people, labor, medical professionals and hospitals - the perspectives necessary to craft an Alaska specific approach to enrolling people in health coverage should be achievable, particularly when we use other states as models.

The National Federation of Independent Business commented on Senate Bill 61 in a letter to Senator French dated January 25, 2009. In particular, the letter stated two specific concerns:

The first concern: "Unfortunately, SB 61 mandates that small employers bear the cost of fixing the problem through mandated tax on a percentage of their gross payroll."

Senate Bill 61 has a unique section regarding employer contributions, as described during the March 2 bill hearing. The rules are simple. There is no levy for businesses whose payroll is less than $500,000 a year. For businesses with a payroll between $500,000 and $1 million annually, the levy is 1%. For businesses with a payroll greater than $1 million annually, the levy is 2% of payroll. The 'bar' of what it means to provide health coverage is set relatively low – either an employer must offer to pay 33% of a premium cost or they must successfully enroll 25% of employees in their program – regardless of their level of contribution – to avoid the employer levy. In addition, if an employer establishes a Section 125 account that allows employees to purchase health

[5] http://www.mahealthconnector.org - Overview -> Public Education and Outreach
[6] http://www.mahealthconnector.org - January 11, 2008 press release

insurance with pre-federal tax dollars, they too avoid the levy, since the establishment of such an account produces great tax savings for employees. The cost of section 125 accounts are relatively cheap – quotes last year were around several hundred dollars a year total for a small employer, covering all employees. This means that an employer can fulfill all provisions of the employer levy simply by giving employees access to a Section 125 account, at a total cost of several hundred dollars – for all employees – per year.

On the broad scale of health reform options, Senate Bill 61 includes very few obligations on non-providing employers. Massachusetts requires a payout of $295 per non-covered employee per year, and includes a provision which also encourages the creation of Section 125 accounts. California proposals on the table last year included payroll taxes that ranged from 1% to 6.5%. In San Francisco, a plan that requires businesses with over 100 employees in the city to pay at least $1.76 per hour towards health benefits was affirmed by the 9th circuit court of appeals just last year, it not being an excluded policy option for the city due to ERISA preemption.

The second concern: "It also creates mandated coverage design that will increase the cost of basic coverage that might be offered by small employers."

The legislation broadly defines 'essential health care services' as including preventative and primary care, emergency services, inpatient services and hospital treatment, ambulatory patient services, prescription drug coverage and mental health services[7]. It does not specify benefit levels that must be provided in each category, nor does it address permissible co-pays, co-insurance, deductibles, or other fiscal elements of a plan. For a private offering to fulfill the individual responsibility clause proposed in Sec 21.54.240, a private plan must 'meet or exceed' the definition of essential health care services provided in that section[8].

Currently most employer based group health plans are subject to regulation under ERISA, and health insurers that are licensed in the state are regulated by state insurance law, as well[9]. The concern about mandated benefits may be rooted in the specific medical procedures that current Alaska law requires as elements of state regulated health insurance plans. Examples of such mandates include cancer screening procedures, well baby examinations and limited alcoholism and drug abuse treatment. The more benefits a plan includes, the higher cost of the plan.

Language should be changed in Senate Bill 61 to say that a health care insurance plan sold in the group market fulfills the individual responsibility clause of the legislation. This change would help alleviate the concerns expressed by the National Federation of Independent Business, because the comprehensive group plans that currently provide benefits to employees around the state would fulfill the legislation, without requiring a modification of the benefits that they offer.

[7] Senate Bill 61 – Sec. 21.54.250
[8] Senate Bill 61 – Sec. 21.54.250 (a)(1) and (a)(4)
[9] http://www.dol.gov/ebsa/publications/selfcompliancetool.html

Senator Hollis French

Capitol Room 417
465-3892
465-6595 fax

MEMORANDUM

Date: 1/28/2009

To: Senator Bettye Davis, Chair
Senate Health and Social Services Committee

From: Senator Hollis French

RE: Request for Hearing -- SB 61

This is a request that you schedule a hearing on SB 61 "Affordable Universal Health Insurance" at the earliest possible date.

I have attached a sponsor statement, a sectional summary, a copy of the bill, and a bill packet for your use. I appreciate your consideration.

Attachments

26-LS0312\E
Bailey
3/11/09

CS FOR SENATE BILL NO. 61( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS FRENCH, Ellis

A BILL

FOR AN ACT ENTITLED

"An Act establishing an Alaska health care program to ensure insurance coverage for essential health services for residents of the state, the Alaska Health Care Board to administer the Alaska health care program and the Alaska health care fund, the Alaska health care clearinghouse to administer the Alaska health care program under the direction of the Alaska Health Care Board, and eligibility standards and premium assistance for health care coverage of persons with low incomes; creating the Alaska health care fund; providing for review of actions and reporting requirements related to the health care program; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

FINDINGS; PURPOSE. (a) The legislature finds that

(1) the current health care system is unsustainable;

(2) improving and protecting the health of Alaskans must be a primary goal of the state;

(3) all Alaskans should have access to essential health care services that are affordable, that are based on publicly debated criteria, and that consider the well-being of individuals across their life spans;

(4) Alaska has an economic interest in ensuring equitable financing of essential health care for Alaskans who do not have access to basic health care;

(5) health care policies should emphasize public health and encourage the use of quality service and evidence-based treatment that are appropriate and safe and that discourage over-treatment;

(6) health care providers and informed patients must be the primary decision makers who are accountable for an individual's health;

(7) health care funding should be explicit, predictable, and economically sustainable;

(8) an economically sustainable health care system requires that providers receive fair and adequate compensation;

(9) health care must be balanced with other programs that also affect health; and

(10) health care must account for the allocation of resources and the human consequences of funding decisions.

(b) The purpose of this Act is to address the findings and concerns listed in (a) of this section by creating the Alaska health care program.

*** Sec. 2.** AS 21.54 is amended by adding new sections to read:

Article 2A. Alaska Health Care Program.

Sec. 21.54.200. Alaska health care program. The Alaska health care program is established to

(1) ensure that residents of the state have access to affordable health care insurance;

(2) require that residents of the state have, at a minimum, insurance covering essential health care services;

(3) reduce unsustainable health care cost increases;

(4) establish a system of health care insurance that integrates public involvement and oversight, consumer choice, and competition within the private health care insurance market;

(5) use models of health care insurance benefits, service delivery, and payments that control costs and overuse, emphasizing preventative care and chronic disease management within a primary care environment; and

(6) provide services for humane and dignified end-of-life care.

Sec. 21.54.210. Alaska Health Care Board. (a) The Alaska Health Care Board is established in the division to manage the Alaska health care program.

(b) The board shall consist of 13 members, including 12 members appointed by the governor, subject to confirmation by the legislature, and the commissioner of health and social services or the commissioner's designee, serving ex officio. The members of the board appointed by the governor must include

(1) one representative who is a licensed insurance producer;

(2) one representative from a health insurance company licensed to transact health care insurance in the state;

(3) two representatives of the business community other than health care insurers, one representing large businesses, and one representing small businesses;

(4) one representative each from two Alaska hospitals;

(5) one representative of a labor organization;

(6) two physicians licensed in Alaska;

(7) two health care consumer advocates; and

(8) one registered nurse.

(c) Except for the commissioner or the commissioner's designee, who serves ex officio, each board member serves for a term of three years beginning on January 1 and until a successor has been appointed. A member is eligible for reappointment.

(d) If there is a vacancy, the governor shall make an appointment, effective immediately, for the balance of the unexpired term.

(e) Members of the board are entitled to per diem and transportation costs

under AS 39.20.180.

(f) The board shall select a member to serve as chair and a member to serve as vice-chair for a term and with duties and powers necessary to perform their functions.

(g) A majority of the board constitutes a quorum for transacting business.

Sec. 21.54.220. Powers and duties of the Alaska Health Care Board. (a) The Alaska Health Care Board shall

(1) administer, as a fiduciary, the Alaska health care fund established under AS 21.54.280 in accordance with the Alaska health care program established by AS 21.54.200 - 21.54.310;

(2) establish types or categories of health care insurance plans offered through the Alaska health care clearinghouse;

(3) classify each plan offered through the clearinghouse as a comprehensive or basic health care insurance plan, based on criteria including the financial cost of the plan, including premium cost, deductible costs, and co-pay provisions;

(4) establish criteria for participation by residents and insurers in the Alaska health care program;

(5) establish an Alaska health care voucher system that provides health care insurance to each individual who meets the needs-based participation criteria set out in AS 21.54.240 or who is the beneficiary of contributions made to the fund that specify the individual as the beneficiary under AS 21.54.280(b);

(6) ensure that eligible individuals are enrolled in a health care insurance plan that provides essential health care services;

(7) prescribe the method for determining individual income for the purpose of the Alaska health care program;

(8) establish procedures for enrolling a participant in the Alaska health care program, including enrollment procedures describing when an individual may enroll or select a different health insurance plan offered through the Alaska health care clearinghouse; the procedures established under this paragraph must allow an individual insured by a health care insurance plan offered through the Alaska health care clearinghouse to select a different health care insurance plan from the plans

offered through the clearinghouse and to make that selection at least annually;

(9) require that participants receive complete information regarding the cost of obtaining health care insurance;

(10) establish procedures for notice and hearings for a person aggrieved by a decision of the board or the Alaska health care clearinghouse; and

(11) ensure that every Alaskan who is required to participate in the Alaska health care program is offered health care insurance that protects the insured from severe financial hardship caused by the cost of receiving medical care.

(b) The board may hold regular and special meetings as the board considers necessary; board meetings may be held by teleconference; meetings shall be recorded and made available on request.

Sec. 21.54.230. Alaska health care clearinghouse. (a) The Alaska health care clearinghouse is established in the division.

(b) The clearinghouse shall be administered by the director.

(c) The clearinghouse shall

(1) administer the Alaska health care program under the direction of the Alaska Health Care Board;

(2) disseminate information about health care insurance products available through the clearinghouse; and

(3) provide assistance in the enrollment process for a small business or an individual.

Sec. 21.54.240. Essential health care services; eligibility. (a) Every resident of the state shall participate in the Alaska health care program except a resident who

(1) is a beneficiary of a health care plan that provides health care benefits that meet or exceed the benefits for essential health care services;

(2) is enrolled in a publicly funded medical assistance program providing services that meet or exceed the benefits required as essential health care services;

(3) is enrolled in Medicaid or Medicare;

(4) is covered under a health benefit plan offered in the group market;

(5) is an individual insured under an individual state plan of health

insurance under the Comprehensive Health Insurance Association under AS 21.55;

(6) is receiving health care benefits under a medical care program of the Indian Health Service; however, a person receiving health care benefits under a medical care plan of the Indian Health Service may elect to participate in the Alaska health care program;

(7) has resided in the state for less than one year; however, a person who has resided in the state for less than one year may receive services provided by the Alaska health care clearinghouse under AS 21.54.230; or

(8) demonstrates satisfactorily to the board, under criteria established by the board, that the person has deeply held religious beliefs contrary to the Alaska health care program and the requirement to purchase health care insurance for essential health care services.

(b) Except as provided in (g) of this section, the Alaska Health Care Board shall provide a voucher to a resident with an income that is not more than 450 percent of the most recent federal poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), and who is only eligible for coverage through the Comprehensive Health Insurance Association (AS 21.55). A voucher authorized by this subsection must equalize the cost of insurance under the Comprehensive Health Insurance Association with the cost of purchasing a health care insurance plan that provides substantially equivalent benefits through the Alaska health care clearinghouse. For purposes of cost comparison under this subsection, the board shall determine whether a plan provided under the Comprehensive Health Insurance Association provides substantially equivalent benefits to a health care insurance plan offered through the clearinghouse.

(c) Except as provided in (g) of this section, a resident with an income that is not more than the most recent federal poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), who is required to participate in the Alaska health care program shall receive private health care insurance coverage for essential health care services at no cost, paid from the fund.

(d) Except as provided in (g) of this section, a resident with an income between 100 percent and not more than 300 percent of the most recent federal poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), who is required to participate in the Alaska health care program shall pay premiums for health care insurance for essential health care services on a sliding scale established by the board.

(e) A resident with an income of 300 percent or more of the most recent federal poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), who is required to participate in the Alaska health care program shall pay the premium for health care insurance for essential health care services.

(f) A person who is an alien is not eligible for assistance under AS 21.54.200 - 21.54.310 unless the person is a qualified alien, as defined under 8 U.S.C. 1641, or an alien excepted under 8 U.S.C. 1612(b). However, a qualified alien may only be eligible for assistance under AS 21.54.200 - 21.54.310 if the person is not precluded by the limited eligibility provision of 8 U.S.C. 1613.

(g) A person who is exempt from being required to participate in the Alaska health care program under

(1) (a)(1) - (5) of this section, but who is eligible to participate in a program identified in (a)(1) - (5) of this section, may not receive benefits under (b) - (d) of this section.

(2) (a)(7) of this section may not receive benefits under (b) - (d) of this section until the person has resided in the state for one year or more.

Sec. 21.54.250. Essential health care services. For purposes of AS 21.54.200 - 21.54.310, essential health care services means medical services performed for an individual covered by a health care plan for the diagnosis or treatment of nonoccupational disease or nonoccupational injury. The medical services that must be performed for an individual covered by a health care plan include, as a minimum,

(1) preventative and primary care;

(2) emergency services;

(3) inpatient services and hospital treatment;

(4) ambulatory patient services;

(5) prescription drug coverage; and

(6) mental health services.

Sec. 21.54.260. Alternative or additional health care services. (a) An employer may offer health insurance coverage that meets or exceeds coverage for essential health care services.

(b) An individual or employer may purchase health care insurance for health care services in addition to the essential health care services required under AS 21.54.200 - 21.54.310.

(c) If an employer does not provide a health care insurance plan for all employees or provides a health care insurance plan that meets or exceeds coverage for essential health care services but does not enroll at least 25 percent of the employer's employees in the plan or does not offer to pay at least 33 percent of the premium for health care insurance under the plan, the employer shall pay the department as follows:

(1) if an employer's annual gross payroll paid to employees who are required to participate in the Alaska health care plan under AS 21.54.240 is $500,000 or less, no payment is required;

(2) if an employer's annual gross payroll paid to employees who are required to participate in the Alaska health care plan under AS 21.54.240 is greater than $500,000 but less than $1,000,000, the employer shall pay one percent of the gross payroll; or

(3) if an employer's annual gross payroll paid to employees who are required to participate in the Alaska health care program under AS 21.54.240 is $1,000,000 or greater, the employer shall pay two percent of the gross payroll.

(d) An employer that establishes a cafeteria plan under 26 U.S.C. 125 (Internal Revenue Code) that offers employees the option to elect health care insurance coverage that meets or exceeds essential health care services is not subject to the payment requirements under (c) of this section, regardless of whether an employee elects to receive the offered health care insurance.

(e) In this section, "essential health care services" means those services set out in AS 21.54.250.

Sec. 21.54.270. Health care insurance plan; children's coverage. (a) A health care insurance plan that is approved by the director that provides coverage for essential health care services under AS 21.54.200 - 21.54.310 and meets the other requirements established under this title may be offered through the Alaska health care clearinghouse.

(b) A health care insurance plan offered through the Alaska health care clearinghouse may not deny enrollment to an eligible individual.

(c) A health care insurance plan offered through the Alaska health care clearinghouse may include

(1) different benefits for network or out-of-network providers;

(2) varied levels of copayment, coinsurance, deductable amounts, out-of-pocket maximums;

(3) high deductible health plans as defined by 26 U.S.C. 223(c)(2) (Internal Revenue Code); and

(4) special insurance terms applicable only to individuals between 18 and 30 years of age.

(d) A health care insurance plan offered through the Alaska health care clearinghouse that covers children must provide that the coverage will continue until the earlier of the child's reaching 25 years of age or two years after the child no longer resides with the family.

(e) Notwithstanding AS 21.54.110(a), a health care insurance plan offered through the Alaska health care clearinghouse may not exclude coverage for a preexisting condition that

(1) relates to a condition, regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received more than two years before the enrollment date;

(2) considers genetic information as a condition for which a preexisting exclusion may be imposed in the absence of a diagnosis of the condition related to the genetic information;

(3) extends more than 12 months after the enrollment date; or

(4) excludes a condition relating to pregnancy.

(f) A period of a preexisting condition exclusion permissible under (e) of this section must be reduced by the aggregate periods of creditable coverage, if any, as determined under AS 21.54.120, including creditable coverage resulting from participation in a plan offered through the Alaska health care clearinghouse, or a plan described in AS 21.54.240(a)(1) - (6). The aggregate of periods of creditable coverage is determined by adding all periods of creditable coverage before the enrollment date, excluding periods of creditable coverage before a continuous break in coverage of more than 90 days. This subsection does not apply if an individual's most recent period of creditable coverage ended on a date more than 90 days before the enrollment date. This subsection does not preclude application of a waiting period to all new enrollees under a health care insurance plan.

Sec. 21.54.280. Alaska health care fund. (a) The Alaska health care fund is established as a separate trust fund of the state. The fund consists of

(1) state money appropriated to the fund;

(2) federal money appropriated to the fund;

(3) private employer and employee health care contributions or fees received by the department and appropriated to the fund;

(4) health care premiums received by the department and appropriated to the fund;

(5) other appropriations by the legislature;

(6) contributions appropriated to the fund from the United States government and its agencies or from any other source, public or private, provided for purposes that are consistent with the goals of the Alaska health care program; and

(7) interest earnings from investments of the fund appropriated to the fund.

(b) Contributions may be made to the fund by an employer, employers, or an individual that is specified for a particular beneficiary. If a contribution is made to the fund for the benefit of a particular beneficiary, the beneficiary shall receive a health care voucher in the amount of the contribution that may be used to purchase a health

care insurance plan. Money collected under AS 21.54.260(c) is not considered made for the benefit of a particular beneficiary.

(c) The board may use the fund for the purpose of administering the Alaska health care program consistent with AS 21.54.200 - 21.54.310.

Sec. 21.54.290. Disputes and appeals. A person is entitled to notice and an opportunity for a hearing under regulations adopted by the Alaska Health Care Board if

(1) the board or the Alaska health care clearinghouse denies enrollment to the person;

(2) an accountable health care plan refuses to enroll an individual or fails to provide essential health care services; or

(3) the person is adversely affected or aggrieved by a decision of the board or the clearinghouse.

Sec. 21.54.300. Reporting. The Alaska Health Care Board shall submit a written report on the operation of the Alaska health care program to the commissioner and to the legislature by January 1 of each year. The report must include

(1) the number of individuals enrolled in the Alaska health care program;

(2) the cost savings to the state, to employers, and to health care providers;

(3) a measure of patient satisfaction;

(4) an assessment of patient access to essential health care services;

(5) a description of the changes or adjustments made to the program during the period covered by the report;

(6) a discussion of the state agencies delivering redundant services, if any, relating to health care benefits;

(7) an evaluation of state programs that regulate or deliver health care benefits;

(8) recommendations for legislative changes necessary to meet the goals of the program;

(9) an evaluation of and recommendations on the following topics:

(A) the use of electronic health records;

(B) children's health insurance programs;

(C) the effectiveness of Medicaid and the potential expansion of the Alaska Medicaid program, including a comparison between the costs of expanding the Alaska Medicaid program and the cost of providing benefits through the Alaska health care program;

(D) the effect of mandated benefits;

(E) prescription drug bargaining;

(F) evidence-based treatment procedures including a comparison of the use of evidence-based treatment in other states;

(G) the recruitment and retention of medical professionals in the state;

(H) expanding offerings of the University of Alaska in medical fields;

(I) maximizing federal funding to implement the program;

(J) innovations that could produce health care cost savings, including waivers under 42 U.S.C. 1315 (sec. 1115, Social Security Act), which allows experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute.

Sec. 21.54.310. Regulations. The Alaska Health Care Board shall adopt regulations under AS 44.62 (Administrative Procedure Act) consistent with AS 21.54.200 - 21.54.310.

*** Sec. 3.** AS 21.54.500 is amended by adding new paragraphs to read:

(30) "alien" means a person who is not a citizen or national of the United States;

(31) "board" means the Alaska Health Care Board;

(32) "fund" means the Alaska health care fund;

(33) "resident" has the meaning given in AS 01.10.055.

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITIONAL PROVISIONS. Notwithstanding AS 21.54.210, enacted by sec. 2

of this Act, the initial terms for members of the Alaska Health Care Board, except for the commissioner of health of social services who serves ex officio, are as follows:

(1) four members shall be appointed to serve for a term ending December 31, 2010;

(2) four members shall be appointed to serve for a term ending December 31, 2011; and

(3) the remaining members shall be appointed to serve for a term ending December 31, 2012.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITIONAL PROVISIONS: REGULATIONS. The Alaska Health Care Board established under AS 21.54.210, enacted by sec. 2 of this Act, may proceed to adopt regulations necessary to implement this Act under AS 21.54.310, enacted by sec. 2 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

*** Sec. 6.** AS 21.54.210, 21.54.220, and 21.54.230, enacted by sec. 2 of this Act, and sec. 5 of this Act take effect immediately under AS 01.10.070(c).

*** Sec. 7.** Except as provided in sec. 6 of this Act, this Act takes effect January 1, 2010.

Alaska State Legislature

Senator Hollis French

Sponsor Statement

SB 61 - Affordable Health Insurance for All Alaskans

The time has come for us to begin addressing the health care crisis in Alaska. Increasing costs have made it difficult for businesses and individuals to acquire the health services they need. This crisis is only getting worse; family health insurance premiums have risen 4.6 times faster than the median earnings of Alaskans over the past 6 years. As costs continue to increase, it is likely that additional hard working Alaskans will go uninsured. Employers who choose to provide employee health plans will watch their costs go up, making it difficult to run a competitive business in the state. The federal government might take action, but if it doesn't, Alaska needs to be ready to take the lead.

Many other states have joined the universal health care debate, but this bill is uniquely Alaskan. SB 61 puts people in control of their own health, giving them the tools they need to make smart investments. Vouchers, funded by a variety of stakeholders, make the prospect of acquiring health coverage realistic to all Alaskans. By guaranteeing that everyone has coverage, insurance premiums will go down. This bill ensures that everyone can purchase an affordable health plan that they select to fulfill their medical needs.

This bill establishes a framework mandating and ensuring affordable health coverage for all Alaskans. A board of 13 stakeholders will oversee the plan, making certain that residents are able to choose and purchase coverage that provides adequate care. The bill also provides:

A framework for personal choice: This bill facilitates a relationship between health insurance providers and individuals, and doesn't assume that a one size fits all solution will meet the health care needs of all Alaskans.

A unique voucher system: By pooling money from all stakeholders, a sliding scale voucher system will ensure that every Alaskan can take personal responsibility for acquiring health insurance coverage. The system will also make it easy for multiple entities to contribute towards a health plan for an individual.

A health care clearinghouse: The clearinghouse will disseminate information about quality health care products, assisting Alaskans who are utilizing vouchers under the Alaska health care plan.

The Alaska health care fund: This fund will receive contributions from individuals, businesses and government to ensure that all interested parties contribute to the health of Alaskans.

Satisfied with your current coverage? This bill will not affect employer based health plans that provide quality health care coverage. In addition, the bill may reduce cost increases for those who currently pay for coverage. A hospital cannot turn down anyone in need of emergency care, and when someone cannot pay their medical costs, those who can pay are forced to subsidize the cost of the uninsured. A recent study estimated that Alaska health insurance premiums are 13.6% higher than they would be if everyone had health coverage (Families USA report). Through ensuring equitable financing of the health care system, SB 61 will reduce the burden on individuals and businesses currently buying coverage.

This bill isn't really about reforming the health care system; it is about ensuring the health of residents across the state. I urge you to consider supporting this bill as we work to improve the quality of life for all Alaskans.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 61
() Publish Date:

Identifier (file name):SB61-CED-INS-03-02-09
Title: MANDATORY UNIVERSAL HEALTH INSURANCE
Sponsor: Senator French
Requester: Senate Health & Social Services

Dept. Affected: DCCED
RDU: Insurance
Component: Insurance Operations
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	878.1		1,756.1	1,756.1	1,756.1	1,756.1	1,756.1
Travel	48.2		96.4	96.4	96.4	96.4	96.4
Contractual	1,979.5		1,134.0	1,134.0	1,134.0	1,134.0	1,134.0
Supplies	24.0		12.0	12.0	12.0	12.0	12.0
Equipment	431.4		9.0	9.0	9.0	9.0	9.0
Land & Structures							
Grants & Claims							
Miscellaneous (Premium Costs)	1,146,000.0		1,146,000.0	1,146,000.0	1,146,000.0	1,146,000.0	1,146,000.0
TOTAL OPERATING	**1,149,361.2**		**1,149,007.5**	**1,149,007.5**	**1,149,007.5**	**1,149,007.5**	**1,149,007.5**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (1105)	**564,000.0**		**564,000.0**	**564,000.0**	**564,000.0**	**564,000.0**	**564,000.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	585,361.2		585,361.2	585,361.2	585,361.2	585,361.2	585,361.2
1005 GF/Program Receipts	564,000.0		564,000.0	564,000.0	564,000.0	564,000.0	564,000.0
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**1,149,361.2**		**1,149,361.2**	**1,149,361.2**	**1,149,361.2**	**1,149,361.2**	**1,149,361.2**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	24		24	24	24	24	24
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The purpose of this bill is for all Alaskans to have access to essential health care services. It requires all residents to have health insurance and creates an Alaska health insurance program. The bill establishes the Alaska Health Care Board to oversee the program and the Alaska Health Care Clearinghouse to administer the program, under the direction of the Board. The effective date of the Act is January 10, 2010.

(Continued on page 2)

Prepared by: Linda Hall, Director — Phone (907)269-7900
Division: Insurance — Date/Time 3/2/09 9:00 AM
Approved by: Emil R. Notti, Commissioner — Date 3/2/2009
Department of Commerce, Community and Economic Development

(Revised 9/10/2008 OMB)

3652

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB 61

ANALYSIS CONTINUATION

Caveat: The Division of Insurance has no existing expertise in establishing or administering State benefits programs. The Division of Insurance oversees the conduct of insurance companies, ensures solvency, and approves rates and forms. The Division of Insurance does not determine what are minimum essential health services or how they should be priced. Further, the Division of Insurance has no expertise in determining the eligibility of individuals for government subsidies. All of this expertise will have to be developed by the Division of Insurance from scratch, primarily by recruiting and hiring a substantial number of employees with this type of expertise.

Senate Bill 61 allows for a wide range of options that may be considered essential health care services. As a result, it is not possible to determine the cost of the bill with a high confidence in accuracy. The range of possible costs is wide, depending upon how the Board defines certain terms.

This fiscal note examines the potential cost of the program , as well as the estimated cost of administering the benefit. Costs for insurance premiums are very preliminary until the "essential health care services" are defined. This fiscal note reflects the high-premium scenario using the State of Alaska employee plan as a model and is not broken out by budget component.

Assumptions:
*The Health Care Fund only pays for the non-Medicaid eligible population. State matching funds for Medicaid do not come from the Fund.
*The estimated cost for insurance premiums is $12,000 per person per year (based on the State of Alaska employee insurance plan).
*The cost of premiums to purchase insurance are on a needs-based sliding scale. The State share of premiums will be paid from the Fund.
*Co-pays and deductibles are not addressed in the bill so we assume none are required by any plan.
*There are an estimated 115,000 uninsured persons in Alaska, 83% of whom are adults.

Cost Estimates for Alaska Health Care Program:
*There are 27,000 uninsured persons who are below 100% of the poverty level. Insurance is provided at no cost to the individual. Total cost to the state is $324,000,000.

*43,000 have incomes between 100% and 300% of poverty. They would pay premiums on a needs-based sliding scale. With an estimated average cost of $6,000 per person, the total cost to the state is $258,000,000.

Above 300% of poverty: $0 total. No cost to the State.
*There are about 25,500 uninsured individuals who are above 300% of the poverty level. They would bear the full cost of the mandatory insurance. These individuals would bear a total cost of about $306,000,000.

Fund Source
*A portion of the cost will be paid by a payroll tax of up to 2%, depending upon the size of the business. The Division of Insurance is aware of no statistics on which to estimate the amount of money that would be raised by the tax.

* A portion of the cost will also be funded by premiums paid in part by persons with income between 100% and 300% of the poverty line. These revenues are shown in the general fund program receipts fund source.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB061
() Publish Date:

Identifier (file name): SB061-DHSS-PAFS-02-28-09
Dept. Affected: Health & Social Services
Title: Mandatory Universal Health Insurance
RDU: Public Assistance
Component: Public Assistance Field Services
Sponsor: French
Requester: Senate HSS
Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	1,234.7		1,646.3	1,646.3	1,646.3	1,646.3	1,646.3
Travel	10.0		10.0	10.0	10.0	10.0	10.0
Contractual	255.3		340.4	340.4	340.4	340.4	340.4
Supplies	35.6		47.5	47.5	47.5	47.5	47.5
Equipment	250.0						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**1,785.6**	**0.0**	**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	892.8		1,022.1	1,022.1	1,022.1	1,022.1	1,022.1
1003 GF Match	892.8		1,022.1	1,022.1	1,022.1	1,022.1	1,022.1
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**1,785.6**		**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	**23.0**		23.0	23.0	23.0	23.0	23.0
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The purpose of this bill is for all Alaskans to have access to essential health care services. It requires all residents to have health insurance and creates the Alaska health care program, which is administered by the Division of Insurance.

The bill is expected to increase enrollment in Medicaid, since enrollment in Medicaid is one of the criteria that makes a person ineligible for health care coverage under the new program. The Division of Public Assistance accepts applications and determines whether a person meets program criteria and financially qualifies for the Medicaid program. This fiscal note reflects the additional administrative costs needed to support the increased workload as a result of more people applying for Medicaid.

(continued on page 2)

Prepared by: Ellie Fitzjarrald, Director
Phone (907) 465-5847
Division: Public Assistance
Date/Time 2/27/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/28/2009
DHSS Finance & Management Services

(Revised 9/10/2008 OMB)

3654

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB061

ANALYSIS CONTINUATION

SB 61 has a January 1, 2010 effective date.

Assumptions:

In FY2010, the department anticipates receiving 14,000 Medicaid applications from persons who do not currently receive Medicaid, and that 10,000 will qualify and be enrolled. Additional staff will be needed to manage the increased application volume and workload. The Division of Public Assistance assumes that funding for additional staff in FY 2010 will include a three month start-up period beginning October 2009 to accommodate hiring and training of new staff.

Fourteen Eligibility Technicians are needed to make decisions on applications and act on changes in household income or other factors affecting a household's eligibility; two Lead Eligibility Technicians are needed to perform quality assurance, training on program rules, and other lead worker duties; one Eligibility Supervisor is needed to oversee and manage the work of the new staff; and four administrative support staff are needed to provide customer service, manage phone lines, and perform clerical support.

The increased volume of applications is anticipated to result in increased denials of eligibility and fair hearing requests. Hearing requests usually result when applicants do not receive an affirmative decision on their application. This increased demand will result in the need for one additional Public Assistance Analyst to serve as a hearing representative and support the fair hearing function.

Additionally, interaction with another department will also increase complexity of referrals and processing of applications. A Program Coordinator is necessary to establish and maintain service coordination and collaboration with the Alaska Health Care Program, and to facilitate consumer education, etc.

FY 2010 Administrative Costs (for 9 months): $1,785.6
Personal Services: $1,234.7 (salary and benefits for 23 new positions)
Travel: $10.0 (for training)
Contractual: $255.3 (for 9 month's cost for information technology, telecommunication, office space, phones)
Supplies: $35.6 (program materials and general office supplies
Equipment: $250.0 (One-time cost for desktop computers, printers, and workstations, and other office equipment

FY 2011 – FY 2015 Annual Administrative Costs: $2,044.2
Personal Services: $1,646.3 (salary and benefits for 23 new positions)
Travel: $10.0 (for training)
Contractual: $340.4 (annual cost for information technology, telecommunication, office space, phones)
Supplies: $47.5 (program materials and general office supplies)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB061**
() Publish Date:

Identifier (file name): **SB061-DHSS-BHMS-02-28-09**
Dept. Affected: Health & Social Services
Title: Mandatory Universal Health Insurance
RDU: Behavioral Health
Component: Behavioral Health Medicaid Services
Sponsor: French
Requester: Senate HSS
Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	3,000.0		6,000.0	6,000.0	6,000.0	6,000.0	6,000.0
Miscellaneous							
TOTAL OPERATING	**3,000.0**	**0.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,830.0		3,660.0	3,660.0	3,660.0	3,660.0	3,660.0
1003 GF Match	1,170.0		2,340.0	2,340.0	2,340.0	2,340.0	2,340.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**3,000.0**	**0.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The purpose of this bill is for all Alaskans to have access to essential health care services. It requires all residents to have health insurance and creates the Alaska health care program, which is administered by the Division of Insurance. The effective date for coverage is January 1, 2010.

This bill is expected to increase enrollment in Medicaid, which will increase costs. This fiscal note reflects the portion of additional costs to the Medicaid program for behavioral health services.

continued on page 2

Prepared by: William J. Streur, Deputy Commissioner
Phone 907-269-7827
Division: Health Care Services
Date/Time 1/27/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/28/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB061

ANALYSIS CONTINUATION

ASSUMPTIONS

Enrollment

Participation is required for every resident who is not enrolled in a public medical assistance program (e.g. Medicaid, Medicare) or a private insurance program that provides essential health care services. About 20% of the uninsured are Native who have coverage under Indian Health Services. Most children who need long term care are expected to have already applied for Medicaid.

There are an estimated 109,500 uninsured persons in Alaska (children = 17,200, adults = 91,500, and elderly = 800) who would be required to take up coverage. Of the 109,500 uninsured persons, **an estimated 10,000 persons, mostly children below 175% of poverty, could be enrolled in Medicaid/SCHIP** without changes to the current eligibility guidelines. This includes the eligible Native population who we assume would enroll in Medicaid as a result of outreach/advertising for the AK Health Care program.

Cost of Benefits

Once deemed eligible, a Medicaid enrollee is entitled to all Medicaid services, and is not limited to only those "essential health care services" listed in the bill. The average cost for all Medicaid benefits for children is **$3,000 per person per year** (based on analysis of Medicaid claim payments for non-disabled children). The total additional cost for benefits (all Medicaid components) is $30 million per year (10,000 persons x $3,000).

This component is allocated about 20% of the total Medicaid costs. Behavorial Health Medicaid Services include acute psychiatric hospital, residential psychiatric treatment centers and outpatient mental health services.

Fund Source

The federal government reimburses the state approximately 50% of the cost for most Medicaid claims. Some claims get an enhanced match rate (e.g. Indian Health Services is 100% federal). The fund source is based on the projected weighted average federal revenue for Behavioral Health Medicaid Services of **61% federal funds**. State matching funds for Medicaid are GF/M and do not come from the AK Heath Care Fund.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB061
() Publish Date:

Identifier (file name): SB061-DHSS-MS-03-06-09
Dept. Affected: Health & Social Services
Title: Mandatory Universal Health Insurance
RDU: Health Care Services
Component: Medicaid Services
Sponsor: French
Requester: Senate HSS
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	12,000.0		24,000.0	24,000.0	24,000.0	24,000.0	24,000.0
Miscellaneous							
TOTAL OPERATING	**12,000.0**	**0.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	8,112.0		16,224.0	16,224.0	16,224.0	16,224.0	16,224.0
1003 GF Match	3,888.0		7,776.0	7,776.0	7,776.0	7,776.0	7,776.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**12,000.0**	**0.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The purpose of this bill is for all Alaskans to have access to essential health care services. It requires all residents to have health insurance and creates the Alaska health care program, which is administered by the Division of Insurance. The effective date for coverage is January 1, 2010.

This bill is expected to increase enrollment in Medicaid, which will increase costs. This fiscal note reflects the portion of additional costs to the Medicaid program for health care services, other than behavioral health.

continued on page 2

Prepared by: William J. Streur, Deputy Commissioner
Phone 907-269-7827
Division: Health Care Services
Date/Time 3/6/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/6/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB061

ANALYSIS CONTINUATION

ASSUMPTIONS

Enrollment

Participation is required for every resident who is not enrolled in a public medical assistance program (e.g. Medicaid, Medicare) or a private insurance program that provides essential health care services. About 20% of the uninsured are Native who have coverage under Indian Health Services. Most children who need long term care are expected to have already applied for Medicaid.

There are an estimated 109,500 uninsured persons in Alaska (children = 17,200, adults = 91,500, and elderly = 800) who would be required to take up coverage. Of the 109,500 uninsured persons, **an estimated 10,000 persons, mostly children below 175% of poverty, could be enrolled in Medicaid/SCHIP** without changes to the current eligibility guidelines. This includes the eligible Native population who we assume would enroll in Medicaid as a result of outreach/advertising for the AK Health Care program.

Cost of Benefits

Once deemed eligible, a Medicaid enrollee is entitled to all Medicaid services, and is not limited to only those "essential health care services" listed in the bill. The average cost for all Medicaid benefits for children is **$3,000 per person per year** (based on analysis of Medicaid claim payments for non-disabled children). The total additional cost for benefits (all Medicaid components) is $30 million per year (10,000 persons x $3,000).

This component is allocated about 80% of the total Medicaid costs. Health Care Services - Medicaid Services include inpatient/outpatient hospitals, physicians & clinics, prescription drugs, dental, transportation, lab/x-ray, durable medical equipment, physical/occupational/speech therapy, vision, and home health/hospice.

Fund Source

The federal government reimburses the state approximately 50% of the cost for most Medicaid claims. Some claims get an enhanced match rate (e.g. Indian Health Services is 100% federal). The fund source is based on the projected weighted average federal revenue for Health Care Services - Medicaid Services of **66.7% federal funds.** State matching funds for Medicaid are GF/M and do not come from the AK Heath Care Fund.

SB 61 *Health Insurance For All Alaskans*

Detailed Bill Summary

SECTION 1 of the bill – Findings **Corresponds with version \R**

SECTION 2 of the bill - Provides the framework for the bill

Sec. 21.54.200: Establishes the health care program
This section lays out what the legislation will accomplish.

- it ensures that all state residents can afford quality health coverage that suits their particular needs
- it requires that health coverage is meaningful, as discussed later in AS 21.54.250
- it reduces unsustainable health care cost increases, through encouraging primary care and prevention
- it centers on consumer choice by providing a framework for competition, where insurance plans must compete to acquire and retain customers

Sec. 21.54.210: Establishes the Alaska Health Care Board
This section establishes the Alaska Health Care Board under the Division of Insurance. The board will have 13 voting members, and will include:

- one insurance producer licensed to do business in the state
- one representative from a health insurance company licensed in Alaska
- one representative that works for a large business
- one representative that works for a small business
- two representatives from Alaska hospitals
- one representative of a labor organization
- two licensed Alaska physicians
- two consumer advocates
- one registered nurse
- the commissioner of Health and Social Services, or their designee

Each member, except the commissioner, serves a 3 year term and are subject to appointment and reappointment by the Governor. Members will be entitled to standard per diem and transportation costs under AS 39.20.180. The board will select a chair and a vice chair, and a majority of the board will be considered a quorum for transacting business.

Sec. 21.54.220: Defines the powers and duties of the Alaska Health Care Board
The board oversees two of the main elements in this bill: the health care Clearinghouse and the health care fund, the function of which are described in later sections of the bill.

In particular, the board will:

- ensure that a variety of plans are available in the clearinghouse, where individuals make plan selections based on their personal needs
- help educate the public about different plan options, and ensure that residents are enrolled in a health benefit plan
- establish enrollment criteria and procedures for individuals, and provide for an annual open season when customers can change their plan selections.

For more information, contact Sen. French's office:
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Detailed Bill Summary

In particular, the board will *(continued)*:

- The board will hear complaints or objections to decisions made by the program or clearinghouse. Individuals who feel aggrieved by a decision of the board are entitled to a hearing
- Establish criteria and implement the voucher system, which will be discussed in a later section
- Ensure that plans protect individuals from severe financial hardship in times of medical need

Sec. 21.54.230: Alaska Health Care Clearinghouse
The health care clearinghouse will be the 'place' where Alaskans are connected up with private health plans that suit their needs. The clearinghouse will disseminate information about health insurance and the plans that are 'certified' to fulfill the essential health care services criteria, as defined later in the bill.

The Clearinghouse will be the place where individuals with health care vouchers make plan selections and are connected up with quality insurance products.

Sec. 21.54.240: Establishes the Voucher system, and includes the individual responsibility clause
This section ensures that all Alaskans can afford quality health coverage. It begins in (a) with the individual responsibility clause, which requires that all Alaskans have health coverage that provides essential health care services. This requirement will only affect those who don't currently have coverage: (1) – (8) outline specific examples of individuals who will be exempt from the individual responsibility clause. Excepted from the requirement are individuals who receive benefits under employer plans or publicly funded programs, including IHS recipients. In addition, individuals who have objections to the requirement to have health coverage on religious grounds can apply to be exempt from the individual responsibility clause.

Subsections (b) through (e) describe the sliding scale voucher system which makes health coverage affordable for all legal residents. Sliding scale vouchers are issued to individuals in households based on the federal government's federal poverty level criteria (FPL), which sets a poverty line annually based on household size. This year the FPL has been set at $13,000 of gross income a year for an individual, or $26,500 per year for a family of four.

Subsection (c) provides a guarantee that anyone who falls below the federal poverty line won't have to pay for health coverage.

Subsection (d) provides vouchers, on a sliding scale, to individuals in households that earn between 100% and 300% of the FPL. Using the numbers from above, this means that an individual who earns between $13,000 and $39,000 a year or a family of four that has a household income between $26,500 and $79,500 will be eligible for a sliding scale voucher that makes health insurance affordable. The amount of these vouchers will be set by the board, and will vary, with more assistance going to those who earn less.

Subsection (e) requires that all individuals over 300% of the FPL acquire health coverage. While these individuals will not receive needs based vouchers, they will be eligible to receive specified beneficiary vouchers, which are discussed in a later section of the bill.

Detailed Bill Summary

Subsection (b) provides larger vouchers to individuals who only qualify for ACHIA coverage, making the cost of coverage equal to that available in the normal market. These vouchers will be issued to people who earn up to 450% of the FPL.

Subsection (f) ensures that only legal residents of Alaska receive needs based vouchers.

Subsection (g) clarifies that an individual who is eligible for health coverage funded by a source other than the health care clearinghouse won't receive needs based vouchers to make insurance affordable.

Sec. 21.54.250: Defines essential health care services
This section defines the benefits that all health insurance plans sold through the clearinghouse must include. Insurance plans will include coverage for:

- preventative and primary care
- emergency services
- inpatient services and hospital treatment
- ambulatory patient services
- prescription drug coverage
- mental health services

Sec. 21.54.260: Relates to employer provided health coverage
(a) and (b) are included to make it clear that nothing in this legislation changes employer based health coverage for companies that elect to provide it.

(c) and (d) relate to the employer levy, which ensures that all employers contribute to the health of employees around the state. This tax is only levied against employers who don't offer health coverage, and the amount depends on the number of employees who lack health coverage and are required to attain it under this legislation. For businesses that pay below $500,000 gross annually to employees that are required to participate, no levy will be charged. For businesses with $500,000 to $1 million a year in gross payroll to employees required to participate in the plan, the levy will be 1% of gross payroll. For $1 million or greater, the levy will be 2%. If an employer either a) offers to pay 33% of premium costs or b) successfully enrolls 25% of employees in an employer sponsored plan they will be exempt from this tax. In addition, if an employer establishes a so-called 'Section 125' cafeteria plan that allows employees to purchase health coverage with pre-federal tax dollars, the employer will be exempt from this levy.

Sec. 21.54.270: Relates to the structure of insurance plans available in the clearinghouse
This section requires that plans provide coverage for essential health care services, as described in 21.54.250. (b) in this section mandates that an insurance company not turn down an individual looking for coverage.

Subsection (c) makes clear that health insurance plans can have varied levels of deductibles, co-pays, co-insurance and out of pocket maximums. They can include high deductible health care plans, and benefit levels can be different for in network and out of network providers. In addition, this subsection encourages lower

Detailed Bill Summary

cost plans that are especially designed for young adults, ages 18-30, which have different terms than are found in normal plans.

Subsection (d) increases the length of time that a child must be covered under a clearinghouse plan to 25 years of age, or until 2 years after the dependent no longer resides with the family.

Subsection (e) borrows language from Alaska's small group health insurance law that limits the length of time a preexisting condition limitation can be imposed on new enrollees to a maximum of 12 months. It also only allows a two year look back for determining when preexisting conditions exist.

Subsection (f) requires insurers to give credit for prior coverage when determining preexisting condition exclusion periods on newly issued health insurance plans sold through the clearinghouse.

Sec. 21.54.280: Establishes the Alaska Health Fund and Specified Beneficiary vouchers
The health fund is established as a separate trust fund of the state, and will include:

- state money and appropriations
- federal money, pursued through a variety of routes including 1115a waivers
- employer levy established in 21.54.260
- health care premiums received and appropriated to the fund
- money from any source that is given with purposes consistent with the purpose of the program

(b) establishes specified beneficiary vouchers, which gives an employer, employers or individuals the ability to contribute to the health premium of a given individual, through a voucher.

Sec. 21.54.290: Disputes and appeals
This section gives an individual the opportunity for a hearing if they are denied health coverage by a certified plan, or if a plan fails to deliver essential health care services. In addition, if a person feels adversely affected or aggrieved by a decision of the board or clearinghouse, they have the right to a hearing.

Sec. 21.54.300: Reporting
This section provides for an annual report by the health care board that includes statistics relating to how the health reform program is performing. In addition, the board will also give an evaluation and recommendations on a variety of important health reform topics, including the use of electronic health records, S-CHIP, the effect of mandated benefits, prescription drug bargaining, ways to maximize federal health care dollars, recruitment and retention of medical professionals, evidenced based treatment procedures, Medicaid effectiveness/expansions and more.

Sec. 21.54.310: Regulations
This section requires that the board establish regulations under the Administrative Procedure Act.

The remainder of the bill deals with definitions, transitional provisions and effective dates.

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[redacted]

Health Insurance For All Alaskans

A Bipartisan Solution To Cover The Health Needs Of All Alaskans

SB 61 - AFFORDABLE HEALTH INSURANCE

Comments about the legislation:

Anchorage Daily News Editorial:

"BOTTOM LINE: Here's a promising, market-based, consumer-driven approach to universal health insurance in Alaska."

- Published September 23rd, 2007

Al Parrish, VP/Chief Executive, Providence Health Systems Alaska:

"I believe it is crucial for Alaskans to engage in a public policy debate on this important issue and this legislation provides an excellent forum around which this discussion can be held."

- Written in a letter to Senator French and included in this packet

Laile Fairbairn, Managing Owner, Snow City Café (located in Anchorage, AK):

"I feel that [this bill] is a very promising solution to a significant problem faced by a large number of Alaskan businesses."

- Testimony during a September 10th, 2007 bill hearing in Anchorage, AK

SB 61 *Health Insurance For All Alaskans*

Legislation Summary

Senate Bill 61 is an innovative, market based solution to the national health care crisis in Alaska. It is not socialized medicine. By maximizing consumer choice and creating a health insurance clearinghouse, this legislation guarantees affordable quality health coverage for all legal Alaskan residents.

Many working Alaskans cannot acquire insurance because the cost of coverage places a plan out of reach. While all Alaskans have legal 'access' to insurance products, those who cannot afford the full cost must hedge their bets on good health. Alaska's unique economy adds additional challenges: seasonal employees, for instance, find themselves outside the traditional 'group' market, lacking an easy route to maintain continuous, portable coverage. And with the amount of uncompensated care rising, the pressure on individuals and businesses who do buy coverage will only increase, because unpaid hospital bills are essentially transferred to those who pay for services. SB 61 will reduce uncompensated care and ensure that all Alaskans have meaningful access to health coverage, regardless of job type.

The solution requires that all Alaskans participate. While individuals will have the responsibility to acquire coverage under the bill, the state will guarantee that a quality insurance product will be affordable. Sliding scale vouchers will assist Alaskans that cannot afford the full price of coverage on their own. The bill allows for unique plans that cater specifically to young Alaskans. This legislation does not assume that a one size fits all solution will work for Alaska.

The health care 'clearinghouse' will give participating Alaskans choices when it comes to health coverage, in a competitive marketplace framework. It allows for unsatisfied consumers to change insurers or plans without a loss of benefits, and provides a private market solution to rising costs. By placing the consumer in control and providing information about comparable products, the clearinghouse should reduce cost increases while increasing customer satisfaction.

In short, this legislation will ensure that all Alaskans have access to health care in times of great need, through an equitably financed system.

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For more information, contact Sen. French's office:
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SB 61

Health Insurance For All Alaskans

Frequently Asked Questions

Why is this bill necessary?
As medical costs increase uninsured Alaskans have greater difficulty taking charge of their own health, because the cost of insurance becomes prohibitive. Through a unique voucher system, this bill will allow individuals to purchase coverage that is affordable, putting everyone in charge of their own medical future.

Why is this bill necessary now?
Recent reports show that medical expenses for Alaska's families have increased 4.3 times faster than the median family income. Businesses across the country have expressed concern about rising insurance costs and the difficulty of providing quality health coverage to employees. The time has come to ensure that all Alaskans have access to affordable coverage, since without action things will only get worse.

How many Alaskans currently lack health insurance?
The latest numbers developed by the Lewin Group estimate that 15.5% of Alaskans lack health insurance, for a total uninsured population of 97,689.

I already have insurance, so why should this bill be of interest to me?
The impact of the uninsured is felt by all Alaskans, not only socially, but economically. When someone cannot pay their medical bills, the costs for their care is essentially covered by hospitals, businesses and the individuals who can pay. A recent legislative research report found that the State of Alaska, as an employer, paid an extra 18.9 million dollars for state employee benefits because of the increased prices caused by uncompensated care.

This bill ensures equitable financing of the health care system while reducing expensive emergency room procedures by encouraging preventative care.

Does this bill change my current employer based health insurance plan?
No – if you are satisfied with your current coverage and it provides essential health services no changes will occur.

Is this bill socialized medicine?
No, and far from it. Socialized medicine is characterized by government run health care; this bill protects consumer choice and encourages competition through a unique voucher system. Under the bill, the government only acts as a facilitator in the health coverage arena, making certain that everyone can afford quality health coverage.

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SB 61

Health Insurance For All Alaskans

Personal Choice Under The Bill

For more than 70 years a majority of Americans have received health coverage through their employer. Some see the system of employer based coverage as an unfortunate historical accident, largely resulting from federal tax loopholes following World War II. Others note that employers worldwide play a large role in providing coverage to their employees. SB 61 works within this country's traditional employer-based framework while guaranteeing portable, consumer centric coverage. This legislation places Alaskans in full control of health care decisions that dramatically affect their lives.

Nothing in SB 61 would require a person to change their health coverage if they are satisfied with the benefits they receive today. However, many Alaskans want more options. Through the health care Clearinghouse, this legislation will facilitate a new relationship between individuals and insurance providers: the bill does not assume that a one size fits all solution will work for all Alaskans.

SB 61 places individuals in control of their coverage decisions. Under the employer based system, the employer is a middleman between an individual and health coverage. Currently 80% of employer offerings give only one plan option to employees, and the individual must either accept or refuse that coverage. When employers decide which insurance company to contract with, the way a plan serves employees is clearly considered but coverage decisions aren't left to the individual. The clearinghouse under this legislation provides consumers with information, leaving decisions of plan type and provider up to the person who is affected most by the decision.

The health care clearinghouse established under this legislation will create a marketplace where health insurance information is shared. The annual open season encourages competition by allowing individuals to change plan types and providers seamlessly, which has the potential to reduce rates. In short, this legislation will put Alaskans in a new position of control when designing their plan and choosing an insurer, through a competitive, market based framework.

80% of employers who offer subsidized health plans only offer employees one type of plan design.

- Heritage Foundation

References/For More Information:
Edmund Haislmaier - "The Mass. Health Reform: Assessing Its Significance and Progress" - Heritage Foundation 2007

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SB 61

Health Insurance For All Alaskans

Reducing Medical Bankruptcy

Half of all personal bankruptcies in America are caused by medical problems. While health insurance alone won't provide perfect protection from large health costs, SB 61 could dramatically reduce the bankruptcy rates of Alaskans who will be faced with high medical expenses.

Coverage through the Clearinghouse separates insurance from employment, making a health insurance plan continuous despite job status. Sliding scale vouchers will exist for those who truly cannot afford the full price of a plan on their own, helping those who haven't had access to health coverage. For seasonal employers who generally don't offer a group plan to employees, the option of contributing some funds towards an employee's plan would become easier, and multiple employers could contribute. By ensuring affordable coverage, individuals will have financial protection in times of great need.

Three out of four people who cite medical problems as a partial reason for declaring bankruptcy had health coverage when their ailment began, but most had a lapse in that coverage before declaring bankruptcy. In an employer based coverage system, a job loss is coupled with a loss of employer subsidized benefits. While options do exist to extend coverage, these options charge an individual the full price of the employer offering, and often leave little or no choice in plan design. As mentioned earlier, over 80% of employer sponsored health plans across the country only offer one type of plan that employees can either accept or reject. Often, employees with pre-existing conditions must either drop coverage altogether or pay for a 'Cadillac' plan if they want continuation of benefits, since private carriers in the individual market aren't required to provide them with a plan. For people participating in the clearinghouse, this legislation would open up options when it comes to plan design and portability.

To protect Alaskans, SB 61 makes certain that insurance products are of good quality, with the capability to protect the plan holder from a medical catastrophe. Insurance plans come in all shapes and sizes today, and that is a great thing for consumer choice. However, a one size fits all approach won't work in Alaska. As an example, while many Alaskans may prefer a low premium, high deductible health plan, a policy that has a $10,000 deductible won't be of much use to an individual who makes minimum wage, amounting to approximately $15,000 a year. By setting deductible, co-pay and out of pocket maximums for plans that qualify for sliding scale vouchers, SB 61 ensures that everyone has access to quality coverage that fits their financial needs.

References/For More Information:
David U. Himmelstein et al - "Marketwatch: Illness And Injury As Contributors To Bankruptcy"-Health Affairs 2005

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SB 61

Health Insurance For All Alaskans

Voucher System Ensures Affordability, Access

The voucher system in this legislation promotes consumer choice for all Alaskans. Two types of vouchers will be issued under the bill. The first type puts the price of insurance within the reach of all Alaskans by providing assistance, on a sliding scale, to those who cannot afford the full cost of a plan. The funding for these vouchers would come from the levy charged to non-providing employers, as well as from state and federal contributions. Without sliding scale vouchers the individual responsibility component of the legislation wouldn't be meaningful, because insurance is priced out of reach for many working Alaskans.

The second type of voucher is issued to specified individuals, who have had contributions made on their behalf by an employer or another individual, for use on health insurance products. These vouchers create a convenient way for employers to pool health contributions for an individual, whether they have one or many jobs. In particular, specified beneficiary vouchers are particularly appealing for individuals with multiple jobs, because it helps multiple employers share the cost of coverage. The system also gives businesses some certainty of their health expenditures in a given year, since expenses can be defined by contribution level and not by benefit package. The choice of plan type is left to the individual, for the obvious reason that he or she is most affected by the selection.

Contributions to specified beneficiary vouchers will not be mandated; instead, that element of the bill promotes equitable financing of health coverage by making it easier than ever for employers to contribute to the health and well being of their employers.

Alaskans spent $5.3 billion on health care in 2005, a 230% increase from 1991.

- ISER

Affordability provides true access

Under current Alaska law any small business can buy private coverage, and every individual can buy an insurance plan, either through the private market or ACHIA (the state high risk pool). However, claiming that this equals access to health insurance is simply false. Access to health care must be more than just the legal right to buy a policy; it should ensure that all Alaskans have coverage in times of need. SB 61 mandates true access to health care through a unique voucher system that makes coverage affordable for all Alaskans.

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SB 61

Health Insurance For All Alaskans

Prevention, Innovation and The Affordability Guarantee

Prevention and Innovation

This legislation acknowledges that lowering costs while improving quality requires innovative solutions to old problems. Under SB 61, the Alaska health care board will weigh in on potential cost and quality improvements, including but not limited to recommendations on:

- Electronic health records and health information exchanges
- Denali Kid Care/Medicaid effectiveness
- Prescription drug bargaining
- Insurance market reforms
- Mandated benefits
- Evidence based treatment procedures
- Recruitment and retention of medical professionals
- University of Alaska offerings in medical fields

The health care board's suggestions regarding cost and quality improvements will be given to the commissioner of the Department of Health and Social Services and the legislature in an annual report. This report will get the consideration of both the legislative and executive branches, where substantive health policy changes can be considered, discussed and implemented.

More than half of Alaska's uninsured population is employed.

- Families USA

The Affordability Guarantee

SB 61 requires that quality basic health insurance is made affordable for all Alaskans. If an individual feels that he or she cannot afford coverage under the legislation's framework, that person has a right to an appeal before the health care board. If the board reviews the case and agrees that an insurance plan places an undue financial burden on the household, the requirement to have coverage will be lifted. While SB 61 should place the price of coverage within reach for all Alaskan families, the affordability clause in the bill provides a guarantee that no one will be forced to purchase coverage they cannot afford.

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SB 61

Health Insurance For All Alaskans

Individual Responsibility - Financial Relief

Critics of the new type of universal health care efforts being implemented around the country have questioned the necessity of requiring that all residents have some form of health coverage. Yet, judging from these efforts, a consensus has been reached: Until something is enacted on a federal level, mandating coverage is the only responsible option for promoting universal health coverage in a state today. Beyond the social benefit of making certain that all residents have better access to health care, there are also economic reasons why reform efforts must include everyone.

Financial Relief For Current Policyholders

In a sense, universal health care is already provided in America because emergency rooms cannot turn down a person in need of medical attention. While this system may provide emergency care for all Alaskans, it doesn't equal universal access to health care in times of need, nor does it protect the financial concerns of the insured or uninsured alike. In addition to producing less than ideal health outcomes for those who lack coverage, it also places an undue financial burden on people who do buy coverage. And this financial burden is large.

The amount of uncompensated care in Alaska is staggering. Families USA estimate that $125 million of uncompensated care is provided each year in Alaska, and that only 21% of that bill is reimbursed by federal, state and local governments. That leaves medical providers with $100 million of unpaid bills every year. This doesn't mean that hospitals 'lose' money every year: To make up for outstanding bills, hospitals charge more to people who can actually pay for services. Since government health care reimbursement rates are often at or below the actual price of providing care in Alaska, nearly the entire burden of uncompensated care is recouped through inflated insurance premiums.

How much does the cost of an average plan go up? Families USA estimates that 13.6% of an insurance premium in Alaska covers uncompensated care costs, meaning that, for a family of 4 with a comprehensive policy, nearly $1,500 a year go towards covering uncompensated care. SB 61 ensures that everyone can afford quality basic coverage, potentially reducing the amount of uncompensated care given out by hospitals. This element of the bill will give much needed relief to everyone who currently invests in health coverage.

An estimated 125 million dollars of medical bills aren't paid each year in Alaska.

- Families USA

References/For More Information:
Families USA - "Paying a Premium: The Added Cost of Care for the Uninsured" - June 2005

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SB 61 *Health Insurance For All Alaskans*

Individual Responsibility - Improving The 'Pool'

Improving the 'Pool' to Increase Affordability

An insurance 'pool' is a bundle of risks. It works this way: for the sake of determining premiums, a 'pool' is a group of individuals who are considered together when determining expected medical costs. Once anticipated costs are determined, each member of that pool can be billed for a fair portion of what expenses the 'pool' is likely to incur on their behalf.

Adverse selection occurs when individuals utilize their private knowledge of their own health when deciding whether to buy health insurance. Since an individual has better knowledge of their lifestyle, habits and health then an insurance company, adverse selection has the potential to greatly affect who buys insurance. Simply put, people who expect to be sick want health insurance more than healthy people.

Certain pools are affected by adverse selection more than others. As an example, in the individual market, the decision to buy or forego insurance isn't left to chance – someone must make the conscious decision to buy a plan. Employer provided coverage, on the other hand, doesn't always require that the employee opt in: Often coverage is highly subsidized or provided free of cost.

The best insurance pool includes both healthy and sick individuals. If pools are structured to distinguish between people by health, the cost of insurance for those with severe illnesses will be extraordinarily high, and out of reach for most Alaskans. Similarly, if a pool only includes healthy individuals, the costs of a plan may be lower for those who are included, but the amount of uncompensated care would be high, since plans for those with severe health problems would be cost prohibitive. Today the amount of uncompensated care is large, and as discussed earlier, that cost is transferred to Alaskans that do have coverage.

Adverse selection has undoubtedly raised the costs of plans in Alaska's health insurance marketplace through self selection within the individual market. And while the Alaska Comprehensive Health Insurance Association (ACHIA) was created by the state to provide health coverage to individuals with pre-existing health conditions, the offered plans are often cost prohibitive for normal Alaskans. This legislation will reduce adverse selection by ensuring that all Alaskans participate.

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SB 61 *Health Insurance For All Alaskans*

Individual Responsibility - Avoiding Price Spirals

Damaging price spirals are often caused by adverse selection in voluntary participation health reform efforts. When an individual weighs the decision to buy coverage they consider many factors, including the cost of a plan, what they can afford, and the probability of requiring care. This often causes people of good health to forego insurance, since they figure the odds are in their favor. And when healthier individuals don't acquire coverage, the pool of people who do purchase insurance is more likely to require health attention. As a result, premiums increase.

The price of coverage in voluntary state reform efforts that include some individual contributions have often spiraled upward after introduction, with plan costs increasing when the healthiest individuals decide to hedge their bets on good health. Once the healthiest people in the pool leave, the expected cost per member increases. If these price increases are charged to individuals within the pool, additional people may reconsider their participation in a voluntary plan. Maine's Dirigo program ran into this problem, when fewer people than expected signed up, and once the program began, the spiraling effect occurred as the participation price increased. If everyone is required to get 'in the pool' this price spiral will be eliminated.

"The problem is that the individuals in the insurance pools don't cooperate. Guaranteed issue and community rating regulations cause premiums to be higher than would otherwise be the case. As a result, the healthiest individuals drop their coverage, leaving the members with the highest health care costs in the pool. As the cost of care rises, premiums also go up, causing more members to drop out and creating a rising spiral of cost and premium increases."

- Portland Press/Maine Sunday Telegram, October 28, 2007

References/For More Information:

David U. Himmelstein et al - "Marketwatch: Illness And Injury As Contributors To Bankruptcy"-Health Affairs 2005

Martin Jones - "Rules make health insurance in Maine costly" - Portland Press/Maine Sunday Telegram, published October 28th 2007

Not Socialized Medicine

This legislation does not create a socialized system of medicine in Alaska. Socialized medicine is characterized by government run health care: Under this legislation, the only role of the government is to guarantee that all residents have true access to health coverage.

For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us

www.healthyalaskans.com

SB 61

Health Insurance For All Alaskans

Proven Concepts - Learning From Programs That Work

While many critics of consumer centered health reform claim that the ideas haven't been tested, these critics fail to recognize several extremely successful consumer driven programs in place today.

The first is the Federal Employees Health Benefit program. This program provides federal employees, retirees and their survivors with the "widest selection of health plans in the country" through a mechanism much like the clearinghouse under SB 61. The program provides information about numerous plan providers and types, giving consumers a meaningful role in choosing their health coverage. Plans offered through the FEHB program feature no waiting periods for enrollees, and all participants are guaranteed that a plan will accept them. The health care clearinghouse in SB 61 will provide a similar system which can be accessed by all Alaskans.

The bi-partisan reform effort being implemented in Massachusetts is still young, but the results thus far are encouraging. One year after the legislation was enacted over 200,000 previously uninsured residents gained health coverage in Massachusetts. This effort ensures that similar successes can be seen in Alaska, largely through the Massachusetts inspired sliding scale voucher system under SB 61.

Since the passage of Governor Romney's health reform effort, consumer choice has drastically increased while uncompensated care has decreased in the state of Massachusetts. Over 44 different types of plans are available in the Massachusetts Connector, which, when compared to the standard employer offering of only one plan type, represents a large improvement of choice for residents of the state. Furthermore, uncompensated care has decreased by almost 13% in the state during the first year, even though the plan was just being implemented during that time. When everyone has coverage further declines should be seen.

By no means is this to say that a silver bullet exists, but, so far, the results of both programs are encouraging. This legislation builds an Alaskan version of health reform practices like these that are working in different parts of the country.

Learn about these successful programs online

Federal Employee Health Benefits Program:
http://www.opm.gov/insure/health/

Massachusetts Commonwealth Connector:
http://www.mahealthconnector.org/

References/For More Information:
Federal Employee Health Benefits Program:
http://www.opm.gov/insure/health/about/fehb.asp

Lisa Eckelbecker - "The Insurance Countdown" - Worchester Telegram and Gazette, published November 18th, 2007

For more information, contact Sen. French's office:
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SB 61

Health Insurance For All Alaskans

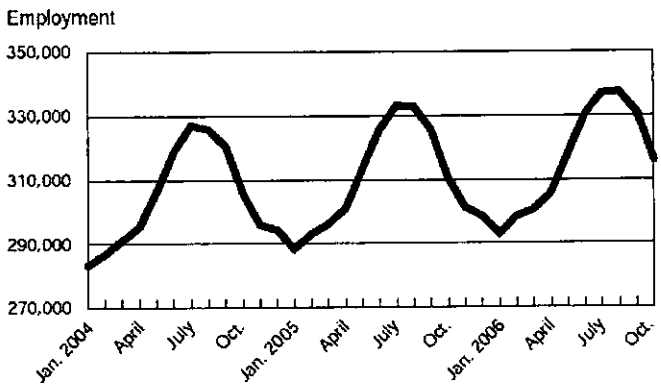
Continuity of Coverage

Seasonal Employment Requires a Creative Solution

Alaska's natural landscape provides unique employment opportunities in the state. Both the tourism and fishing industries peak during summer months, with relatively little activity during the middle of winter. Judging from historic employment data, there are roughly 45,000 fewer jobs during the peak of winter compared to the busiest months in the summer. While the economic benefits that come with seasonal employment are great for Alaskans – tourism alone brought $1.8 billion into the state last year - many workers in seasonal industries work for multiple employers over the course of a year. Unfortunately, this doesn't line up with the traditional employer based health insurance model.

The United Fishermen of Alaska have expressed particular concern over this issue, noting that a lack of health insurance options creates a significant barrier of entry for future generations of commercial fishermen. In particular, they note difficulty with the traditional group market structure, because fishing organizations don't fit the traditional mold of a group client. The marketplace solution provided through the health care Clearinghouse should help fishermen, and all other seasonal employees, get many of the group benefits of coverage while maintaining the portability that seasonal workers require. Edmund Haislmaier, a senior research fellow at the Heritage Foundation, noted that few people are uninsured for years at a time: In fact, he has found that up to 40% of the national uninsured problem could be solved if coverage was tied to an individual, and not an employer, because the shorter lapses of coverage could be prevented. Alaska's seasonal industries give the state even more reason to tie coverage to the individual, to make certain that benefits are available when they are needed.

Chart from "Making sense of Alaska's unruly numbers":



Source: Alaska Department of Labor & Workforce Development, Research and Analysis Section: Employment and Earnings Report

References/For More Information:

Dan Robinson - "Making sense of Alaska's unruly numbers" - Alaska Economic Trends, December 2006

United Fishermen of Alaska - "Alaska Fishermen's Health Care - Challenges and Opportunities" - Aug. 2001

For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us

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SB 61

Health Insurance For All Alaskans

Unique Solutions for Business, Young Alaskans

Structured With Small Business In Mind

Most Alaskans who lack health coverage also work for a living, leaving behind the notion that only the unemployed require assistance when it comes to making health coverage affordable. Even the most successful small Alaskan businesses can have difficulty providing coverage, because of the high costs of health plans. This legislation aims to strengthen businesses around the state by putting coverage in reach for all employees.

Clearly a healthy workforce is more productive, because absenteeism and productivity is tied to the health of an individual. But in addition to health benefits that would arise if everyone had access to basic medical care, Alaska's businesses have much to gain through this legislation economically. Retaining qualified employees is difficult for businesses that cannot afford coverage. This forces high retraining expenses on employers, since they must fill vacancies more frequently than businesses that provide coverage. In addition, recruitment is more difficult for companies that don't offer coverage.

Not all businesses can afford the full price of health coverage. In addition, not all employees need insurance through their employer - many have coverage through spouses or public programs. Roughly 20% of Alaskans have limited health coverage through the Indian Health Service. Because of this, an employer will not be taxed under this legislation for not providing coverage to someone that already has health access, as defined in the legislation.

The employer levy is simple. It is calculated by adding up the gross payroll of all employees who participate in the framework of this bill. For businesses that pay less than $500,000 gross annually to employees who lack health coverage, no levy will be collected. For businesses that pay between $500,000 to $1,000,000 a year, the levy will be 1% of payroll. For over $1,000,000 annually, the payroll tax will be 2%. Companies that currently invest even a small amount of money into employee health coverage will be exempt from this levy, whether that investment consist of a modest contribution towards the price of a premium, or through the establishment of a Section 125 account, which facilitates pre-federal tax purchases of health coverage.

Young Alaskans Have Unique Needs

Young Alaskans have special needs when it comes to their health coverage. Statistically, they require less health services than their older counterparts. They also show less of a willingness to pay for expensive, comprehensive coverage, and even a moderate deductible can be difficult to pay, particularly for college aged students. This legislation acknowledges that young Alaskans have unique needs, and it provides for a special category of plans that are designed specifically to fulfill their health requirements.

For more information, contact Sen. French's office:
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www.healthyalaskans.com

SB 61

Health Insurance For All Alaskans

Massachusetts and SB 61 Compared

Issue Area	Alaska - SB 61	Massachusetts - Enacted
Sliding Scale Subsidies *Definitions:* FPL = Federal Poverty Line	**Yes:** Households with incomes below 300% of the FPL will receive vouchers to make the price of coverage affordable. Residents only eligible for ACHIA coverage will receive vouchers up to 450% FPL. Health care vouchers will put the consumer in control when choosing a plan and a provider.	**Yes:** Households with income below 300% receive subsidized health coverage through the connector. For individuals who utilize vouchers, one plan type is available to households below 200% FPL and two plan types are available to those earn between 200-300% FPL.
Establishing A New Insurance Marketplace	The health care Clearinghouse will disseminate information, encourage competition, and help residents learn about different health coverage options.	The Connector provides information, encourages competition, and helps residents learn about different coverage options. It is a web-based marketplace.
Requirements for Consumers	All Alaskans would be required to have a minimum level of coverage, as defined by statute. If a product isn't affordable a hearing process allows for some exceptions.	All residents must have a minimum level of coverage, as defined by the Connector board. However, some residents have been exempted from the mandate because an affordable product isn't available to them.
Effect on Existing Public Programs	No changes to existing publicly funded programs.	Free care funds will still be available to hospitals, but the program will shift dollars from this account to the reform effort as more people get coverage and don't require free care. Medicaid reimbursement rates were also increased under the legislation.
Financing	Employer payroll tax, varying from 0-2% of payroll depending on payroll size and the number of uncovered employees. Federal dollars will be pursued through 1115 waivers. State funds will also be used.	Employer payroll tax of up to $295 per employee for employers with more than 10 full time workers. A free rider surcharge can also be assessed if employers don't help employees get coverage and they utilize free care. Federal dollars from 1115 waivers have been funneled to the project.
Insurance Market Reforms	**Yes:** Guarantee Issue for individual health plans, on the premise that the individual responsibility clause will prevent adverse selection. Preexisting condition limitations can extend no longer than 12 months for plans sold under the clearinghouse, and credit for prior coverage is required.	**Yes:** By merging the non-group and small group markets, insurance is portable and not tied to employment. Massachusetts already had guarantee issue laws and provisions that regulate preexisting condition limitations and credit for prior coverage within the individual market.

For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

SB 61

Health Insurance For All Alaskans

Other State Reform Efforts

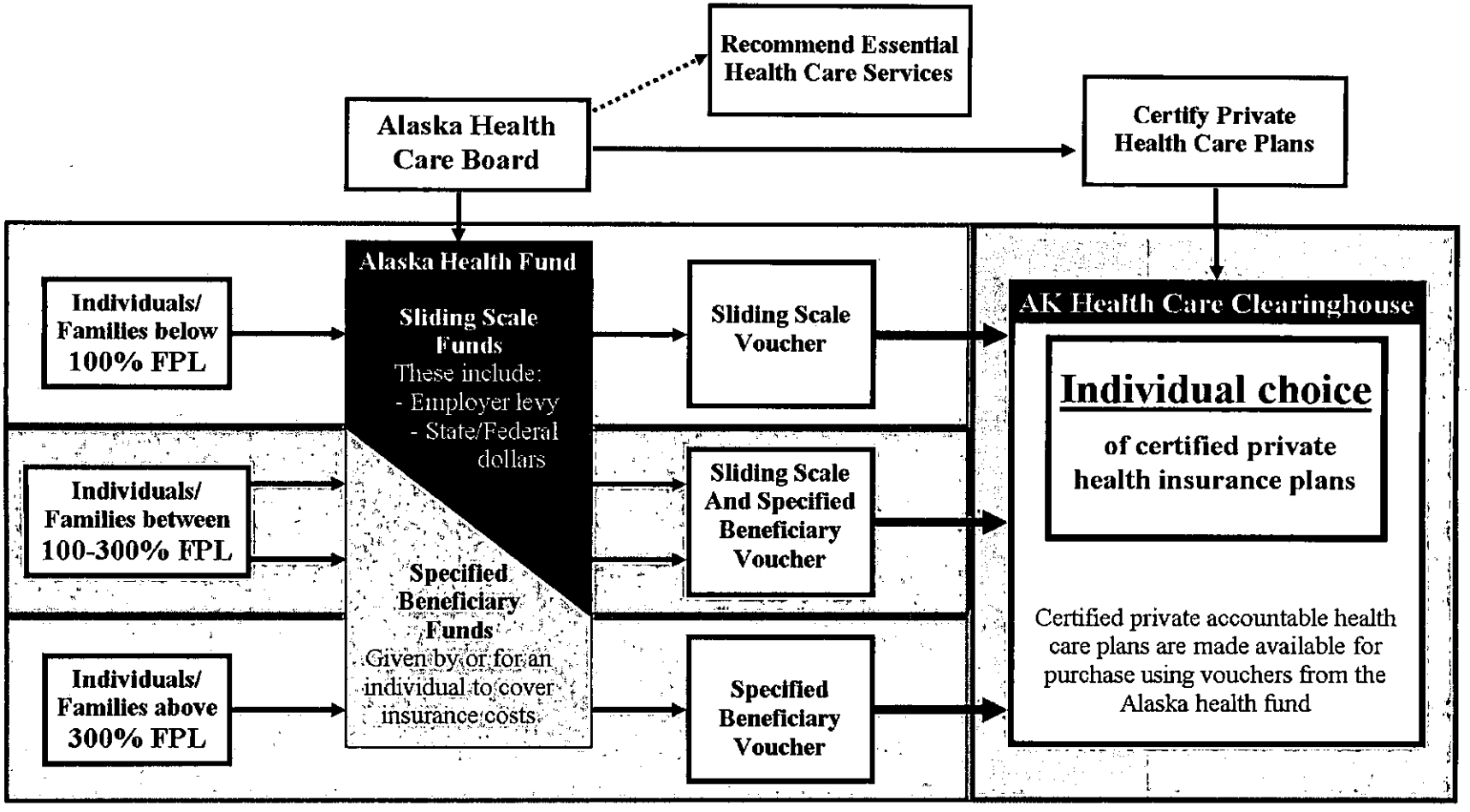
Issue Area	**Alaska** - Senate Bill 61	**California** - Governor Schwarzenegger's Plan 2008	**Colorado**–Legislature's Blue Ribbon Commission '08
Sliding Scale Subsidies *Definitions:* FPL = Federal Poverty Line	**Yes:** Households with incomes below 300% of the FPL will receive vouchers to make the price of coverage affordable. Residents only eligible for ACHIA coverage will receive vouchers up to 450% FPL. Health care vouchers will put the consumer in control when choosing a plan and a provider.	**Yes:** Households with incomes below 400% of the FPL will receive a tax subsidy to help cover insurance costs, residents below 250% FPL won't pay more than 5% of income for coverage, and individuals below 150% FPL won't pay anything- including co-pays and deductibles - for health care	**Yes:** Full subsidy of most basic plan for households with incomes below 250% FPL and partial subsidy for households below 300%. Colorado is also proposing a asset test and an additional subsidy to households below 400% of the FPL if a premium will be more than 9% of household income.
Establishing A New Insurance Marketplace	The health care Clearinghouse will disseminate information, encourage competition, and help residents learn about different health coverage options.	A purchasing pool will be established for residents who receive sliding scale assistance to cover health insurance costs.	The Coverage Clearinghouse will disseminate information, encourage competition, and help residents learn about different health coverage options.
Requirements for Consumers	All Alaskans would be required to have a minimum level of coverage, as defined by statute. If a product isn't affordable a hearing can allow an exception.	All Californians must have a minimum level of coverage, as defined by the Secretary of Health and Human Services, through the regulatory process.	All legal residents of Colorado must have basic plan coverage, with some exceptions if a product isn't affordable. Basic coverage includes plans with benefit caps.
Effect on Existing Public Programs	No changes to existing publicly funded programs.	Expansion of S-CHIP to 300% regardless of immigration status, and Medicaid expansions to certain groups up to 250% FPL.	Expansion of S-CHIP to 250% and Medicaid. Allows for a Medicaid buy in program for households at 200% FPL and up.
Financing	Employer payroll tax, varying from 0-2% of payroll depending on payroll size and the number of uncovered employees. Federal dollars will be pursued through 1115 waivers. State funds will also be used.	Employer payroll tax, varying from 1-6.5% of payroll depending on payroll size. Hospitals will pay 4% of revenue towards the reform effort. Federal dollars will be pursued through 1115 waivers.	Increases in alcohol and tobacco taxes. In addition, taxes on snacks and soda will be established. Increase the state income tax. Federal dollars will be pursued through 1115 waivers.
Insurance Market Reforms	**Yes:** Guarantee Issue for individual health plans, on the premise that the individual responsibility clause will prevent adverse selection. Preexisting condition limitations can extend no longer than 12 months for plans sold under the clearinghouse, and credit for prior coverage is required.	**Yes:** Guarantee issue and guarantee renewal to all Californians in the individual market. Rating bands will ensure that only age and geography determine premiums. Health plans will have to spend 85% of premiums on patient care.	**Yes:** Guarantee Issue for individual health plans, on the premise that the individual responsibility clause will prevent adverse selection. High risk pool will exist for those who currently are uninsured. Premiums will equal the normal price paid in the individual market.

For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

Alaska Health Care: The Framework For Change

SB 61

Health Insurance For All Alaskans



For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

Testimony 3/9/2009 SB 61

The Alaska Nurses Association is pleased to support Senator French's Senate Bill 61, Mandatory Universal Health Insurance. The legislative committee of the Association also represents the affiliate groups of the Alaska Chapter of Nurse Midwives, Alaska Home Health and Hospice Association, Alaska Nurse Anesthetists Association, Alaska Nurse Practitioner Association, Alaska School Nurses Association and the Alaska Chapter of the Forensic Nurses Association.

Our members are on record in support of innovative legislation that would make health insurance affordable for businesses and individuals. This bill meets that goal. According to a national survey by Consumer Reports [3/2008], 81% of respondents were concerned about being able to afford health care in retirement, 68% worry about being bankrupted by medical bills following a serious illness or accident and 65% feared losing their job-related coverage. The current economic picture with rising unemployment has exposed the weakness of relying on job-related health insurance. Senator French's bill addresses that problem.

The Alaska Nurses Association applauds Senator French's commitment to ensuring that health care become available for all Alaskans. We sincerely hope that SB61 will pass in the 26th legislative session.

Respectfully,

Lynn Hartz MSN
Family Nurse Practitioner
For the legislative committee of the Alaska Nurses Association
3701 E Tudor, ste. 208
Anchorage, AK 99507

Senator Hollis French

Anchorage LIO
269-0234
269-0238 fax

MEMORANDUM

Date: March 10, 2009

To: Senator Bettye Davis, Chair
Senate Health and Social Services committee

From: Senator Hollis French
Senate Bill 61 Prime Sponsor

RE: Background information for SB 61 Senate HSS subcommittee

On March 2 the Senate Health and Social Services committee formed a subcommittee to consider several issues related to Senate Bill 61 that were brought up during the legislation's first hearing. In an effort to assist the subcommittee discussion on these questions, this memo provides background information from the bill sponsor for use during the March 10 subcommittee meeting.

The AARP letter of support for Senate Bill 61 noted a particular concern about health coverage for Alaskans between the ages of 50-64. The subcommittee has expressed an interest in determining how Senate Bill 61 will impact this group of Alaskans.

AARP's Public Policy Institute[1] goes into detail about the difficulty Americans between the ages of 50-64 have when they attempt to access, and afford, health care. While Medicare kicks in at 65, many people retire before they become eligible for those benefits, and often standard individual market offerings are withheld, forcing older Alaskans into ACHIA plans which can cost up to 50% more than the price of standard risk premium rates[2].

Senate Bill 61 will ensure that all Alaskans have access to affordable, quality health coverage by putting the price of a plan within reach. Like most Americans who lack health coverage, a majority of individuals who lack benefits between the ages of 50-64 are still members of the workforce[3]. The bill will assist these

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[1] AARP Public Policy Institute, "Health Coverage among 50- to 64-Year-Olds," Data Digest #155, May 2007
[2] AS 21.55.150 (c)
[3] AARP Public Policy Institute, "Health Coverage among 50- to 64-Year-Olds," Data Digest #155, May 2007

working, uninsured individuals in the same way that it will work for all other Alaskans.

In addition, there are some elements of the legislation that should be of particular interest to Alaskans between the ages of 50-64:

Guaranteed Issue, Credible Coverage and Preexisting Condition Exclusions:

Medical underwriting in Alaska's individual market can result in denial of standard coverage by private insurers, particularly when an applicant has less than perfect health. Since the need for medical attention often increases with age, this trend is particularly worrisome for older Alaskans, who are more likely to have identified medical needs than 20 year olds. And while the state's high risk pool cannot reject an individual, these plans are often too expensive for applicants. Senate Bill 61 requires that health insurance plans for sale through the health care clearinghouse offer coverage to any applicant, preventing a scenario where the only course of action is purchasing a plan through ACHIA.

The legislation also requires that plans sold through the clearinghouse give credit for prior coverage, and that preexisting condition exclusions be reduced by any length of "continuous credible coverage" that an individual had before they applied for coverage. For Alaskans that are leaving the workforce who aren't provided benefits through a retirement package, these protections will ensure a more seamless transition into retirement.

The final element that will assist individuals acquiring coverage for the first time through Senate Bill 61 is the provision that prohibits preexisting condition limitations from extending for over one year. By capping limitations at one year, Alaskans will still be discouraged from buying coverage only when it is medically necessary, but it will also ensure that health coverage sold through the clearinghouse is a quality product for those who haven't been able to buy coverage in the past, due to cost or other circumstances.

The three consumer protections listed above – guarantee issue, credit for continuous coverage, and preexisting condition limitation caps - are currently required elements of small group, employer based plans available in Alaska. Extending these protections to individual plans sold in the clearinghouse will level the playing field for all Alaskans, both young and old.

What is the structure of the clearinghouse, and how will it take into account Alaska's unique geographic and technological situation when attempting to reach all Alaskans?

The health care clearinghouse is the entity that is charged with administering the program, under the direction of the health care board. In particular, the bill specifies that the clearinghouse will disseminate information about health care insurance products, and provide assistance in the enrollment process for businesses or individuals[4].

[4] Senate Bill 61 – Sec. 21.54.230

During the Senate Health and Social Services committee hearing on March 2, 2009, the clearinghouse was characterized as an electronic web-based 'place' where health plans can be compared and purchased. This concept, taken from Massachusetts and the Federal Employee Health Benefits program, is an innovative model that has proven successful in both instances. That being said, nothing in the bill confines how the board can structure the clearinghouse, despite the recent successes of an electronic, web based solutions.

In Massachusetts, a variety of means have been used to implement health reform. The Commonwealth Connector website touts advertizing efforts, along with partnerships, mailings, employer education and grassroots initiatives as successful elements to educating the public[5]. As one example, 'Connect to Health' events were held throughout the state to educate and enroll residents in health insurance plans through the connector. A press release noted that these forums were made possible through the involvement of public officials, community health centers, hospitals, business groups, public school districts and health care advocates[6].

Customer service centers were also created to help implement the legislation, and toll free call centers are open daily to answer questions and provide enrollment assistance.

As currently drafted, the bill leaves all options open for the health care board to determine how to communicate with and enroll eligible Alaskans. Given the broad composition of the board - which includes consumer advocates, insurance representatives, business people, labor, medical professionals and hospitals - the perspectives necessary to craft an Alaska specific approach to enrolling people in health coverage should be achievable, particularly when we use other states as models.

The National Federation of Independent Business commented on Senate Bill 61 in a letter to Senator French dated January 25, 2009. In particular, the letter stated two specific concerns:

The first concern: "Unfortunately, SB 61 mandates that small employers bear the cost of fixing the problem through mandated tax on a percentage of their gross payroll."

Senate Bill 61 has a unique section regarding employer contributions, as described during the March 2 bill hearing. The rules are simple. There is no levy for businesses whose payroll is less than $500,000 a year. For businesses with a payroll between $500,000 and $1 million annually, the levy is 1%. For businesses with a payroll greater than $1 million annually, the levy is 2% of payroll. The 'bar' of what it means to provide health coverage is set relatively low – either an employer must offer to pay 33% of a premium cost or they must successfully enroll 25% of employees in their program – regardless of their level of contribution – to avoid the employer levy. In addition, if an employer establishes a Section 125 account that allows employees to purchase health

[5] http://www.mahealthconnector.org - Overview -> Public Education and Outreach
[6] http://www.mahealthconnector.org - January 11, 2008 press release

insurance with pre-federal tax dollars, they too avoid the levy, since the establishment of such an account produces great tax savings for employees. The cost of section 125 accounts are relatively cheap – quotes last year were around several hundred dollars a year total for a small employer, covering all employees. This means that an employer can fulfill all provisions of the employer levy simply by giving employees access to a Section 125 account, at a total cost of several hundred dollars – for all employees – per year.

On the broad scale of health reform options, Senate Bill 61 includes very few obligations on non-providing employers. Massachusetts requires a payout of $295 per non-covered employee per year, and includes a provision which also encourages the creation of Section 125 accounts. California proposals on the table last year included payroll taxes that ranged from 1% to 6.5%. In San Francisco, a plan that requires businesses with over 100 employees in the city to pay at least $1.76 per hour towards health benefits was affirmed by the 9th circuit court of appeals just last year, it not being an excluded policy option for the city due to ERISA preemption.

The second concern: "It also creates mandated coverage design that will increase the cost of basic coverage that might be offered by small employers."

The legislation broadly defines 'essential health care services' as including preventative and primary care, emergency services, inpatient services and hospital treatment, ambulatory patient services, prescription drug coverage and mental health services[7]. It does not specify benefit levels that must be provided in each category, nor does it address permissible co-pays, co-insurance, deductibles, or other fiscal elements of a plan. For a private offering to fulfill the individual responsibility clause proposed in Sec 21.54.240, a private plan must 'meet or exceed' the definition of essential health care services provided in that section[8].

Currently most employer based group health plans are subject to regulation under ERISA, and health insurers that are licensed in the state are regulated by state insurance law, as well[9]. The concern about mandated benefits may be rooted in the specific medical procedures that current Alaska law requires as elements of state regulated health insurance plans. Examples of such mandates include cancer screening procedures, well baby examinations and limited alcoholism and drug abuse treatment. The more benefits a plan includes, the higher cost of the plan.

Language should be changed in Senate Bill 61 to say that a health care insurance plan sold in the group market fulfills the individual responsibility clause of the legislation. This change would help alleviate the concerns expressed by the National Federation of Independent Business, because the comprehensive group plans that currently provide benefits to employees around the state would fulfill the legislation, without requiring a modification of the benefits that they offer.

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[7] Senate Bill 61 – Sec. 21.54.250
[8] Senate Bill 61 – Sec. 21.54.250 (a)(1) and (a)(4)
[9] http://www.dol.gov/ebsa/publications/selfcompliancetool.html

Lynda Zaugg

From: Andy Moderow
Sent: Monday, March 02, 2009 5:15 PM
To: Lynda Zaugg
Cc: Amory Lelake; Sen. Hollis French
Subject: SB 61 Subcommittee

Lynda,

Does this look accurate re: our conversation earlier? I'm sending this along to Amory in the Ellis office as well for her review.

240 - A8

1. As noted in the AARP of support, Senator Davis is concerned about individuals in the 50-64 age group and how the bill would address their needs. She would also like to see those questions answered or at least discussed.

2. Christian Science proposal – she is curious if there is a way to deal with their concerns (without necessarily doing exactly what they proposed, depending on how the discussion goes.)

3. Discuss the NFIB letter, and see if there is a way to make the bill more palatable to small businesses who share their concerns.

4. Provide more guidance about the clearinghouse, in regards to the question from Senator Thomas who wanted to ensure that individuals without internet had the resources they needed to utilize clearinghouse services.

I spoke with Senator French about these questions/concerns, and he has mentioned his willingness for our office to produce, in writing, a 'report' addressing these question. After this is complete, maybe we could have one meeting of the subcommittee, where it is presented, questions can be asked, and further action is decided on? We could be ready for such a meeting by next week, and it probably wouldn't take too long.

Thoughts?

Andy Moderow
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www.healthyalaskans.com

Christian Science Committee on Publication for Alaska

P. O. Box 240976, Douglas, AK 99824
Phone: (907) 789-1544 Fax: (907) 364-2468
Email: Alaska@compub.org

Memo

TO: Senator Bettye Davis, Chair, Senate HSS Committee
FROM: Bev Smith, Christian Science Committee on Publication for Alaska BLS
DATE: March 9, 2009
RE: SB 61

Thank you for considering religious nonmedical healthcare as a covered benefit under SB 61.

I would like to bring to your attention California SB 840(sponsored by Sen. Kuehl) that passed both chambers of the legislature in August 2008 but was vetoed by the governor. In trying to provide a system of universal health care coverage for California residents the bill included in its list of covered benefits, Section 140501(z): "Benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means provided by a duly authorized and accredited practitioner or nurse of that bona fide church, sect, denomination, or organization." This same language was included in a recent refile of the bill last week (SB810) in the current 2009 California session by Sen. Leno, who has replaced Sen. Kuehl as the principal bill sponsor following Sen. Kuehl's exhaustion of her term limits last session.

Similar language was also provided in another California bill ABx1. In Section 12739.50(c) it says: " In establishing the standards for minimum creditable coverage, including the scope of services, enrollee and dependent deductible, copayment requirements, and coverage of services outside the deductible, the board shall consider all of the following:...(4) The extent to which and under what circumstances benefits offered or provided by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means may be included in or qualify as meeting the requirement to maintain minimum creditable coverage under Section 8899.50 of the Government Code."

The latter bill passed the Assembly but it never came before the Senate.

I offer these examples of California legislation to support including benefits for religious non-medical health care in SB 61. I hope you find them helpful. Please feel free to contact me with any questions you may have.

Thank you.

NFIB
The Voice of Small Business®

Alaska

January 25, 2009

The Honorable Hollis French
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

RE: Senate Bill 61

Dear Senator French,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 61. The National Federation of Independent Business is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues.

We're reminded weekly, if not daily, that 47 million Americans are uninsured. This hits especially close to home for small businesses, since approximately 27 million of those uninsured are the self-employed and small-business owners, their employees and their families. Many of those are in Alaska. Insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term.

National Federation of Independent Business — ALASKA
P.O. Box 34761 • Juneau, AK 99803 • 907-723-6667 • denny.dewitt@nfib.org

Unfortunately, SB 61 mandates that small employers bear the cost of fixing the problem through mandated tax on a percentage of their gross payroll. It also creates mandated coverage design that will increase the cost of basic coverage that might be offered by small employers.

The NFIB has adopted **Small Business Principles for Health Care Reform**. I have enclosed a copy for your review. NFIB knows that no one solution will help all the uninsured Alaskans cover health-care costs, but a multi-faceted approach will allow many more to find health care at costs they can afford. This approach should include health-insurance purchasing pools for small businesses, tax-based incentives to assist with the purchase of health insurance and implementing cost-containment measures.

Sincerely Yours

Dennis L. DeWitt
Alaska State Director

Enclosure

NFIB

The Voice of Small Business®

Small Business Principles for Health Care Reform

Our current system of health insurance and health care is financially unsustainable and threatens the health and financial security of the American people. Small-business owners and their employees are especially vulnerable to the weaknesses of our current system. NFIB supports policy reforms to balance the competing goals of access to quality care, affordability, and predictability and consumer choice. The resulting health care system would be:

Universal: All Americans should have access to quality care and protection against catastrophic costs. A government safety net should enable the neediest to obtain coverage.

> Several reasons underlie our support for universal access to care. First, lack of insurance is especially problematic for small businesses and their employees. Second, having millions of uninsured Americans distracts us from focusing on affordability, quality and comprehensiveness of care and coverage. Third, laws already provide some level of insurance for everyone, but coverage is expensive, inefficient and often inadequate – guaranteed access to emergency rooms is one example. Under this piecemeal coverage, costs fall arbitrarily and inequitably on individuals, providers, governments and businesses.

Private: To the greatest extent possible, Americans should receive their health insurance and health care through the private sector. Care must be taken to minimize the extent to which governmental safety nets crowd out private insurance and care.

> One-size-fits-all insurance and care are not wise options in a nation of 300 million people. Restoring and invigorating America's health care system requires rapid innovation; history shows that such rapid advances rarely come from government and more often come from private enterprises. America's health care system is far from perfect, but the world's single-payer systems have deep problems of their own. We need better health care delivery models, financial-management systems and risk-sharing arrangements. America remains the world's engine of health care innovation, and entrepreneurship is the key to that innovation. Given the current financial path of health care, governments ought to be wary of taking on the entire burden.

Affordable: Health care costs to individuals, providers, governments and businesses must be reasonable, predictable and controllable.

> America's health care costs are high and growing more rapidly than earnings. The burden of costs often falls arbitrarily on individuals, businesses, providers and governments. Wages stagnate as health care costs eat further into take-home pay. Employers and governments struggle to balance budgets as health care costs rise. Health care uncertainties paralyze long-term financial planning. Through excessive malpractice judgments, we penalize good doctors practicing good medicine when their patients happen to experience bad outcomes.

Unbiased: Health care and tax laws should not push Americans into employer-provided or government-provided insurance programs and hobble the market for individually purchased policies. Small employers should be treated the same as large employers, who can already pool across state lines. A health care system built on employer mandates or on play-or-pay taxes is unacceptable.

Today, our tax and insurance laws riddle the health insurance market with inefficiencies. An employer who buys insurance for employees can write off the cost on its taxes. But if employees wish to purchase different policies on their own, they receive no tax benefit. Thus, an oddity of the tax code, not economic efficiency, artificially herds businesses and workers into the employer-based market. Current laws allow large employers to build large interstate risk pools and enjoy a reasonable level of regulatory oversight. Laws deny small employers the same opportunities, forcing them to offer insurance with inadequate risk pools. The result is to arbitrarily load a competitive disadvantage on the small firms that are an engine of America's productivity. Employer mandates compound the problem, penalizing the most vulnerable firms and workers, including cutting-edge startups, lower-income workers striving to rise and companies operating in economically disadvantaged markets. These mandates can force a promising enterprise out of business, sweeping away jobs and future economic growth.

Competitive: Consumers should have many choices among insurers and providers. Policymakers must alleviate the limitations that state boundaries and treatment mandates place on competitiveness.

In the next decades, America's capacity to deliver high-quality health care will face increased financial pressures. Maintaining or improving upon our current quality of care will depend critically upon our ability to develop newer and less expensive modes of treatment and delivery systems. Innovation is unlikely to come from a system where insurers or providers face little risk of competition. Under our current system, restrictions on interstate purchases of policies place powerful limits on choice. Some states are left with close to monopoly control on the issue of insurance as fewer and fewer insurers offer coverage in the small-group market. A cautionary note is in order: Any competitive system must guard against adverse selection—a situation in which some individuals purchase policies only after learning that they are likely to face high medical costs. Adverse selection can render insurance too expensive for healthier individuals. (In property insurance, an example would be someone who buys fire insurance only after he moves dangerous, combustible materials into his house.)

Portable: Americans should be able to move throughout the United States and change jobs without losing their health insurance.

Our current health-insurance system locks people into jobs and localities. An existing health problem may make it impossible for an individual to change jobs. Employer-based health insurance and restrictions on purchasing insurance across state lines limit a worker's ability to seek higher pay, greater opportunity, or a better locality for his or her family. This phenomenon of job lock is not only a tragedy for the locked-in worker. It harms the overall economy by preventing workers from discovering their own entrepreneurial talents or accepting more productive jobs. It creates a significant impediment to those who wish to leave positions as employees and start small businesses of their own. Health care reform must maximize the mobility of American workers by eliminating health insurance as an impediment to changes in job and residence.

Transparent: Information technology should enable all parties to access accurate, user-friendly information on costs, quality and outcomes. Providers must be able to obtain relatively complete medical histories of patients. At the same time, patients' privacy must be guarded zealously. The private sector must play a vital role in developing the new technologies.

In any market, buyers and sellers need accurate and useful information on costs, quality and performance of the product. Health care is no different in this respect. Well-functioning health insurance and health care markets require information that is easy for consumers, providers and insurers to obtain and that is comprehensible to all. Today, information is often difficult to obtain and incomprehensible to consumers and providers alike. This is a function of the system we have, and not an inherent characteristic of health care

data. Governments will have a role in the development of new and better information technologies, but many of the breakthroughs can come only from the private sector.

Efficient: Health care policy should encourage an appropriate level of spending on health care. Laws, regulations and insurance arrangements should direct health care spending to those goods and services that will maximize health. Adequate risk pools throughout the health care system are vital to accomplishing these goals.

Today's health care system encourages misallocation of resources. All parties lack access to vital information for making medical decisions. Providers can give too little guidance on cost-effective treatments because they lack access to accurate, comprehensible, comparable cost data that provide true "apples-to-apples" comparisons of services and treatments. Reimbursement systems encourage excessive spending on health care and poor spending choices within health care. Medical delivery systems are poorly structured. American health care is on an impossible path, with costs rising much more rapidly than the country's real economic output. To avoid catastrophe, incentive structures across the system need to be reconfigured to give consumers, providers and insurers the educational tools and the motives to use their dollars wisely and efficiently.

Evidence-based: The health care system must encourage consumers and providers to accumulate evidence and to use that evidence to improve health. Appropriate treatment choices and better wellness and preventive care should be key outcomes.

Current information and decision systems make it difficult to accumulate, interpret and use evidence affecting treatment decisions. One result is overspending on treatments and underspending on prevention. Decision-makers must understand the impact of their decisions on both costs and outcomes. Such an understanding must be based on solid clinical and economic evidence.

Realistic: Health care reform should proceed as rapidly as possible, but not so quickly that firms and individuals cannot adjust prudently. It is important to assure that no one's quality of care suffers as we move to provide coverage for all Americans.

Reform is a delicate balancing act. Moving too slowly will allow costs to rise too far and too fast. In the process, the health of Americans will suffer, and the financial security of some will be disastrously impacted. But excessive speed is also risky. Thus, we must assure that reform does not allow some Americans to slip through the cracks—to lose coverage or see their costs rise too rapidly. Somewhere in between is a seamless transition from the status quo to a more efficient and equitable system.

FOR IMMEDIATE RELEASE

Contact: Stephanie Cathcart, (202) 314-2056
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Employer Healthcare Mandate Would Wipe Out 1.6 Million Jobs

Business Simulations Show Negative Impact on Local Jobs, Revenue

WASHINGTON, D.C., January 28, 2009 – In a study released this week, the National Federation of Independent Business Research Foundation analyzed the potential impact of a national employer mandate on small businesses to provide healthcare.

The study conducted business simulations to measure the effects of a hypothetical national mandate requiring employers to offer private health insurance to all employees starting in 2009, and to finance a minimum of 50 percent of the cost. The simulation ran six classes of business to determine the impact on employers of different sizes. The results show that an employer mandate would have significant negative impacts on local jobs and on state revenues, particularly considering the rising costs of health insurance.

"In the current environment, an employer mandate could wipe out 1.6 million jobs in just five years and reduce the GDP by around $200 billion," said NFIB Senior Research Fellow William "Denny" Dennis. "This research should alarm everyone about the consequences of costly mandates to small businesses. It is essential that our leaders take into account the drastic impact a mandate like this would have on the livelihood of small businesses and families in local communities."

Simulation Results (Fact Sheet attached)

- Of the more than 1.6 million jobs lost between 2009 and 2013, small businesses would account for more than 1 million, 66 percent, of all jobs lost.
- U.S. real GDP would contract by approximately $200 billion between 2009 and 2013.
- Small businesses would lose roughly $113 billion in real output and account for 56 percent of all real output lost.
- Labor intensive industries (e.g. construction or restaurant) and businesses with 20 – 99 employees would experience the most job loss.

"In our current economic environment, it is so important that we stimulate and support our country's job creators – small businesses. Enacting healthcare reforms that fail to address rising costs, and place unmanageable burdens on business, is not a viable pathway for meaningful reform," said Todd Stottlemyer, president and CEO, NFIB. "It is important that reform fosters growth and doesn't place undue burdens or new financial pressures on these small employers."

Healthcare premiums continue to skyrocket, increasing by nearly 130 percent in just eight years, and are, on average, 18 percent higher than those of large businesses. These unsustainable costs significantly hinder small businesses' ability to invest in and grow their business. Healthcare reform legislation must take steps to curtail costs for small businesses, individuals and the self employed by pursuing creative approaches to pooling, tax code parity, and improved, competitive insurance markets.

-more-

About the Simulation Model

NFIB used a proprietary Business Size Impact Module (BSIM) to simulate the impact of a national employer healthcare mandate on businesses by size of firm. The BSIM consists of a series of ten regional models designed to measure macroeconomic changes due to increased business costs. It receives inputs (new costs and spending) and generates outputs (macro variables) according to firm size. The unique capability of this model is important because often government policies have financial effects on businesses, and regulatory costs per unit are often higher on small firms than their larger counterparts.

The assumed mandate used in the study required that all employers must offer private health insurance to their employees, and that employers must finance at least 50 percent of their employees' health insurance premiums. The remaining share of employee premiums was assumed to be financed by employee contributions and federal subsidies. Implementation of the mandate is assumed to begin in 2009. Employment and output effects of the mandate were forecast for years 2009 to 2013, the first five years of program implementation.

For a copy of the full report, written by Michael Chow and Bruce Phillips, please contact Stephanie Cathcart, stephanie.cathcart@nfib.org, 202-314-2056.

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***Solutions Start Here** is a campaign developed and led by NFIB and its members as the small business platform for healthcare reform. By working to engage and educate policymakers about the unique healthcare issues faced by small business, Solutions Start Here will drive and integrate the concerns and needs of America's small business community into the national health reform debate. Because when healthcare is fixed for small business, it's fixed for America. For more information, visit www.FixedForAmerica.com.*

***NFIB** is the nation's leading small business association, representing small businesses in Washington, D.C. and all 50 state capitals. Founded in 1943 as a nonprofit, nonpartisan organization, NFIB gives small and independent business owners a voice in shaping the public policy issues that affect their business. NFIB's powerful network of grassroots activists send their views directly to state and federal lawmakers through our unique member-only ballot, thus playing a critical role in supporting America's free enterprise system. NFIB's mission is to promote and protect the right of our members to own, operate and grow their businesses. More information is available online at www.NFIB.com/newsroom.*

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March 2, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

Re: SB 61 (French)—Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 61, authored by Senator Hollis French and co-sponsored by Senator Johnny Ellis.

We applaud Senator French's efforts to develop a health care plan that works toward access to adequate coverage for all residents of all ages.

AARP pledges that we will work with Senator French and your colleagues in the Legislature to support efforts to provide high quality, accessible and affordable health care that offers reasonable choices for all Alaskans.

The current health system costs too much, makes too many mistakes, and often returns little value for our money. Access to affordable coverage is increasingly difficult—especially for AARP's 50- to 64-year old members who are among the fastest growing groups of uninsured. Even those with Medicare, if they can find a physician, are struggling to keep up with rapidly rising premiums costs that threaten their health and financial security.

One of the basic legislative principles AARP supports is that expansion of health coverage is desirable. Those who lack either private or public coverage are less likely to receive access to timely medical care and more likely to experience adverse health outcomes.

We understand that SB 61 is a work in progress and is probably the initial effort in what make take several sessions to work out. That's fine with us. The more participatory the debate, the more all Alaskans will understand how important it is to cover all of us. There are major issues that should be addressed in SB 61 and each of these issues should be thoroughly debated in the Legislature, in the media, and over the dinner table by Alaskan families.

Who is covered and how comprehensive is the coverage?

Jennie Chin Hansen, President
William D. Novelli, Chief Executive Officer

Is SB 61 efficient and economically practical?

Will the bill result in fairness and equity?

How much choice and autonomy does the bill permit?

Health care, as you know, is extremely complex. For example, if SB 61 passes, will there be a need for additional physician visits and nursing care? Do we have the health professionals to provide them? What new or expanded medical technology resources will be consumed as a result of coverage expansion? Conversely, what will we save in fewer visits to an emergency room through program expansion?

What will be the effect on quality of care, eg., medical outcomes and patient satisfaction?

What will be the effect on physician patterns of practice, eg., will we have greater adherence to practice guidelines?

The questions can go on for pages...and they should. SB 61 is a bill that deserves serious debate in every Committee of referral. AARP believes that we will eventually come out with a bill that all of us can live with and one that will improve the health status of all Alaskans of all ages. Let's keep that discussion going in the Senate Health and Social Services Committee.

We urge an "AYE" vote on SB 61.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
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586-3637 (voice)
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CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Hollis French

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Monday, March 02, 2009 9:18 AM
To: Andy Moderow; Lynda Zaugg
Cc: Fick, Tyson C (CED); Fitzjarrald, Elinor A (HSS); Sherwood, Jon (HSS)
Subject: SB 61 hearing today

Just wanted to give you a heads up that I will be available to testify for the department on SB 61 this afternoon if needed. DPA director Ellie Fitzjarrald and HCS medical assistance administrator Jon Sherwood will be available to answer questions on the fiscal notes.
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Christian Science Committee on Publication for Alaska

P. O. Box 240976, Douglas, AK 99824
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To: Senator Bettye Davis, Chair
Members of the Senate Health and Social Services Committee

From: Beverly Smith, Christian Science Committee on Publication for Alaska

Date: March 2, 2009

RE: Senate Bill No. 61
An Act establishing an Alaska health care program to ensure insurance coverage for essential health services for residents of the state;...

Thank you for giving me the opportunity to testify regarding SB 61.

In my capacity as Christian Science Committee on Publication for Alaska, one of my roles is to ensure that you have accurate information concerning spiritual healing as practiced in Christian Science, so that this cost effective, reliable and effective form of care is not overlooked or restricted in the State's health care reform efforts. In this regard, it is important to preserve the choice of Alaskans to pursue spiritual means for the prevention and cure of disease, including Christian Science treatment and care, and this legislation can be an important avenue for doing so.

I would like to thank the sponsors for including in the bill under Sec. 21.54.240(a) (8) an opportunity for some Alaskans to "opt-out" of participation in the Alaska health care program if "that...person has deeply held religious beliefs contrary to the Alaska health care program and the requirement to purchase health care insurance for essential health care services." However to meet the health care needs of ALL Alaska residents we feel that health care reform legislation should include coverage for spiritual care similar to state and federal government plans that currently do so.

To accomplish this, we request that the following amendment be incorporated into such legislation to provide for consideration of spiritual care benefits as follows:

Amend Section 2 of the bill, by adding the following

"21.54.251. Definitions. The term "essential health care services" as used in Section 21.54.250 shall be interpreted to include nonmedical health care services provided by a religious nonmedical provider as defined in AS 21.07.250 (15)." *

I have provided an attachment which sets forth the explanation for including religious nonmedical care in legislation such as SB 61.

This document provides some examples of religious nonmedical care addressed in various government and private insurance plans. Note that the final bullet under Recommendation #1 shows Premera, Blue Cross Blue Shield of Alaska, covers treatment by Christian Science practitioners.

I am happy to work with lawmakers to make sure language is included so that insurance coverage is provided for those Alaskans choosing spiritual care to meet their healthcare needs.

This care is both reliable and effective. If people are achieving complete healing through spiritual care without incurring large medical bills, society is benefited.

We applaud you for your efforts in bringing solutions to the health care challenges in Alaska and we appreciate the desire to make humanity safer and healthier. We respectfully request that the inclusion of religious nonmedical health care as a covered benefit be expressed clearly within SB 61.

* Chapter 21.07. REGULATION OF MANAGED CARE INSURANCE PLANS

Sec. 21.07.250. Definitions.

In this chapter, ...

(15)"religious nonmedical provider" means a person who does not provide medical care, but who provides only religious nonmedical treatment or nursing care for an illness or injury;

ACCESS TO SPIRITUAL CARE

Recommendations for
Health Care Reform Legislation

As the Alaska legislature considers health care reform, it is important that any new framework include spiritual care. Prayer-based healing has been a mainstay in American life for years. Despite the progress in medical science, many Americans continue to rely on prayer as their primary means of health care for one simple reason: they trust its effectiveness, its completeness and its reliability. For millions of other Americans, the issue at hand is, in some ways, more fundamental: having the option to choose the method of health care that is most effective for them.

Everyone deserves access to reliable and cost-effective health care. This should be one of the primary goals of health care reform. Because spiritual care is reliable and cost-effective, it should be part of the solution in addressing the health care challenges facing our nation.

Christian Science is a method of spiritual care that is available to everyone. For over a century, individuals from many different faith traditions have found Christian Science to be reliable and effective in addressing the challenges posed by injury, illness, and disease. For this reason, they will often choose religious nonmedical health care in lieu of medical care. The practice of Christian Science includes assistance from Christian Science practitioners (individuals who have been recognized as having demonstrated the ability to help others achieve healing through prayer), as well as from Christian Science nurses (individuals who provide physical assistance for the patient's daily needs while the patient prays for healing).

We have identified two areas where statutory provisions may be needed to achieve public access to spiritual care within the context of health care reform legislation, and make the following two recommendations:

Recommendation # 1: Provide Public Access to Spiritual Care.

Health care reform legislation should provide the public with access to spiritual care. Existing law contains numerous examples of programs that offer benefits for spiritual care, including:

- Four plans under the Federal Employees Health Benefits Program (FEHBP) cover religious nonmedical nursing care and/or Christian Science practitioner services:
  - Government Employees' Health Association (GEHA)
  - Mail Handlers Benefit Plan
  - Special Agents Mutual Benefit Association
  - Association Benefit Plan

- Religious nonmed[redacted] nursing services are covered un[redacted] the Medicare and Medicaid programs (see 42 U.S.C. §§ 1395x(ss) and 1395i-5).

- TRICARE (for military dependents) – Covers care in Christian Science nursing facilities, Christian Science nursing services, and Christian Science practitioner services.

- Under Section 223 of the Internal Revenue Code ("IRC"), funds contained in a Health Savings Account may be used to pay for spiritual care. Section 223 references the definition of "medical expenses" in Section 213(d) of the IRC, which has been interpreted to include Christian Science practitioner services and Christian Science nursing care.

- Alaska and a number of other states (e.g., California, Illinois, Kansas, Missouri, Oklahoma, Oregon, Texas) allow coverage of spiritual treatment through prayer in their governmental employees' health insurance plans. Premera, Blue Cross Blue Shield of Alaska, under the Alaska Care plan for state employees and retired state workers, covers treatment by "Christian Science Practitioners authorized by the Mother Church, First Church of Christ, Scientist, Boston, Massachusetts." (See Select Benefits Booklet, pg. 27-8.)

Recommendation # 2: Application of Nonmedical Requirements for Quality Assurance

Statutory provisions that require insurers to make determinations of "medical necessity" and to provide medical oversight for services rendered serve as important patient protections in the context of medical care. However, patients choosing spiritual care in lieu of medical care do not want medical requirements applied to the services they receive. In addition, spiritual care providers do not diagnose disease or provide any form of medical intervention or treatment. For these reasons, the application of medical requirements to spiritual care providers can limit patient access to care. While accommodation from medical criteria may be necessary, we support the application of nonmedical safeguards to ensure that funds are spent appropriately. Some examples of existing laws that contain this type of accommodation are:

- The federal Medicare law accommodates patients in religious nonmedical health care institutions from being required to have a medical diagnosis and from the activities of peer review organizations, but requires religious nonmedical health care institutions (RNHCIs) to meet detailed requirements designed to protect patient health and safety. 42 U.S.C. §§ 1395x(ss)(3); 42 U.S.C. § 1320c-11; 42 C.F.R. § 403.700, et seq.

- Some states' insurance laws, including Alaska's, specifically accommodate health plans that include religious nonmedical providers by allowing the plans not to apply medical requirements that would limit patient access to religious nonmedical care. (see, e.g., Alaska Stat. Ann. § 21.07.080 and Me. Rev. Stat. tit. 24-A, § 4307(4); Mass. Gen. Laws Ann. 176O, § 11; Wash. Rev. Code Ann. § 48.43.520).

Thank you for considering these important issues. We offer to act as a resource regarding spiritual care, and would appreciate being included in future health care reform discussions and stakeholder meetings.

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Christian Science Committee on Publication for Alaska

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Memo

TO: Senator Bettye Davis, Chair, Senate HSS Committee
FROM: Bev Smith, Christian Science Committee on Publication for Alaska BLS
DATE: March 9, 2009
RE: SB 61

Thank you for considering religious nonmedical healthcare as a covered benefit under SB 61.

I would like to bring to your attention California SB 840(sponsored by Sen. Kuehl) that passed both chambers of the legislature in August 2008 but was vetoed by the governor. In trying to provide a system of universal health care coverage for California residents the bill included in its list of covered benefits, Section 140501(z): "Benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means provided by a duly authorized and accredited practitioner or nurse of that bona fide church, sect, denomination, or organization." This same language was included in a recent refile of the bill last week (SB810) in the current 2009 California session by Sen. Leno, who has replaced Sen. Kuehl as the principal bill sponsor following Sen. Kuehl's exhaustion of her term limits last session.

Similar language was also provided in another California bill ABx1. In Section 12739.50(c) it says: " In establishing the standards for minimum creditable coverage, including the scope of services, enrollee and dependent deductible, copayment requirements, and coverage of services outside the deductible, the board shall consider all of the following:...(4) The extent to which and under what circumstances benefits offered or provided by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means may be included in or qualify as meeting the requirement to maintain minimum creditable coverage under Section 8899.50 of the Government Code."

The latter bill passed the Assembly but it never came before the Senate.

I offer these examples of California legislation to support including benefits for religious non-medical health care in SB 61. I hope you find them helpful. Please feel free to contact me with any questions you may have.

Thank you.

SB 65

Alaska State Legislature

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Senator Bettye Davis

SB 65 "An Act repealing the repeal of preventative and restorative adult dental services reimbursement under Medicaid; providing for an effective date by repealing the effective date of sec. 3, ch. 52, SLA 2006; and providing for an effective date"

Sponsor Statement

The purpose of this bill is repeal the termination date on June 30, 2009 of coverage for adult restorative and preventative dental services under Medicaid. Without this repeal the coverage for adult dental services would revert to minimal treatment for the immediate relief of pain or to reduce the spread of infection. Coverage of adult preventative and restorative dental services under Medicaid began in 2006 with the passage of HB 105.

It has been demonstrated that across the continuum of the average life span, good preventative and restorative oral and dental health is not just a luxury, but a necessity – and far less expensive in the long run. Delaying or under-utilizing dental care causes more harm and expense than preventing or treating problems when they occur. If adult dental services under Medicaid only covered emergencies and abatement of pain and infection, long-term costs of dental care and other preventable medical conditions would increase. Studies have found that lack of preventative and restorative dental services is linked to increased diabetes, cancers, and cardiovascular disease. A correlation also has been found between pre-term low birth-weight babies and delay of necessary dental services.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB065
() Publish Date:

Identifier (file name): SB065-DHSS-APDMS-01-30-09
Dept. Affected: Health & Social Services
Title: Medicaid for Adult Dental Services
RDU: Adult Preventative Dental Medicaid
Component: Adult Preventative Dental Medicaid
Sponsor: Davis
Requester: Senate HSS
Component Number: 2839

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	0.0	6,133.8	7,246.1	7,484.2	7,722.2	7,960.2	8,198.2
Miscellaneous							
TOTAL OPERATING	**0.0**	**6,133.8**	**7,246.1**	**7,484.2**	**7,722.2**	**7,960.2**	**8,198.2**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0	3,531.8	4,309.8	4,429.4	4,570.2	4,711.1	4,853.3
1003 GF Match	0.0	2,602.0	2,936.3	3,054.8	3,152.0	3,249.1	3,344.9
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**6,133.8**	**7,246.1**	**7,484.2**	**7,722.2**	**7,960.2**	**8,198.2**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill eliminates the sunset date of June 30, 2009 on enhanced dental servcies for adult Medicaid recipients. Services for adult Medicaid recipients would otherwise revert to emergent dental services (treatment for immediate relief of pain and acute infection), only. During FY2008 about 7,600 adults received treatment under this program. Forecasted expenditures are based on an analysis of paid claims. The estimated federal portion is based on projected federal financial participation rates for 2010 through 2015. The fiscal note amount for 2010 anticipates continuation of the adult dental program without anticipating program growth. FY 2010 projections will be updated to reflect the most recent trends during the course of the legislative session.
(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 279-7827
Division: Health Care Services
Date/Time 1/29/09 12:00 AM

Approved by: William H. Hogan, Commissioner
Date 1/30/2009
Dept. Health & Social Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB065

ANALYSIS CONTINUATION

In April 2007, Alaska began providing preventive and restorative dental care for adults age 21 and older enrolled in Medicaid. The Legislature established a three year trial period to evaluate the new program, which will end June 30, 2009, if not reauthorized. Services provided under the Adult Preventative Dental Medicaid program must be preauthorized and are subject to a $1,150 annual cap per individual. Services include exams, cleanings, fillings, root canals and dentures. Total program costs are limited to fiscal limits set by the legislature, ensuring that total program spending remains within the budgeted amount.

The Adult Preventative Dental Medicaid program helps protect and promote the health of Alaskans by improving affordable access to dental care services to the nearly 40,000 eligible adult Alaskans enrolled in Medicaid annually. During fiscal year 2008 about 7,600 adults received treatment under this program. In the past, Medicaid only treated emergency pain relief and acute infection for adult dental needs. This coverage expansion was added because infections in the mouth are no different than infections in other parts of the body. Dental infections cause pain and lost time at work, and affect overall health. Waiting until a dental emergency occurs can result in more expensive dental care. Missing teeth can affect employability.

The Alaska Mental Health Trust Authority contributed to state matching funds during the first three years of the program but will not do so after June 30, 2009. Fund source calculations for this fiscal note assume only GF match for the state portion. The federal portion is estimated for 2010 through 2015 based on the proportion of tribal and Title XIX reimbursable costs as forecast for 2010, and the estimates of federal matching percentages for 2010 through 2015. Approximately 18% of the claims are eligible for Indian Health Services which receives 100% federal reimbursement. The remaining 82% of claims are eligible for regular title XIX FMAP, which is projected to average 51.21% for state FY2010, 50.36% for FY2011 and 50% for FY 2012 to FY 2015.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 30, 2009

SUBJECT: SB 65 Sectional Summary (Work Order No. 26-LS0224\R)

TO: Senator Bettye Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Repeals two sections, secs. 3 and 5, from HB 105, 24th Legislature. HB 105 provided broader medicaid coverage for adult dental services for a three year period. Section 3 of HB 105 revived the previous definition of "adult dental services" that limited medicaid reimbursement to minimal treatment that was being temporarily repealed in the bill. Section 5 provided a sunset date of June 30, 2009, for the higher level of dental services added in HB 105.

Section 2. Makes this bill retroactive to June 30, 2009, to avoid a conflict with HB 105's effective dates if this bill passes after that date.

Section 3. Repeals section 7 of HB 105, 24th Legislature. Section 7 of HB 105 provided a delayed effective date of July 1, 2009, to revive the minimal treatment definition of "adult dental services" provided in sec. 3 of HB 105.

Section 4. Provides an immediate effective date for this bill.

JMM:ljw
09-049:ljw

SB 65 - Adult Dental Services under Medicaid

Talking Points

Focus on Prevention

- **Healthy smiles = improvement in employment opportunities.** Decayed or missing teeth can be a significant factor in employability and/or job advancement. Welfare recipients who received rehabilitative dental treatment (including fillings, extractions, and dentures) were "...twice as likely to receive favorable or neutral employment outcomes as they were to receive unfavorable employment outcomes."[1]
- **Improvement in dental care access helps those most in need.** The American Dental Association recommends that adult preventive and restorative dental services be included in all state Medicaid programs. Alaska tribal health programs and community health centers have embraced adult preventative and restorative dental care under Medicaid and are providing such care to those most in need.

Reduction in Medicaid Expenses

- **Prevention = reduction in Medicaid expenses for adult emergency care.** Preventive and restorative dental care avoids many emergencies and costly care later. Prior to the enactment in 2006 of HB 207 which added adult preventative and restorative dental care under Medicaid, adult dental services were limited to expensive emergency care for relief of pain and acute infection only and often included expensive, painful, and avoidable extraction of permanent teeth.
- **Possible reduction in Medicaid expenses for clients with chronic diseases.** Studies show links between oral health and other systemic/chronic disease including diabetes and cardiovascular disease. [2]
- **Possible reduction in Medicaid expenses for children with poor birth outcomes.** Maternal periodontal disease is linked with pre-term, low birth-weight (PTLBW) births. One recent study indicated women with periodontal disease are 7.5 times more likely to have a PTLBW baby. [3]
- **Annual cap controls costs.** The maximum cap of $1,150 per adult encourages the dentist and client to discuss priorities and treatment options, which in some cases can pay for a set of dentures over a two-year period.

---

[1] "Dental Treatment Highly Effective in Helping Welfare Recipients Gain Employment", University of California – San Francisco School of Dentistry, press release, March 10, 2004.
[2] Okero, CA et al., "Tooth Loss and Heart Disease: Findings from the Behavioral Risk Factor Surveillance System" *American Journal of Preventive Medicine*, 2005; 29:5 (supplement 1)
[3] Lieff S, Hared H, McKaig R et al., "Periodontitis and Preterm Low Birth Weight in Pregnant Women" *Journal of Dental Research*, 2000;79(supplemental):608

Improved Overall Health

- **Alaskan children will experience better dental health and less dental infection.** Studies show increased risks of early childhood caries in infants with mothers/caregivers who have active dental decay due to transmission of bacteria.[4]
- **Alaskan adults will experience less dental decay and periodontal disease.** While much of the focus on dental decay is on children, adults remain at high risk for two common health problems: dental decay and periodontal disease. Cancer treatment and medications that reduce saliva flow can further elevate risk for oral diseases.[5]

[4] Li Y et al., "Characterization of Maternal Mutans Streptococci Transmission in an African American Population." *Dental Clinics of North America* 2003; 47(1):87–101.
[5] "Oral Health for Older Americans", Centers for Disease Control (2004), Retrieved February 13, 2006 from: http://www.cdc.gov/OralHealth/factsheets/adult-older.htm

3708

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TTY 1-877-434-7598
www.aarp.org/ak

February 2, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 65 (Davis)–Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage your colleagues on the Senate Health and Social Services Committee to support SB 65, authored by you and co-sponsored by your Committee colleague Senator Johnny Ellis.

SB 65 would eliminate the sunset date on the adult dental benefit in the Medicaid program. This program has proven to be invaluable over the past years not only for dental exams, prevention, and treatment but also for providing dentures, primarily to older Alaskans in long term care facilities. In addition, adults who had low incomes and qualified for Medicaid were able to see a dentist and have the restorative work completed that allowed them to be able to successfully participate in job interviews.

Older Alaskans who have dental problems, missing teeth, or are in need of dentures often have accompanying nutrition problems. These nutrition problems can exacerbate other health issues and create an overall deterioration in health status. AARP believes that dental care is essential to quality health care. Funding for dental care should be considered sensible prevention with the long term possibility of saving Medicaid funds that would not need to be spent on more serious health care problems resulting from poor oral health status.

The current program has a limit of $1,150 per year per Medicaid beneficiary. Originally this figure was used because it was the amount that would pay for either upper or lower dentures. We understand that the average cost for dentures has gone up to $1,700 or $1,800 for just one set. We recommend that some appropriate increase in the annual benefit be included with the passage of SB 65. If possible, some form of "cost of dentures" inflation could be built into the program to keep up with dental inflation.

AARP requests an "AYE" vote on SB 65.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

Don Burrell

RECEIVED
FEB 0 2 2009

From: david logan [drdave@acsalaska.net]
Sent: Saturday, January 31, 2009 12:47 PM
To: Sen. Johnny Ellis; Sen. Bettye Davis; Sen. Fred Dyson; Sen. Joe Paskvan; Sen. Joe Thomas
Subject: SB65 and SB82
Attachments: Alaska Dental Society Medicaid Priority List.doc

Senate HESS Committee Members

This week all Legislators will receive a mailing from the Alaska Dental Society (ADS) on dental issues in Alaska. One of our focus areas this legislative session will be on dental Medicaid and changes we believe are long overdue to the Medicaid system. At this point in the legislative session we offer cautious support for SB65 and its companion bill HB26. We have had preliminary discussions with the House sponsor, Rep. Hawker but were unable to discuss our position with committee members before Monday's hearing. The ADS feels it would be better to repeal the sunset date rather than extending as the Governor's bill, SB82 does.

A letter outlining the ADS position on Medicaid will be in our packet of information; I have copied a portion below:

A limited "Adult Dental" Medicaid program that provides for basic preventative and restorative services to adults is set to sunset this year. The Alaska Dental Society **cautiously supports** the continuation of this program and the expansion of our Alaska Denali Kid Care Program under the State Children's Health Insurance Program (SCHIP).

While the intent of both of these programs is good -- to increase the level of dental care within the state, the fact is that the existing Medicaid delivery system for dental benefits is already severely strained and discourages dentists from participating.

Therefore the ADS recommends that bills repealing the sunset of the adult Medicaid program and extending adult benefits and bills expanding eligibility for the Denali Kid Care include meaningfully changes to the Medicaid program that will remove barriers to participation by providers.

To this end, the ADS has been working with coalitions of health care groups, advocacy groups, along with representatives of the Medicaid Division and private practitioners over the past two years. Progress has been made on some of the issues, while others remain a "work in progress." The ADS has become convinced that without legislative a mandate some or all of the progress that has been made may fall by the wayside.

The ADS is planning an informal meeting in February with legislators, the Medicaid program leaders and other stakeholders. We will be asking about dates shortly and hope that a time can be chosen to allow as many to participate as possible.

A separate sheet is enclosed listing some of the key issues and reasons change is needed is attached

If there are any questions on the issues raised I can be reached at drdave@acsalaska.net or 723-2884.

David Logan, DDS
Legislative Chair, Alaska Dental Society

Alaska Dental Society Medicaid Priority List

- Removal of dentistry from state audits.
  - Superseded by federal audits
  - General consensus that this can be done
- Reimburse provider for treatment if patient is eligible for services at initial treatment date.
  - Currently payment will be denied if patient is eligible when treatment started but ineligible when treatment completed.
  - Key dental procedures such as crowns and dentures require 2-3 weeks to be completed after treatment is begun.
  - Insurance industry standard is 30 days to complete treatment if patient is eligible for benefits at time of initial treatment
- Provide yearly reimbursement adjustments.
  - Yearly increases will provide consistency and fairness to offset cost of delivering care. The 8 year gap between rate adjustments before fees were adjusted last year caused providers to drop out.
  - Set reimbursement at 65th percentile of UCR from a verifiable source.
- Remove eligibility from non federally mandated recipients who chronically abuse system.
  - Patients who schedule appointments and fail to show or cancel
  - Patients who use travel benefits then fail to show for appointments
  - Patients who engage in drug seeking
- Have Medicaid act as secondary insurance for non EPSDT recipients
  - Current system for patients with private insurance and Medicaid is confusing
  - Cost to Medicaid system would be less then acting as sole primary payer and forgoing private insurance
- Remove Hold Harmless provision from provider agreement
  - Opinion from AG's office it can be removed
  - Little legal consequence
  - Barrier to participation by providers

STATE OF ALASKA
DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SARAH PALIN, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

January 31, 2009

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

Subject: Support Letter for SB 65

The Alaska Commission on Aging (ACoA) encourages support of SB 65, a bill to reauthorize preventive and restorative dental services for adult Medicaid recipients, sponsored by you and co-sponsored by Senator Ellis. Medicaid coverage for these services will sunset June 30, 2009 without legislative reauthorization.

Good nutrition is vital for health and wellness across the life span and depends on oral health. Dental pain, missing and decayed teeth affect dietary choices for seniors which impacts overall health and wellness. Without preventive and restorative dental services, which include exams, fillings, extractions, and dentures, older vulnerable Alaskans are at risk of developing dental infections that have been associated with periodontal disease, diabetes, pneumonia, and other chronic diseases including cardiovascular disease. Currently, Medicaid dental services are limited to expensive emergency care for immediate relief of pain and acute infection, with no coverage for preventative and restorative dental care. These limited services often lead to extraction of permanent teeth.

Children can also benefit from the enhanced Medicaid adult dental program. Research has shown that bacteria involved with the dental decay process are typically passed from parent to child or from grandparent to grandchild, in situations where the grandparent is the primary caregiver, and that part of the efforts to reduce dental decay in young children relates to reducing the level of dental infection in the caregiver. Moreover, primary caregivers with dental coverage are more likely to access dental services for their children.

In addition to the health issues involved, decayed or missing teeth can be a factor in employability or job advancement, which is of concern to all persons seeking employment, regardless of age. Preventive and restorative dental services result in fewer tooth extractions for Medicaid clients and offer increase chance of employment.

Preventive and restorative dental services can help prevent the progression of serious dental disease and discomfort which may result in more costly emergency care. These services contain future Medicaid costs for emergency dental work, assist in chronic disease prevention, and promote healthy lifestyles.

Since inception on April 1, 2007 through September 30, 2008, this program has served 9,267 unduplicated persons with 283 providers participating who have performed 42,268 procedures. During FY 2008 alone, 7,470 Alaskans received services through this program.

Because infections in the mouth are no different than infections in other parts of the body, ACoA believes that the enhanced dental program should continue for as long as possible and we appreciate the retroactive feature of your bill that extends coverage if the legislation is passed after the sunset date. We also suggest that the cap for services be reexamined in light of current costs for providing dental care. According to estimates from the National Dental Advisory Service, for example, the estimated median charge in Alaska for a complete set of dentures is in excess of $2,900.

ACoA supports SB 65 and believes that this program is a wise public investment that will help reduce expensive emergency dental needs, associated costs in health care, and enhance health and wellness for elderly Alaskans. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879), should you have any questions regarding our position. Thank you for your consideration.

Sincerely,

Sharon Howerton-Clark
Chair Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

CC: Senator Joe Paskvan, Vice-Chair
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

ASDHA
Alaska State Dental Hygienists' Association

P.O. Box 240247 " Anchorage, AK 99524 " www.asdha.com

February 26, 2009

Senator Bettye Davis
State Capitol, Room 30
Juneau, AK 99801-1182

Re: Support for SB 65 – Medicaid for Adult Dental Services

Dear Senator Davis:

The Alaska State Dental Hygienists' Association (ASDHA) supports Senate Bill 65. As dental hygienists, we are a community of professionals devoted to the prevention of disease and the promotion and improvement of the public's health. There is a strong body of evidence that supports the relationship between oral health and overall health. It is crucial that individuals in our state have access to and receive dental care. Medicaid coverage for adult dental services provides funding for individuals in our state in need of assistance, and potentially experiencing untreated dental disease. SB 65 will continue to provide dental coverage for these Alaskans and ultimately aid in employability and cost effective care for the state. The ASDHA supports SB 65, and is hopeful more legislation in the future will address issues surrounding Medicaid reimbursement and increased funding for oral health care in Alaska.

Sincerely,

Gail Walden

Gail Walden
Alaska State Dental Hygienists' Association

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SB 66

Psychiatric Patient Survey

We are trying to improve the complaint procedure for psychiatric patients in Alaska.

We want to reduce unnecessary trauma to psychiatric patients.

Please help by filling out this survey and sent it to the address on the bottom of the page before December 1st, '08.

Age: Check one Male: Female:

1. Have you ever felt you were abused or traumatized during psychiatric treatment in a psychiatric facility or unit in Alaska—either physically, mentally or emotionally?
   Describe How?

2. Have you ever tried filing a complaint or filing a grievance with a psychiatric facility or unit in Alaska?
   Were you treated fairly and were you satisfied with the results? Explain.
   (Use next page if necessary.)

Send to: Mental Health Advocates—Faith Myers/Dorrance Collins, 3240 Penland Pkwy, Sp. 35, Anchorage, AK. 99508

Psychiatric Patient Survey

Send to: Mental Health Advocates, Faith Myers / Dorrance Collins, 3240 Penland Pkwy, Sp. 35, Anchorage, AK. 99508

Excerpts from: Trauma within the Psychiatric Setting: A Preliminary Empirical Report

Karen J. Cusack, Ph.D.; B. Christopher Frueh, Ph.D.; Thom Hiers, Ph.D; Samantha Suffoletta-Maierle, Ph.D; and Sandy Bennett, BSW, LMSW

Evidence indicates that PTSD (Posttraumatic stress disorder) is associated with nearly the highest rate of medical and mental health service use, making it one of the costliest mental disorders (Greenberg et al., 1999) Given this, it is clear that trauma has a prominent impact on public health and it should be of great interest to those concerned with public mental health administration and policy. However, trauma survivors tend to receive inadequate mental health services (Amaya-Jackson et al.,1999; Freugh et al.,2002)...

In our own recent review of the literature, we noted that there had been virtually no empirical investigation of trauma within the psychiatric setting (Frueh et al., 2000)...

Clinic rosters at five community mental health centers in the state public mental health system were used to recruit subjects...subjects would receive $25 compensation for their time...Subjects were men and women with a history of psychiatric hospitalization who were attending one of five mental health center clinics in a state public mental health system. All subjects were adults between the ages of 19 and 73...

A commonly held belief among clinicians is that asking vulnerable consumers detailed questions about their trauma history may be too upsetting to the consumer. However, none of the subjects in this study were significantly upset over questions related to their trauma history. In fact, many subjects reported at the conclusion of the interview that they found it helpful; some even indicated that they would like to further address these issues in their treatment. The notion that the interview is helpful for subjects is consistent with other studies conducted with public mental health consumers (Goodman et al., 1999)...

Conclusions: One of the goals of the study was to determine rates of traumatic events, as defined by the DSM-IV criteria for PTSD, occurring in the psychiatric setting (sanctuary trauma). Forty-seven percent of subjects reported experiencing a DSM-IV-defined traumatic event while in the hospital...

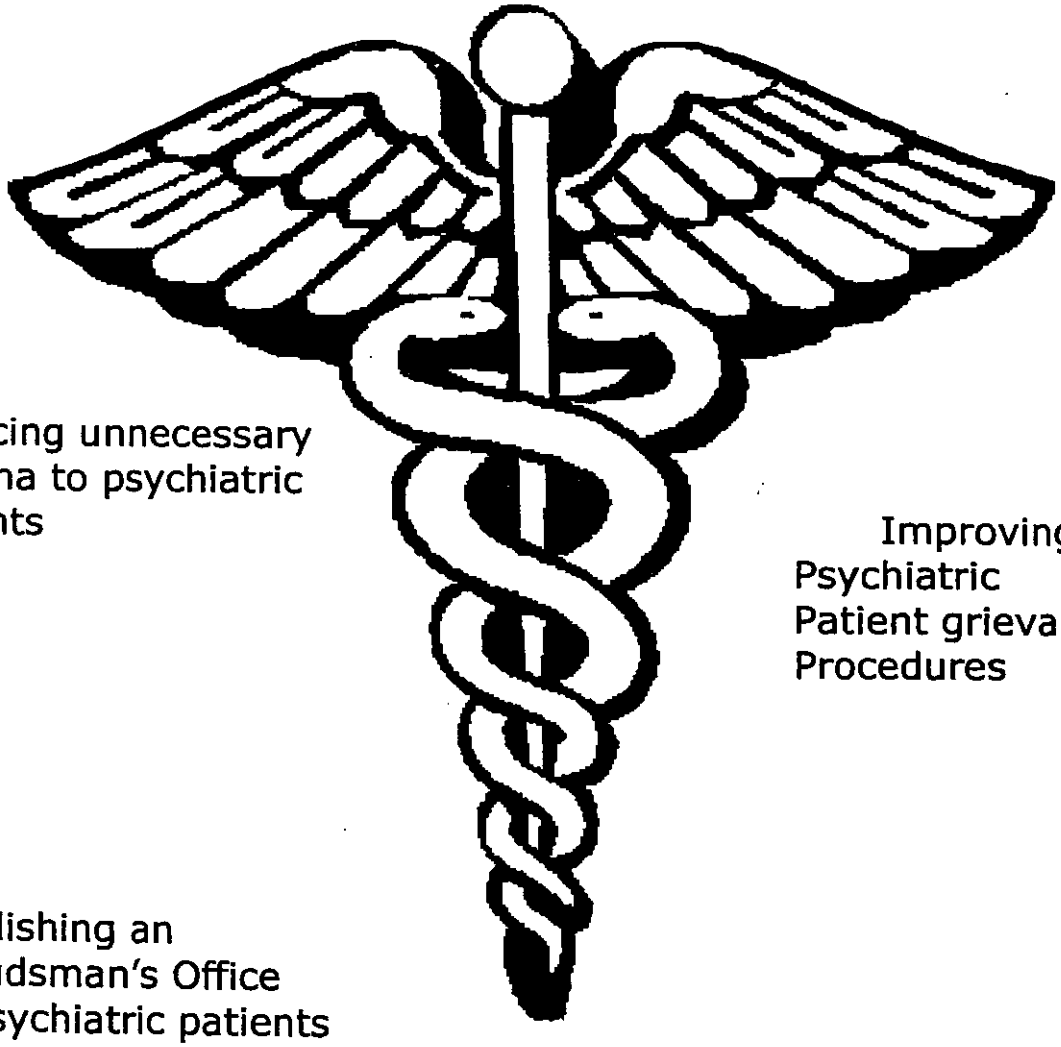
Events that were not traumatic, but were nevertheless thought to be harmful or capable of producing or exacerbating symptoms from previous traumas were also assessed. The events reported most frequently by subjects included being placed in seclusion (58%), being around other patients who were very sick and/ or frightening (56%), being handcuffed and placed in a police car (53%), and witnessing other patients being taken down (47%). Thirty-three percent of the subjects had been put in restraints (of any kind).

Subjects consistently reported experiencing fear, helplessness, or horror in response to these events...Only 24% of subjects had ever been asked about these types of events by (public-sector) mental health staff...

For more information: Charleston/Dorchester Community Mental Health Center, 701 East Bay St., MSC/1110, Charleston, SC 29403

THE ALASKA ADVOCATE

Improving psychiatric patient rights in Alaska
2009-2010



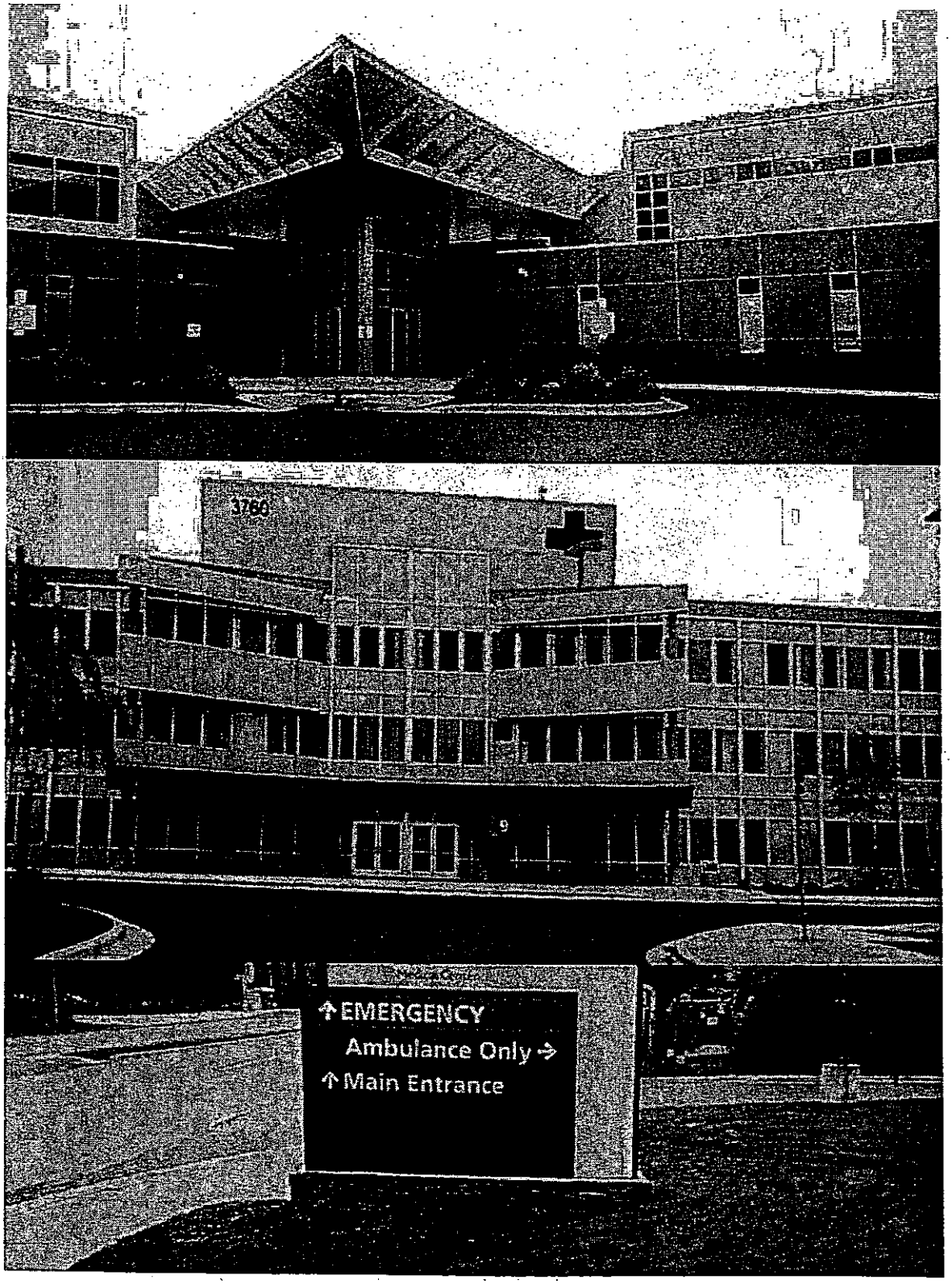
Reducing unnecessary
Trauma to psychiatric
Patients

Improving
Psychiatric
Patient grievance
Procedures

Establishing an
Ombudsman's Office
For Psychiatric patients

Produced as information for the Alaska Legislature

3720


3780
↑EMERGENCY
Ambulance Only →
↑Main Entrance

THE FIRST RULE OF MEDICINE

"DO NO HARM"

For some reason the first rule of medicine is not always followed by Alaska's psychiatric facilities, including evaluation units.

In a recent Alaska Supreme Court decision, the Justices stated there is a clear unavoidable tension between psychiatric facilities seeking convenience/ economics and patient rights, which can manifest itself into patient abuse.

The Justices saw it as a given that without oversight / good regulations that patients would be denied their rights and be more likely to experience abuse.

In general, Alaska as a young state has not produced rules that adequately protect psychiatric patients (those civilly committed and those in emergency rooms for forced psychiatric evaluations.)

Published by Mental Health Advocates, Faith Myers / Dorrance Collins, 3240 Penland Pkwy, Sp. 35, Anchorage, AK. 99508 Phone—(907) 929-0532
Unless otherwise stated, all articles are written by the Publisher.

ADVOCACY GOALS

1. Reducing unnecessary trauma to psychiatric patients

Studies show that trauma to psychiatric patients during treatment, civil commitment, transportation can cause or exacerbate a mental illness i.e.--PTSD, which is one of the most costly mental illnesses in America.

2. Improving Alaska psychiatric patient grievance procedures

Alaska has some of the worst psychiatric grievance procedure statute and regulations in America. Alaska needs to revise their grievance procedure statute and regulations.

3. Establishing a state Ombudsman's Office for psychiatric patients

Psychiatric patients need a state office to call concerning the grievance procedure and all patients in treatment must be given their phone number.

4. Encourage proper use of psychotropic drugs for patients

Psychotropic medication allows many patients to conduct reasonable normal lives, but over-prescribing has become an American epidemic and it needs to be curtailed.

Why must the Alaska Legislature be involved in revising psychiatric patient grievance procedure statute AS47.30.847

The current psychiatric grievance procedure statute AS47.30.847 is too vague. And according to a recent letter from the Dept. of Health and Social Services, the current grievance procedure statute, which is expressly meant to protect psychiatric patients, does not apply to some of the new hospital psychiatric units that do forced evaluations, etc.

There is little more fundamentally important to the psychiatric patient than a grievance procedure. A good grievance procedure not only protects and empowers psychiatric patients, it also forces a psychiatric facility to improve.

Psychiatric patients are unique in that they can be picked up by the police for forced evaluations and they can be placed in locked facilities, which makes protecting their rights more imperative.

The current grievance procedure statute and Behavioral Health 4 pages of Grantee grievance procedure requirements have loopholes which have been utilized by psychiatric facilities. The statute says "patients can file a grievance," but it doesn't say <u>when</u> patients can file a grievance. That is a huge loophole. Nowhere in the statute or in Behavioral Health requirements does it say a grievance/ complaint must be answered in writing. Federal regulations only state that hospitals must answer a grievance in writing. <u>The list goes on.</u> The loopholes must be closed.

In the state of Georgia, the legislature got involved and created an office to produce fair grievance procedure rules for psychiatric patients, after an investigation showed that Georgia's equivalent of DHSS was unable or unwilling to produce and administer fair grievance procedure rules for psychiatric patients. Georgia state officials said that DHSS as a provider writing fair rules was like " a fox watching the henhouse."

In the state of Maine, new psychiatric patient grievance procedure rules were produced after the citizens sued the state and their equivalent of DHSS. The citizens prevailed and the state was forced to adopt new and better grievance procedure rules for psychiatric patients.

Remember, Alaska's DHSS is a provider of psychiatric services.

We are asking the legislature of Alaska to take the initiative and produce a grievance procedure statute that will protect <u>all</u> psychiatric patients.

(Refer to back pages for more information on this subject)

Why the Alaska Legislature must create an independent office to investigate complaints from psychiatric patients or an interested party on behalf of patients

The Dept. of Health and Social Services is presently and for years has been required by statute AS47.30.660 to "investigate a psychiatric patient's complaints or the complaints of an interested party on behalf of a patient." Yet DHSS does not post, nor do they require to be posted, their phone number in psychiatric facilities. Federal regulations (hospitals, including the new hybrids) state that if a state office is required to investigate complaints, like DHSS, (which they are), their phone number is required to be posted / given to all patients. But it is not routinely done in Alaska.

DHSS is required to investigate psychiatric patient complaints and DHSS cannot delegate its responsibility to a non-state entity—i.e. a Board of Directors, non-profit agencies, certification organization, etc., but DHSS is presently doing just that.

In the state of Georgia, their equivalent of DHSS was not properly investigating patient complaints or establishing fair rules for psychiatric patient grievance procedures. The Georgia legislature stepped in and created an independent office "charged with promoting the safety, well-being, and rights of consumers."

In a state of Alaska Ombudsman's report (2008) it came to light that the Dept. of Behavioral Health to their knowledge have not even investigated 1 psychiatric complaint in 5 years and that includes some very serious complaints filed by psychiatric patients.

Remember, Alaska's DHSS is a provider of mental health services and should not be investigating itself or even writing rules to govern themselves.

The Long-Term Care Ombudsman's Office, which is Federally mandated, was under the umbrella of DHSS. But that was viewed as a conflict of interest as DHSS is a provider of senior care. The Long-Term Care Ombudsman's Office was moved under the care of the Alaska Mental Health Trust Authority.

The Dept. of Health and Social Services have shown they will not give out their phone number to all psychiatric patients, they will not in a timely way investigate patient complaints, and they will not write fair grievance procedure rules.

We are asking the Alaska Legislature to create an independent office that will assist any psychiatric patient asking for help through the grievance process and investigate psychiatric patient's complaints especially concerning sexual abuse, physical abuse, etc.

Reducing Unnecessary Trauma to a Psychiatric Patient in Emergency Rooms / Evaluations and Psychiatric Facilities In Alaska

A severe mental illness like schizophrenia can happen to everyday people, who may be going about their business of raising children, or going to school; high I.Q, low, mental illness can be an equal opportunity disease.

How a state treats a patient / person may determine the prospects for the person returning to a normal life and as a state, we are certainly not going to help recovery by unnecessarily traumatizing the patient.

The mental illness, schizophrenia or a severe psychotic break can leave a person wandering the streets with a form of dementia. Such a person can be detained, handcuffed, placed in the back of a marked police car and transported to a hospital for a forced evaluation. For the patient it is terrifying, humiliating, embarrassing and intimidating. It is a traumatizing experience that sticks in a person's memory for a long time. The person is not first asked to volunteer to go to the hospital for a psychiatric evaluation; even if cooperative, the person is not given a choice whether they will be handcuffed or ride in a marked police car. (Private transport companies do not always handcuff psychiatric patients when transporting, nor do ambulances.)

Forced Evaluation

A citizen picked up for forced psychiatric evaluation might be put in a E.R. waiting room with an examination table and a chair in a hospital like Providence for up to twelve hours; a person might be picked up at 6 o'clock at night and released back on the street at 1 o'clock in the morning (the hospitals are only required to return the person to the point of pick-up), or the person might be transferred to a psychiatric hospital.

The next thing a patient / person knows, they are in a world that to a great extent is indifferent to their eventual recovery and returning to something of a normal life. Stabilization is the key or buzz-word in some big psychiatric institutions as opposed to psychiatric treatment and recovery. (There must be higher goals and standards for all psychiatric institutions or psychiatric units in Alaska that keep psychiatric patients over three days than just stabilization.)

Corporate greed: making things easy for hospitals as a way to make more money is all too common. In the lower 48, some psychiatric E.R.'s have patients lined up in the corridors strapped down to gurneys as a way of convenience. You can hear patients calling out for a drink of water, asking to please let them up to go to the bathroom; their pleas go mostly unheeded by hospital staff walking past.

(This is not really where Alaska should be going)

Excerpts from: Trauma within the Psychiatric Setting: A Preliminary Empirical Report

Karen J. Cusack, Ph.D.; B. Christopher Frueh, Ph.D.; Thom Hiers, Ph.D; Samantha Suffoletta-Maierle, Ph.D; and Sandy Bennett, BSW, LMSW

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A commonly held belief among clinicians is that asking vulnerable consumers detailed questions about their trauma history may be too upsetting to the consumer. However, none of the subjects in this study were significantly upset over questions related to their trauma history. In fact, many subjects reported at the conclusion of the interview that they found it helpful; some even indicated that they would like to further address these issues in their treatment. The notion that the interview is helpful for subjects is consistent with other studies conducted with public mental health consumers (Goodman et al., 1999)...

Conclusions: One of the goals of the study was to determine rates of traumatic events, as defined by the DSM-IV criteria for PTSD, occurring in the psychiatric setting (sanctuary trauma). Forty-seven percent of subjects reported experiencing a DSM-IV-defined traumatic event while in the hospital...

Events that were not traumatic, but were nevertheless thought to be harmful or capable of producing or exacerbating symptoms from previous traumas were also assessed. The events reported most frequently by subjects included being placed in seclusion (58%), being around other patients who were very sick and/ or frightening (56%), being handcuffed and placed in a police car (53%), and witnessing other patients being taken down (47%). Thirty-three percent of the subjects had been put in restraints (of any kind).

Subjects consistently reported experiencing fear, helplessness, or horror in response to these events...Only 24% of subjects had ever been asked about these types of events by (public-sector) mental health staff...

For more information: Charleston/Dorchester Community Mental Health Center, 701 East Bay St., MSC/1110, Charleston, SC 29403

Excerpts from:

On Being Invisible In the Mental Health System

Ann F. Jennings, Ph.D.
Trauma-Informed Systems Consultant

This chapter brings into question one of the basic assumptions operating in the public mental health field today: that mental illness is biological or genetic in origin and is therefore treatable primarily by symptom control or management...

Anna was a client of the mental health system for 19 years, until age 32. For nearly 12 of those years, she was institutionalized in psychiatric hospitals. When in the community, she rotated in and out of acute psychiatric wards, psychiatric emergency rooms, crisis residential programs, and locked mental facilities...

Anna was hospitalized a total of 4,124 Billing days...Not included ...is the cost of social services, police, ambulance and legal / court services, conservator and patient advocacy services, residential treatment, psychiatric and therapist sessions, crisis services, day programs, and intensive case management...

Four days after Anna's 32nd birthday, after another haunted sleepless night, she hung herself, by her T-shirt, in the early morning bleakness of her room in a California State mental hospital. She was found by a team of three night staff who were on their way in to give her another shot of medication...

A result of ...paradigmatic "blindness," conventionally accepted psychiatric practices and institutional environments repeatedly retraumatized Anna, re-enacting and exacerbating the pain and sequelae of her childhood experience...The effect of the institutional retraumatization was to continually leave Anna "in a condition that fulfilled the prophecy of her pathology."

Institutional Retraumatization

Continue next page

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Institutional Retraumatization

Early childhood Trauma Experience	Common Mental Health Institutional Practices
Anna's child psychiatrist did not inquire into or see signs of sexual trauma. Anna misdiagnosed.	Adult psychiatry does not inquire into, see signs of sexual trauma. Anna misdiagnosed.
Abuser stripped Anna, pulled T-shirt over her head.	Stripped of clothing when secluded or restrained, often by or in presence of male attendants.
Stripped by abuser to "with nothing on below."	To inject with medication, patient's pants pulled down, exposing buttocks and thighs, often by male attendants.
"Tied up," held down, arms and hands bound.	"Take down," "restraint." Arms and legs shackled to bed.
Abuser "blindfolded me with my little T-shirt."	Cloth would be thrown over Anna's face if she spit or screamed while strapped down in restraints.
Abuser "opened my legs." position.	Forced four-point restraints in spread-eagle
Abuser was "examining and putting things in me."	Medication injected into her body against her will.
Boundaries violated. Exposed. No privacy.	No privacy from patients or staff. No boundaries.
Taken by abuser to places hidden from others.	Forced, often by male attendants, into seclusion room.
Isolated in her experience: "Why just me?"	Separated from community in locked facilities.
Anna was defenseless against perpetrator abuse. Her attempts to tell went unheard. There was no safe place for her, even in her own home or room.	Mental patients defenseless against staff abuse. Reports disbelieved. No safeguards effectively protect patients. Personnel policies prevent dismissal of abusive staff.
Appropriate anger at sexual abuse seen as something wrong with Anna. Abuse continued, unseen.	Appropriate anger at abusive institutional practices judged pathological. Met with continuation of practices.

For more information go to: www.TheAnnaInstitute.org

"Recovery or growth begins with being able to effectively complain." (Whether it be) "psychiatric patients—children—husband or wife—etc"

A 2008 survey at state-run Alaska Psychiatric Institute showed 21% of the patients were afraid to complain or file a grievance; 19% did not answer the question with the possibility they were afraid to answer.

The patient's voice must be encouraged and allowed to come forward to facilitate true recovery.

Consumer Survey:

Male states—"They were treating me for my bi-polar and depression, but they were not giving me any treatment that could help--Grievance procedure doesn't work."
(Name withheld by request)

Male states—"My psychiatrist cut me off medication instead of tapering me off. I told him it was harmful. I tried to file a grievance and get my doctor changed. It didn't work."
(Name withheld by request)

Female states—"I was brought to Providence Psychiatric E.R. One of the male staff hit me in the eye with his elbow which knocked me out and he gave me a black eye. I asked to file a complaint. The hospital staff refused to give me a written copy of the grievance procedure. They would only give it verbally and my mental illness made it difficult to follow verbal instructions.

There was no satisfactory outcome to my grievance. Providence's attorney advised me that Providence does not have to follow the grievance procedure statute."
(Name withheld by request)

*Publishers Note: DHSS confirmed that Providence's Psychiatric units do not have to follow Psychiatric Patient Grievance Procedure Statute—AS47.30.847.

Male states—"It's never been really clear to me how the grievance procedure works. It has never been clear who I was supposed to complain to and who was supposed to help me. When I did file a complaint, no one ever answered."
(Name withheld by request)

Consumer Survey continued:

Don Roberts states—"Basically, as of now, the grievance procedures are pretty useless. Anytime a person's grievance can be dismissed as symptoms of their illness there is a problem. People are deemed less than persons with rights. And doctors, psychiatric facilities seem to think that they can set aside those rights. It's an unjust system."

Female states—" I was transported from API to the court house for a hearing. I was accompanied by two males, one an API staff member. I requested to have at least one female accompany me but they sent two males. I went into the bathroom at the courthouse. The API male orderly walked into the women's bathroom to get me to hurry up. The other women there were shocked and upset. I was humiliated. Complaining to the staff didn't help."
(Name withheld by request)

Male states—"I've actually had API give me the wrong medication. It made me sick, nauseous. I couldn't sleep, I came out for water. The staff told me to go to bed or they would give me more medication. I tried to complain to staff but found out it didn't do any good. They just look at you as though you don't know what you are doing."
(Name withheld by request)

*Publishers Note—In 2008, API was often above the national average for medication mistakes.

Female states—"Police surrounded me and told me they were going to take me to Providence Psychiatric for an evaluation. They handcuffed me and put me in a marked police car.

There has to be a better way for transporting a cooperative individual for a psychiatric evaluation than handcuffing them and taking them in a marked police car!"
(Name withheld by request)

A volunteer patient advocate at one of the community centers who works with those with a dual diagnosis (alcohol/mental illness) states—"There doesn't appear to be enough Crisis Intervention Team (CIT) police officers properly trained to deal with psychiatric patients. Not all of our clients know to ask the police to provide a trained CIT officer."
(Name withheld by request)

Female states—"Anchorage Police Department physically and mentally does not have any training on dealing with psychiatric behaviors."
(Name withheld by request)

Which Psychiatric Patients should be allowed to File a Grievance

For over 20 years in Alaska there has been a debate: "which psychiatric patient should be allowed to file a grievance." "And when" can a psychiatric patient file a grievance. The Alaska Legislature needs to weigh in and make clear what patient rights are on this issue.

The Dept. of Health and Social Services (DHSS), Behavioral Health (BH), most psychiatric facilities and even some employees of state-run psychiatric patient rights organizations believe that : "psychiatric facilities need to be able to choose who can file a grievance." They also believe facilities need to be able to choose when a patient can file a grievance as a way to eliminate frivolous grievances. Many psychiatric patients are required to go through an informal complaint process before being allowed to file a grievance.

Granted, there are some frivolous complaints filed. The problem in places like state-run Alaska Psychiatric Institute (API); middle of '05 to middle of '06, over 200 complaints were filed by patients, yet not one was allowed to become a grievance, not one patient received a written response (Federal requirement). API has changed somewhat, but they can always change back when they want to. (In '08 less than 15 patients received a written response.)

Regardless of what API does, it still leaves 50 or so grantee psychiatric facilities that may or may not be doing the right thing. The loopholes in the current state grievance procedure rules need to be closed.

Advocates and former patients believe that patients or a person representing a patient should be able to file a grievance with a psychiatric facility at the time of their choosing and there should be a paper trail for complaints. The state of Maine has come up with a very simple procedure and form to deal with any frivolous grievances.

The one thing that is certain, the state legislature and patient advocates cannot allow psychiatric facilities and providers, and remember, DHSS is a provider, to choose who can and can't file a grievance and when.

The psychiatric facilities have demonstrated in the past, that if given a choice, they will often not let anybody file a grievance.

Reference Information:

AS47.30.840 passed in 1981 and gave 7 basic rights to psychiatric patients. In 1984, major revisions were made and 4 more rights were added.

AS47.30.847, Psychiatric Patient Grievance Procedure Statute passed in 1992, sixteen years ago. To date there have been no major revisions.

The present statute 47.30.847 is vague, with loopholes which allows psychiatric facilities to deny patients due process, an appeal process, and even deny patients their right to file a grievance.

AS47.30.847 was expressly written to protect psychiatric patients. Because of changing times, method of treatment, now the statute only applies to a few facilities. This is verified by a recent letter from DHSS.

The state of Maine through a lawsuit forced their state to develop uniformity in the psychiatric grievance procedure regulations. The state of Georgia recently passed a statute that will bring about uniformity in their psychiatric patient grievance procedures / regulations.

Maine and Georgia found out that a state cannot give a vague set of guidelines or regulations to 50 or 60 psychiatric facilities and expect fair treatment of patients.

Alaska must design a grievance procedure statute that will cover all psychiatric patients/facilities and with enough detail to guarantee the protection and rights of all psychiatric patients.

AS47.30.847 states psychiatric patients can file a grievance but it does not say when. It does not say who the impartial body is. The patient must receive a written answer-etc. For more information, refer to back pages / committee report

Psychiatric patients' grievance procedure Statute AS47.30.847

Sec.47.30.847. Patients' grievance procedures. (a) A patient has the right to bring grievances about the patient's treatment, care, or rights to an impartial body within an evaluation facility or designated treatment facility.

(b) An evaluation facility and a designated treatment facility shall have a formal grievance procedure for patient grievances brought under (a) of this section. The facility shall inform each patient of the existence and contents of the grievance procedure.

(c) An evaluation facility and a designated treatment facility shall have a designated staff member who is trained in mental health consumer advocacy who will serve as an advocate, upon a patient's request, to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights. (10 ch109 SLA 1992)

Should Alaska treat Psychiatric Patients (Those civilly committed—Forced evaluations) the same as Criminals

In the early 80's, the Alaska legislature passed an amendment to a law that included "psychiatric patients have a right to be free of corporal punishment."

It really wasn't that long ago in American history that corporal punishment was seen as a legitimate tool for behavioral modification.

A second very questionable way psychiatric facilities / psychiatrists employ behavioral modification: the in-patient facilities remove a great deal of patient rights that are granted by statute. They then require the patient to earn their rights back and for any minor infraction of hospital rules a patient's rights may be removed again.

Across America, state courts, state supreme courts, Federal courts, have ruled in a unanimous way, that psychiatric patients that have not committed a crime cannot be treated as criminals and a "psychiatric patients rights are to remain intact to the greatest extent possible."

Removal of psychiatric patient's rights as part of a treatment plan is often arbitrary in nature, depending on the mood of the staff person. The legislature should make it clear that patient rights cannot be removed for minor infractions of hospital rules.

In a recent Alaska Supreme Court decision concerning a civilly committed psychiatric patient, the Justices were critical of the Dept. of Health and Social Services, stating DHSS's court briefs almost exclusively referred to people who had committed a crime and were in jail. The Justices reminded DHSS that there is a fundamental difference between people/ psychiatric patients who have not committed a crime and someone who has.

Ultimately, it's going to take more than a few Judges or losing a case and $200,000 to change DHSS's mindset. It will take a directive from the legislature.

Voluntary and civilly committed psychiatric patients who have not committed a crime have a right not to be placed in jail or a forensic unit (unless an emergency exists, and then must be kept separate from criminals.) Conversely, the same rule should apply. But the legislature has not made it clear.

Presently state-run psychiatric facility API uses non-forensic units as a halfway house for murderers, hard-core criminals, etc.

Mixing voluntary patients and criminals is done by the state/DHSS for convenience and to save money. The legislature should weigh in.

Follow the Money, Follow the money

Treating psychiatric patients in a psychiatric facility or unit is a billion dollar business.

Non-profit organizations that specialize in protecting psychiatric patients represent a multi-million dollar business. The job can provide a good paycheck, put the children through college, etc.

HELPING PSYCHIATRIC PATIENTS IS BIG BUSINESS. Some organizations do a lot of good. But psychiatric facilities do not necessarily see a down side to increasing the number of patients or recidivism.

And most patient rights organizations do not see an up side to empowering psychiatric patients to advocate for themselves.

There is a strong, in-bred motivation by service organizations to keep psychiatric patients helpless and to keep them coming back.

The Alaska state Legislature should take into account that psychiatric facilities—drug companies—patient rights organizations are, to a great extent, going to act in their own best interest and their actions may not always be in the best interest of the patient.

It is up to the Alaska Legislature (with the encouragement of advocates) to advance new rules that will empower psychiatric patients—giving patients an increased ability to protect themselves.

A good grievance procedure statute is one example. It has 5 ingredients:

1. It forces psychiatric facilities to respond.
2. Easy to understand.
3. Timely
4. Has a paper trail.
5. Gives patients the right to file a grievance at the time of their choosing.

A good grievance procedure, along with other advancements in patient rights, is needed by psychiatric patients.

(Reprinted from Ketchikan Daily News)

Validating Legitimate Patient Complaints as an Aid to Recovery

(Revising the Psychiatric Patient Grievance Procedure Statute AS47.30.847 Con.)

Recommendations to revise grievance procedure policy (Completed 2007)—A committee worked for one year to revise state-run Alaska Psychiatric Institute's grievance procedure.

The committee was made up of Alaska Mental Health Board members (including the chair), hospital employees, API Board members, Disability Law Center, public members, former patients. Following are their recommendations:

1. If the patient requests to file a grievance, neither the grievance nor the process can be denied because of the availability of a complaint procedure.

2. Patients have a right to a written answer to their grievance / complaint.

3. Each program area shall have complete written copies of the grievance procedure/policy and associated rules and they shall be made available to the patient. Each patient shall be offered a written copy of these rules. (Including Behavioral Health's 4 pages of grantee grievance procedure requirements.)

4. All committee members agree that there should be an urgent formal grievance procedure and urgent grievances should be resolved within 24 hours.

5. It should be made clear that patients can file a grievance on any subject and receive the same due process on any subject.

6. The committee wanted the hospital to adopt a form that could contain the complaint, the hospital's answer and the appeal process all on one form.

7. Timeline for facility resolving a patient grievance. A grievance should be resolved within 5 days not counting weekends or holidays. Facilities can ask for a 5 day extension. The facility is required to inform the patient in writing of the extension and not to exceed three 5 day extensions, not counting the 5 day investigative period initially and to include the reason for the extension. The extension should be for "good cause" such as a staff member needing to be interviewed is on vacation, etc. and the written notification to the patient should include the reason for the extension.

(Continued on next page)

8. Once filed, all formal grievances must be completed to resolution. A reasonable attempt by mail must be made to contact patients who may have left the hospital prior to resolution, informing the patient in writing of the decision.

9. AS47.30.847 states "the facility shall have a designated staff member who is trained in mental health consumer advocacy who will serve as an advocate, upon a patient's request, to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights." The committee recommended that the designated staff person be clearly identified in writing (policy) as the "patient advocate."
(A later committee felt the advocate training could be adequately done by the advocate reviewing an on-line program)

Note: The state of Maine had similar problems with facilities not letting patients file a grievance and they added to their regulations: "Under no circumstances shall the remedies requested in a grievance be denied nor the processing of a grievance be refused because of the availability of a less formal procedure."

The committee spent a year producing recommendations to improve the API psychiatric patient grievance procedure policy. And those recommendations are relevant to the revision of the grievance procedure statute, AS47.30.847.

"Recovery begins with being able to effectively complain."

Support Letters:

Disability Law Center in a letter dated January 9, 2007, addressed to the Alaska Mental Health Board and committee members, endorses the recommended changes to the grievance procedure. Shortly thereafter, the AMHB endorsed the recommended changes to the grievance procedure. And the API Advisory Board endorsed the additions to the grievance procedure.

Also: In a letter, Psychiatric Rights and NAMI—Anchorage called for the improvement of the psychiatric patient grievance procedure statute—AS47.30.847.

Gov. Sarah Palin; **November 5, '08**
Mr. Mike Nizich, Chief of Staff;
Alaska Senate;
Alaska House of Representatives;

We are asking that you help bring Alaska psychiatric patient statute / regulations into the 21st Century. The goal is to reduce unnecessary trauma, improve patient rights and to reduce unnecessary recidivism.

Alaska has some of the worst psychiatric patient rights and government oversight in the nation.

The Department of Health and Social Services (DHSS) is required by law to investigate a psychiatric patient's complaint and cannot delegate its responsibility to a non-state agency.

1. Behavioral Health has not to their knowledge investigated a psychiatric patient's complaint in the last 5 years. (Ombudsman's report '08)

2. DHSS does not routinely give out their phone number to psychiatric patients.

3. DHSS does not keep statistics of the number and type of complaints filed by patients in psychiatric facilities or complaints filed with DHSS.

4. Psychiatric patient grievance procedure statute AS47.30.847 needs to be revised with a goal of fairness and state-wide uniformity.

The enclosed state Ombudsman's report is critical of DHSS.

In closing, as advocates we have looked at numerous other states. No DHSS or their equivalent has made any significant advancement in patient rights or oversight without pressure from a Governor's Office, the courts by way of a lawsuit or the legislature stepping in and writing new rules / statutes.

The examples would be—the state of Maine—lengthy lawsuit—state of Georgia—legislature recently rewrote the statutes after it was shown their equivalent of DHSS was not investigating complaints and was not writing fair grievance procedure rules for psychiatric patients. The state of Washington—the Governor/office stepped in on a couple of issues.

In closing, we are asking for the help of your office in remedying the deficiencies of the DHSS in Alaska in the 4 issues we have set out.

Thank you,

Cc: Open Letter

Mental Health Advocates
Faith Myers / Dorrance Collins
(907) 929-0532

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
and ALASKA MENTAL HEALTH BOARD

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February 12, 2009

Senator Bettye Davis
Alaska State Capitol, Room 30
Juneau, Alaska 99801

Re: SB 66 – Mental Health Patient Grievance Procedure

Dear Senator Davis,

On behalf of the Alaska Mental Health Board, please except our appreciation for your support for Alaskans with mental illness. We appreciate that you are open to hearing about the needs of mental health consumers and are committed to providing them with greater security and dignity.

For the past year or so, our staff and board members have been involved in an extensive discussion around the patient grievance process. Thus, we are familiar with the current procedures in place and the discussions related to the idea of a statutory grievance procedure. Our staff has reviewed SB 66 regarding the establishment of a statutory grievance procedure for mental health patients, and would like to identify some serious concerns we have with the proposed procedure.

We are concerned that the proposed procedure will have a negative effect of patient-centered care, given its complexity and bureaucratization of the grievance process. We are also concerned that it will deter mental health consumers and their providers from reporting crimes against patients to law enforcement. The proposed procedure would add a layer to existing grievance procedure requirements, rather than replace them. We worry that this will increase the complexity for mental health consumers as well as providers, and further reduce the incentives for hospitals to expand their capacity for designated evaluation and treatment/stabilization (DET or DES) services. We also have concern that singling out mental health consumers, rather than looking to a more comprehensive procedure that includes all patients' needs, increases the stigma of mental illness. There are costs associated with this proposed grievance procedure that potentially outweigh the benefits. Finally, the proposed language gives rise to a host of construction concerns, which we worry will lead to litigation and further compromise care available to mental health consumers.

Interference with Patient-Centered Care

We applaud the acceptance of patient-centered care as the model, not just for our psychiatric institution but also for our community mental health centers and hospital services. It has been an arduous process for advocates to shift the thinking to focus on mental health consumer's participation in the treatment process, and to show the value of peer-to-peer services in the continuum of care. As written, SB 66 brings a level of government into the process that we feel compromises that patient-centered focus. We also worry that the potentially adversarial process suggested will damage the relationships between mental health consumers and their treatment teams. Given the scarcity of resources in our communities (some of which have a single provider), we do not want to risk the loss of care by overly polarizing the grievance process.

The definition of "grievance" is far too broad. It includes a "complaint, **concern or suggestion.**" The benefit of patient-centered care is that mental health consumers are able to participate in the development – and evolution – of their treatment plans. If every time a consumer wants to suggest a change to his or her treatment plan they must engage in this grievance procedure, the flexibility and responsiveness of the treatment plan are lost.

The issue of the burden of proof being placed on the provider is also concerning. To ask the provider to prove that the complained of act or behavior did not happen in reality creates a situation in which a grievance cannot be resolved in a manner acceptable to both the mental health consumer and the treatment provider. This will erode the partnership between the two, impairing the treatment process by creating an adversarial relationship.

Minimization of Serious Offenses

As proposed, AS 47.30.847(b)(7) provides an "urgent level of review" for grievances involving sexual or physical abuse, denial of "lifesaving" medical care, or denial of "basic care of human rights." Were these acts to be committed against a mental health consumer by a mental health provider, they would be criminal acts. As such, they should not be minimized or reduced to "grievances." They should be considered crimes and reported to law enforcement immediately for investigation and prosecution if appropriate.

Unfortunately, crimes against persons with disabilities often go unaddressed. Either the victim is blamed or they are undervalued to the point where crimes committed against them no longer matter. To codify this attitude in statute seems to be a step back after so many years of advocacy.

We also wonder if the very broad definition of a "grievance" doesn't minimize serious complaints about patient care. Is the intent that suggestions about menus, décor, etc. are to be considered grievances?

The Impact of Duplication

Currently, mental health providers are already required to have formal grievance procedures by state, federal and accrediting authorities. The Division of Behavioral Health has a policy with which all recipients of community behavioral health grants must comply. Alaska statute and regulations require that the grievance procedure and patient rights be posted at the facility (AS 47.30.855 and 7AAC 71.220). Providers of Medicaid-reimbursed services must comply with the grievance procedure requirements established by CMS. Hospitals and community behavioral health centers accredited by JCAHO must also comply with grievance procedure standards. This is three layers of grievance procedures already imposed upon mental health providers.

To add an additional layer, that is not coordinated with existing procedures, means a more complex grievance process for mental health consumers and a greater burden to providers. We worry that hospitals providing mental services, especially DES/DET services, will see this as another obstacle and will choose not to maintain or expand their capacity to serve people in psychiatric emergencies. We already have a fragile DES/DET system, having lost our beds in Sitka last year. Further reductions will make it even harder for mental health consumers to receive quality care when they most need it.

Exclusivity and Stigma

We agree that all patients have a right to receive quality health care, and to complain or grieve about unacceptable care. We worry that by providing a grievance procedure limited to mental health consumers, we validate the myths and stigma about mental illness by implying that mental health patients are somehow different or more vulnerable that other people with disabilities. We would recommend that a health care grievance procedure that applies to all patients regardless of disability or need as a more inclusive and equitable approach. The Disability Law Center is willing, as are we, to help in creating such a process, should you be interested in pursuing that course of action.

Cost vs. Benefit

Over the past year, we have worked with the Disability Law Center, patient advocates, the Department of Health and Social Services and the public to determine whether mental health consumers are being denied the ability to pursue grievances. We have heard no public comment from mental health consumers or family members who have been denied the right to a grievance. The Disability Law Center reports no applicants calling for assistance in asserting their grievance rights. Other social services agencies and advocacy groups report the same.

The Division of Behavioral Health (DBH) does require grantees to have a grievance procedure (the policy is attached). The policy includes departmental review if the mental health consumer cannot achieve a satisfactory resolution with the treatment provider. Between 2005 and 2007, only **five** grievants sought departmental review. Thus, there is no overwhelming evidence that mental health consumers are being denied their rights to grieve.

As proposed, providers must have a designated staff member to advocate for patients. This is currently required by the DBH policy for its grantees, so it's unclear as to whether that suffices or whether a specific FTE advocate is required by SB 66. The procedure also requires departmental review of all grievances. With the definition of grievance being so broad, this will result in requiring additional departmental staff. The result is a financial burden on providers and the state that outweighs the need.

As discussed above, we have serious concerns that this sort of procedure will damage the relationships so necessary for good patient care. If the intent is to include peer support services under this law, the damage to those relationships is even more concerning. This is an unacceptable cost for such a limited benefit.

Language

There are specific terms and provisions in the bill as drafted which lead to questions of intent and construction of the law should it be enacted.

As discussed above, the definition of "grievance" is far too broad. On its face, this would include "concerns and suggestions" unrelated to patient care. Is this the intent?

What is "a public or private evaluation facility or unit?" Is the intent that only those mental health providers identified by AS 47.30.660-47.30.915 be included, or is the intent to also include community mental health centers and/or peer support services? There is not a statutory definition of a treatment or evaluation "unit," so it's not clear what is included.

There is a great deal of specificity as to the grievance form, which could lead us to construe the statute to prohibit the making of a grievance in person, by telephone, by email, or through a family member or designated representative/advocate. This actually narrows the procedure from what currently exists for behavioral health grantees.

The proposed AS 47.30.847(b)(4)(C) permits an administrative appeal if the executive director of the provider cannot resolve the grievance in a way acceptable to the person making the grievance. Since all of our providers except API are private non-profits, there is no governmental action to be the subject of an administrative appeal. There would need to be some review by the Department of Health and Social Services or Division of Behavioral Health to be appealed administratively.

There are also two legal questions. What is meant by "due process?" Is this a procedural concept requiring notice and hearing or is it a substantive due process concept? Also, the assignment of the burden of proof on the provider in atypical — usually the complainant must establish the grounds for the complaint. As drafted, SB 66 limits the provider to proving "compliance or remedial action" — which presupposes that the facts alleged in the grievance are true (thereby denying the provider its due process).

Please do not interpret this extensive list of concerns as being "anti-patient" or as our taking a position to limit the rights of mental health consumers. The Alaska Mental Health Board strongly supports the rights of mental health consumers and their families and we would like to see an easier, more accessible grievance system for all patients. We simply do not feel that SB 66 as drafted achieves that result. We look forward to partnering with you on this issue, to better serve all our constituents.

Sincerely,

J. Kate Burkhart
Executive Director

State of Alaska
Department of Health and Social Services
Behavioral Health

Policy & Procedure

Topic: State Behavioral Health Requirements for Grantee Grievance Procedures

Policy: All Behavioral Health (BH) grantee treatment organizations are required to develop grievance procedures by which all clients, without regard to services used or funding source, including those clients denied services, may seek redress of grievances. The procedures, written in plain language, should be developed with meaningful consumer participation utilizing the general guidelines established by State Behavioral Health. A copy of the procedures must be filed with BH and should also be posted at the grantee organization's facility(s).[1]

Intent: The Department of Health and Social Services (DHSS) by law is required to adopt regulations to assure patient rights[2], to establish standards for treatment facilities and to keep related records[3], and to investigate complaints made by a patient[4]. This policy outlines the DHSS BH guidelines for grantee grievance procedures, explains BH's role in response to grievances, and lists relevant policy clarifications and all related references of the Alaska Statutes and the Alaska Administrative Code.

Grievance Procedure Guidelines: Grantee consumer grievance procedures must, at a minimum, meet the following criteria:

1. Provision(s) that ensure the right of consumers to file a grievance without intimidation
2. Provision(s) that ensure there is NO retaliation perpetrated against consumers who have filed a grievance
3. Provision(s) that outline a process by which consumers may easily file a grievance, to include:

[1] 7 AAC 13.135 Grievance procedures; 7 AAC 71.220 Grievance procedures
[2] AS 47.30.590 Comprehensive services
[3] AS 47.37.030 Powers of Department; AS 47.37.140 Public and Private Treatment Facilities
[4] AS 47.30.660 (b) (12) Powers and duties of department

APPROVED: 6-18-2007

a. A simple form written in plain language that also provides for an optional waiver of confidentiality which consumers may complete and submit,
b. Procedure(s) that allow consumers to submit a grievance orally
c. Procedure(s) that allow consumers to submit a grievance over the phone or via email

4. Explanation of agency's grievance procedure / policy provided to ALL consumers upon entry to services, to include the following:
   a. Copy of agency procedure / policy
   b. A form for consumers to sign, which shall be maintained in the consumer's clinical record, that declares their receipt and understanding of the agency procedure / policy
5. Provision(s) for consumers to designate a representative or advocate to assist them with all steps of the grievance process
6. Procedure(s) for the agency, upon consumers request, to assist the consumer with filing a grievance, which should include either:
   a. Identifying specific agency staff to provide assistance
   b. Written referral to other consumer advocacy resources such as the Disability Law Center and NAMI-Alaska
7. Step-wise procedures, limited to the following, for resolving ALL grievances:
   a. **Resource and means for commonly resolving consumer disputes to minimize the need to invoke the grievance process**
   b. Communication with consumer upon receipt of grievance that the agency has begun the process to resolve the grievance
   c. Direct resolution through dialogue with the agency staff member involved or with the staff member's supervisor, or with both as consumer requests
   d. Resolution through the agency Executive Director
   e. Resolution through the agency Governing or Advisory Board
   f. Referral of grievances unresolved at the agency's highest level to DHSS Behavioral Health for technical assistance
8. Established time frames to include the following that ensure prompt hearing of grievances:
   a. Initiation of resolution (according to the procedures noted in # 7 above) within 5 days of receiving a grievance
   b. If agency is unable to adequately initiate resolution within 5 days, a written notification shall be sent to the consumer by the end of 5 days from receipt of grievance explaining why and identifying when the grievance process will initiate
   c. Satisfactory resolution to grievances within 30 days of receipt of grievance
   d. Referral to BH, within 5 business days, for technical assistance with grievances that remain unresolved after 30 days.
9. Provision(s) for immediately elevating to the Governing or Advisory Board level any grievances that involve abuse, neglect or unnecessary seclusion or restraint.
10. Procedure(s) that provide for the creation, maintenance and storage of files for each individual grievance which shall contain all related documents, records, actions and communications.

11. Provision(s) that address maintenance of consumer confidentiality throughout the grievance process

BH Role & Responsibility:

DHSS BH shall initially represent the Department of Health and Social Services for any grievance referred for technical assistance involving BH grantee treatment organizations. BH shall take the following steps to assist with these grievances:

1. **Exercise the primary responsibility of DHSS BH to orient consumers, or other individuals calling on behalf of consumers, to the grievance process and procedures available thru the involved grantee organization**
2. For questions regarding grievances which have been heard according to the involved grantee organization's grievance procedures, BH may:
   a. Review any written response from the involved grantee organization regarding their findings and resolution to the grievance.
   b. Investigate whether the involved grantee organization complied with the following, as indicated, in regards to processing the consumer grievance:
      i. Alaska Statute / Behavioral Health Regulations
      ii. Medicaid Regulations
      iii. Special Conditions of Grant Award
   c. Determine if resolution of the grievance is reasonable based on resources available to the grantee organization
   d. Share BH findings with both the consumer and the involved grantee organization
3. In the course of providing technical assistance for any consumer grievance BH may:
   a. Communicate with any involved party to seek clarification of information, or to obtain access to supporting documents
   b. Consult with other Department or division resource
   c. Refer case to other Department or division resource for continued technical assistance or action
   d. Take any other action deemed prudent or necessary to assist consumer and / or grantee organization

Policy Clarifications:

1) The Department of Health and Social Services is authorized to review, obtain, and copy confidential and other records and information about clients, including services requested or furnished, to evaluate a grantee organization's compliance with statutes (AS 47.30.520 – 47.30.620)[5]

2) For substance abuse treatment facilities and programs, DHSS has adopted by reference the standards contained in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) *Standards for*

[5] AS 47.30.590 (b) Patient rights and the confidential nature of records and information

Behavioral Health Care, 2004 – 2005.[6] The Department also provides for exemption from the provisions regarding substance abuse facilities or programs established by the State of Alaska Administrative Code for those private and public treatment facilities currently certified by JCAHO or the Commission on Accreditation of Rehabilitation Facilities (CARF).[7] Therefore:

a. All substance abuse grantee organizations are also obligated to comply with JCAHO standards regarding client Ethics, Rights, and Responsibilities (RI.2.120 – RI.2.130)[8] OR
b. If certified by CARF are obligated to also comply with the CARF standards for rights of persons served (Section 1. Business Practices: Criterion D. Rights of Persons Served)[9]

References:

Alaska Statutes (Authority)

Title 47. Welfare, Social Services and Institutions
- Chapter 30. Mental Health
  - Section 520 - 620. Community Mental Health Services Act
- Chapter 37, Uniform Alcoholism and Intoxication Treatment Act
  - Section 30, Powers of Department
  - Section 140, Public and Private Treatment Facilities

Alaska Administrative Code

Title 7. Health and Social Services
- Chapter 13, Assistance for Community Health Facilities
  - Section 135. Grievance procedures
- Chapter 29, Uniform Substance Abuse Treatment
  - Section 10. Application of standards
  - Section 30. Adoption of standards by reference
- Chapter 71, Community Mental Health Services
  - Section 220. Grievance procedures

[6] 7 AAC 29.030 Adoption of standards by reference
[7] 7 AAC 29.010 Application of standards
[8] Comprehensive Accreditation Manual for Behavioral Health Care, 2004 – 2005
[9] 2007 Behavioral Health Standards Manual, CARF International

Senator Bettye Davis, **February 14, 2009**
Chair---HESS Committee,

We would like to comment on the contents of the letter you received from J. Kate Burkhart, Executive Director of the Alaska Mental Health Board (Feb 12, '09—5 page letter) concerning SB 66.

J. Kate Burkhart does a good job of stating the position of providers and DHSS.

"Alaska needs to improve the psychiatric patient grievance procedure statute / regulations." Not one of J. Kate Burkhart's proposals will do that. In fact, her proposals will actually make it possible to remove some of the patient rights that an API committee worked one year to gain.

From a psychiatric patient's view:

From a psychiatric patient's point of view: it takes less than 5 minutes of reading the current 3 grievance procedure guidelines to know they are inadequate and unfair to psychiatric patients and it takes less than 5 minutes of talking to mental health consumers at places like the Alaska Mental Health Computer Web (which we did) to know consumers are not satisfied with the current grievance process.

SB 66 is a good bill, it is necessary and we are asking that it receives a hearing. When signed into law, SB 66 will give needed protection to Alaska psychiatric patients that is already enjoyed by patients in some other states.

We want to clarify some of the information that J. Kate Burkhart provided in her letter.

Reasons not to combine the grievance procedures:

Psychiatric patients, individuals with a developmental disability, individuals with drug and alcohol addictions, individuals with traumatic brain injury cannot all be included in the same grievance procedure. (with the exception of dual diagnosis)

Psychiatric patients are unique in that they can be civilly committed (locked up), committed for forced evaluation, forced medicated, etc. Psychiatric patients need their own grievance procedure because of the uniqueness of their position.—Those with other disabilities are generally not locked up unless they exhibit symptoms of a mental illness or commit a crime.

The state of Maine came to the same conclusion that they could not combine individuals with a mental illness and individuals with developmental disabilities in the same grievance procedure. (with the exception of dual diagnosis)

Good foundation for SB 66:

Many of the provisions in SB 66 came out of a Bi-Partisan Alaska Psychiatric Institute grievance procedure committee and from other states. The committee recommendations (2007) were endorsed by the Alaska Mental Health Board, Disability Law Center and the API Board.

In many instances, J. Kate Burkhart is speaking against rules that were approved by the AMHB, Disability Law Center and the API Board and also rules in general practice at API today meant to protect psychiatric patients.

As an example:

As an example, in the 2007 committee recommendations, the API committee stated that patients should have a right to file a grievance on any issue and at the time of their choosing.—Just because an issue rises to a level that it should be reported to the police, does not mean that patients should not still retain the right to file a grievance in addition to the reporting to the police—that was a committee decision.—there were too many cases in the past at API where serious issues were never allowed to become a grievance and were also not reported to the police. That is one of the reasons why all psychiatric patients need an absolute right to file a grievance at the time of their choosing.

There are numerous acceptable ways to deal with a frivolous grievance. But the state cannot allow psychiatric facilities / units or DHSS to choose which patient can file a grievance and when.

Keeping statistics as a way to improve care:

In an '08 Ombudsman's report it came to light that DHSS / Behavioral Health has not investigated a psychiatric patient's complaint in 5 years—although they may have accepted a few complaints, they did not investigate them. And they do not routinely give out their phone number to patients...

Also, an '08 Ombudsman's report was critical of DHSS / Behavioral Health for not keeping statistics on the number and type of complaints filed by psychiatric patients in psychiatric facilities and units...SB 66 will require that statistics be kept.

Too many grievance procedure guidelines, too many loopholes:

There are 3 separate grievance procedure guidelines for psychiatric patients in Alaska and no single grievance procedure guideline covers all psychiatric facilities or units. In Maine and Georgia, before they changed their grievance procedures, psychiatric patients were abused and/or died and they were using a JCAHO grievance procedure just like in some Alaskan facilities / units. One of the necessary goals of SB 66 is to consolidate and have one improved grievance procedure statute for all psychiatric patients.

Bring SB 66 into a hearing:

We are asking that SB 66 be given a hearing and passed. (Any minor shortcomings in the bill can be fixed in committee) In the end, it will be the legislature that will have to make the final decision.

DHSS and practically every hospital opposed SB 8 last year—even the Unions opposed it. They were predicting patient treatment as we knew it would end.

When we called the hospitals recently, they stated they were complying with SB 8—no problems.

The same thing will happen with SB 66—Institutions / DHSS will predict the end of the world—but when it passes they will comply and Alaska will be better for it.

Thank you,

Faith Myers / Dorrance Collins
3240 Penland Pkwy, Sp. 35
Anchorage, AK. 99508

(907) 929-0532

Faith Myers
Dorrance Collins

Cc: Ms. J. Kate Burkhart,
AMHB
Mr. Dave Fleurants,
Disability Law Center
James Gottstein, Esq.
Psych/ Rights
Ms. Francine Harbour,
NAMI, Anchorage
Ms. Kathy Fitzgerald,
Partners-in-Policymaking
Mr. Jeff Jesse,
Trust Authority
Open Letter

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

February 24, 2009

Beth Leibowitz
Assistant Ombudsman
PO Box 113000
Juneau, AK 99811-3000

RE: Ombudsman Complaint J2008-0233

Dear Ms. Leibowitz:

This is to confirm the teleconference held on January 15, 2009 regarding the above referenced complaint and your suggestions to the department as set forth in your letter dated November 4, 2008. Participants in the discussion from the Department of Health and Social Services included Patrick Hefley, Deputy Commissioner; Division of Behavioral Health staff Melissa Stone, Director; Stacy Toner, Deputy Director; and Brenda Knapp, Treatment and Recovery Program Administrator. You suggested that the department develop and maintain a logging system for complaints received by DBH and that we clarify which records the Licensing and Certification Section (Division of Public Health) may be appropriately released.

Division of Behavioral Health staff advised you that we thoroughly considered the desirability and practicality of establishing a logging system and reached the conclusion that we do not receive enough complaints to justify the development and maintenance of a tracking system. Nearly all complaints and grievances are handled successfully at the service provider level, as they should be. Since the providers are independent corporations, municipal entities or tribal organizations, they hold responsibility for resolving complaints and grievances that come to them. As a condition of a grant award, each grantee is required to have formal grievance policies and procedures in place.

Your second suggestion was that we determine our authority to release records maintained by the Facilities Licensing and Certification Section, specifically complaint or grievance information. This will not be an issue for us since we do not plan to establish a complaint tracking system.

We appreciate your thorough investigation of the above complaint, and the observations and suggestions you subsequently shared with us. It is always helpful to get feedback on how the department's operations are perceived so that we can make necessary changes and be more responsive to the needs and concerns of consumers, their families and the general public.

Sincerely,

Patrick B. Hefley
Deputy Commissioner

cc: Melissa Stone, Director, Division of Behavioral Health
Stacy Toner, Deputy Director, Division of Behavioral Health
Brenda Knapp, Treatment & Recovery Program Administrator, Division of Behavioral Health

Don Burrell

From: NAMI Anchorage [namianchorage@nami.org]
Sent: Monday, February 16, 2009 4:37 PM
To: Sen. Bettye Davis
Subject: SB 66

RECEIVED
FEB 17 2009

Dear Senator Davis:

NAMI Anchorage is the local affiliate of the National Alliance on Mental Illness. We provide support, education and advocacy to people who experience severe mental illness.

NAMI Anchorage supports SB 66 in its general principles. More particularly, we support uniformity of procedures for all psychiatric hospitals. Uniformity, properly crafted, can provide a guard against arbitrary action or enforcement.

Additionally, we support the adoption of a grievance system specifically for patients with mental illness. The position has been taken by others that making such a distinction somehow diminishes people with mental illness. The distinction is necessary not because these patients have mental illness, but because patients with mental illness can be locked up and forcibly medicated. People with developmental disabilities, substance abuse disorder or traumatic brain injury do not face such losses of liberty unless they have a dual diagnosis or they have committed a crime. It is the possible consequence of this loss of liberty that requires a grievance procedure tailored for people in psychiatric institutions, not the fact that the grievants have mental illness.

Finally, there is a long, sad history of grievances by psychiatric patients not being taken seriously, or being considered a symptom of mental illness. Even if institutions and caregivers today are more progressive in general, there still exists the possibility of this disregard of grievances in particular instances. So again, a strong grievance procedure tailored for those in psychiatric institutions is called for.

NAMI Anchorage will leave it to others more familiar with the proposed legislation to offer suggestions on tightening up some language that appears on the surface vague or too broad. We support a uniform grievance procedure for psychiatric patients in the outline set out in SB 66.

Thank you for your continued advocacy for persons with mental illness.

Francine Harbour
President, NAMI Anchorage
(907) 272-0227

PsychRights®

Law Project for
Psychiatric Rights, Inc.

February 16, 2009

Senator Bettye Davis
State Capitol, Room 30
Juneau, Alaska 99801-1182

Re: SB 66

Dear Senator Davis:

This is to reaffirm[1] the Law Project for Psychiatric Rights' (PsychRights) support for the current iteration of your proposed legislation to beef up psychiatric patients' rights surrounding grievances, SB 66. Our experience is it is common for patients' grievances to be summarily disregarded by psychiatric facilities as symptoms of mental illness.[2] In this way, psychiatric facilities evade accountability. It is well known that even serious events such as rape, especially by staff, when reported by patients, are summarily ignored as "delusions," when in fact, these types of events occur with disturbingly regularity. Psychiatric facilities should be required to treat all grievances with respect as required by SB66. I urge passage of SB 66.

Yours truly,

James B. (Jim) Gottstein, Esq.
President/CBO

cc: Faith Myers/Dorrance Collins

[1] See, attached copy of letter dated March 31, 2008.
[2] Just last month, for example, I was called by a former API patient who told me his grievance was simply ignored by API.

406 G Street, Suite 206, Anchorage, Alaska 99501 ~ (907) 274-7686 Phone ~ (907) 274-8493 Fax
http://psychrights.org

Testimony to the Senate Hess Committee-- **February 2, 2009**

Madam Chair, Senate Committee members,

I support the passage of Sen. Bill 66, which will improve the present psychiatric patient grievance procedure statute AS47.30.847.

As a state, we must protect and guarantee a psychiatric patient's right to file a grievance at the time of their choosing. And above all, a grievance must be fair. The current grievance procedure statute is not fair.

In the state of Maine, the citizens had to sue the state to force the improvement of the psychiatric patient grievance procedure.

In the state of Georgia, within the last couple of years, their legislature stepped in to redo the psychiatric patient grievance procedure statute, after it was shown that Georgia's equivalent of DHSS was not in any legitimate way investigating psychiatric patient complaints. And their DHSS was not keeping statistics of complaints filed by psychiatric patients in facilities. They didn't have a clue.

In the matter of health care, there are a lot of similarities between Alaska, Maine and Georgia. The difference is—they have fixed their grievance procedure statutes and we need to fix ours.

There are now 3 separate grievance procedure guidelines for psychiatric patients in Alaska.

One, grievance procedure statute AS47.30.847 presently only applies to some facilities. It doesn't require that patients receive a written answer to their grievance; there is no due process; there is no appeal process; there is no urgent grievance procedure. Even in-mates in Alaska prisons have an urgent grievance procedure. The present grievance procedure statute has loopholes which allow psychiatric facilities to deny patients a right to file a grievance in a timely manner.

Two, thousands of psychiatric patients must use a Joint Commission for Accreditation of Hospital Organizations (JCAHO) grievance procedure. And that includes some patients civilly committed and those in hospitals for a forced evaluation. --There is no appeal process mandated by JCAHO. There is no urgent grievance procedure. There is no impartial body. Hospitals have 14 days to offer a resolution—the average stay is under 14 days for psychiatric patients.

Three, Behavioral Health's psychiatric patients' grievance procedure requirements for Grantees (4 pages) covers about 50 locations.

Under Behavioral Health guidelines, psychiatric facilities have 5 days to contact a patient after the patient files a grievance. At that point the facility can ask for an open-ended extension. After 35 days, a facility is supposed to forward an unresolved grievance to Behavioral Health for technical assistance. Or the facility can offer a resolution which may deny the patient's request—then the facility does not have to forward the grievance, even if the patient is not satisfied with the resolution.

As of now, the Behavioral Health facilities do not have to offer a written resolution and basically, the facilities have 35 days in which to offer a resolution to a patient.

Sen. Bill 66 will consolidate and improve the present psychiatric grievance procedure guidelines into one statute.

I am asking that you pass Sen. Bill 66 with your support out of the Hess committee.

Thank you,

Dorrance Collins
3240 Penland Pkwy, Sp. 35
Anchorage, AK. 99508

(907) 929-0532

Dorrance Collins

Testimony to Senate Hess Committee **February 2, 09**

Madam Chair, Senate Committee members,

I support the passage of Senate Bill 66.

There is a long applaudable history of improving psychiatric patient rights and care. But we must recognize that we should continue.

In the early 80's the legislature outlawed using corporal punishment on psychiatric patients. It was also written into the rules that psychiatric facilities can no longer experiment on patients. In the 70's and 80's, AS47.30.840 finally granted 11 basic rights to psychiatric patients. About the same time, new rules were put into place that required the psychiatric facilities to include the patient when developing a treatment plan. Prior to that passage, states and facilities would just tell the patient what the treatment was going to be.

In 2008, Sen. Bill 8 was signed into law. It provided that psychiatric patients with trauma in their background would be included in the conversation of which gender staff would provide them their intimate care.

There has never been a shortage of individuals who will testify against patient rights improvements: Even policies that increase quality of care and increase the opportunity for recovery and reduce unnecessary trauma.

In closing, we must revise the grievance procedure statute AS47.30.847 and make it accessible to all patients. We must also see to it that the due process is fair.

Passing a good grievance procedure statute will not only protect psychiatric patients, without costing any more money, it will also require psychiatric facilities to improve.

I am asking for support in the passing of Sen. Bill 66.

Faith Myers
3240 Penland Pkwy, Sp. 35
Anchorage, AK. 99508

(907) 929-0532

Faith Myers

Letters in support of revising/improving psychiatric patient's grievance procedures/statute and in support of a state office/individual to investigate psychiatric patient complaints as per AS47.30.660.

NAMI Anchorage
144 W. 5th Avenue
Anchorage, AK 99501

(907) 272-0227
(phone and fax)

February 17, 2007

Alaska State Legislature
Juneau, Alaska

Re: Request for Amendment to AS 47.30.847
Psychiatric Grievance Procedures

Honorable Senators and Representatives:

NAMI Anchorage provides support, education and advocacy to persons experiencing a mental illness and their families. This letter is about the grievance rights of patients in mental health facilities. Those rights are set out in broad terms in AS 4.30.847. See copy attached.

We have received reports that patients have been unduly burdened by hospital procedures in their efforts to bring grievances. For example, the facility may repeatedly require the patient to confer with members of the very same treatment team that have aggrieved the patient as a pre-condition to filing a formal grievance. It can be traumatizing to a patient to be required to seek redress from the same caregivers with whom the patient has a dispute.

It has also been reported to NAMI that patients are not always being provided a written statement of the grievance procedure upon admission to the facility. The ability of the patient or patient's representative to advocate for themselves requires knowledge of the "what" and "how" of the grievance procedure *prior* to treatment. NAMI believes that self-advocacy is one of the building blocks for real and lasting recovery.

These examples demonstrate that the due process rights of patients can be easily limited or circumvented because the language of AS 47.30.847 is too broad. The statute does not say precisely what the mental health facilities must do, giving them considerable latitude in interpreting the law and developing the grievance procedures as they wish. The statute needs to be amended to state the following specific requirements:

- the written grievance procedure will be provided to the patient at the time of admission.
- the patient's written complaint will be accepted and delivered to the "impartial body" required in subsection (a) without requirement of further consultation with or approval by the treatment team or other precondition.
- the patient will be allowed the assistance of a self-designated representative and will not be limited to a representative as defined by the facility.
- the complaint will be addressed and resolved within specific time frames to be set out in the amended statute.

Additional specific provisions may be required as investigation continues. NAMI Anchorage is prepared to assist in this important revision process as requested. In the meantime, we ask the legislators and the administrators of mental health facilities to bear in mind the trauma that hospitalization by itself causes a patient, on top of the underlying problem resulting in the hospitalization. In such a situation, the balancing of administrative inconvenience with the health and welfare of the patient should weigh in favor of the patient.

Thank you for this opportunity to comment.

NAMI Anchorage

Pat Kouris / by Harbour

Pat Kouris

President, NAMI Anchorage Board of Directors

attachment: AS 47.30.847

cc: Representative Sharon Cissna
James B. Gottstein, Esq.
Faith Myers and Dorrance Collins
David Fleurant, Disability Law Center

PsychRights®
Law Project for
Psychiatric Rights, Inc.

Alaska Legislature
Alaska State Capitol
Juneau, Alaska 99801

January 30, 2006

Re: Psychiatric Rights Legislation

This is to support the proposals by Faith Myers and Dorrance Collins to amend Alaska law to enhance certain rights given to people diagnosed with serious mental illness and held at inpatient facilities.

For example, the wording "patients must be given reasonable opportunity" gives some facilities license to deny patients the rights the statute is intended to ensure. Some facilities turn these rights on their head and make them "privileges." To address this, it is recommended that something like the following be added to AS 47.30.840:

> At no time shall the rights set forth in this chapter be treated as privileges that the recipient must earn by meeting certain standards of behavior.

Of course these rights are meaningless if there is no effective enforcement process. It is therefore suggested that AS 47.30.847 be amended to specify a time limit in which grievances/complaints must be answered and that patients 18 and older have a right to appoint a representative of their choice to help them file and pursue grievances/complaints.[1] Such representatives should have the right to "reasonable access to all living and program areas and to staff involved in the treatment of the patient in order to assist the patient in the protection of his or her rights."

In addition the state Ombudsman or some other state oversight authority should have the right to go into any facility holding people because being diagnosed with mental illness. The Ombudsman's Office is presently excluded from all but state hospitals and would have to he granted a different authority to enter other facilities.

I have known Faith Myers and Dorrance Collins for a number of years and they are absolutely spot on with their suggestions. Alaska citizens deserve the type of consideration Faith and Dorrance are asking for and I urge you to act favorably upon their suggestions.

Yours truly,

James B. (Jim) Gottstein, Esq.

[1] For patients under 18, their guardian would retain that right.

406 G Street, Suite 206, Anchorage, Alaska 99501 ~ (907) 274-7686 Phone ~ (907) 274-9493 Fax

DISABILITY LAW CENTER OF ALASKA

ANCHORAGE
3330 Arctic Boulevard
Suite 103
Anchorage, AK 99503
(907) 565-1002
FAX (907) 565-1000
1-800-478-1234

January 30, 2006

Faith Myers
Dorrance Collins
330 E. 14th Ave., Apt. E
Anchorage, Alaska 99501

Dear Faith and Dorrance:

You have requested a letter of support from the Disability Law Center of Alaska for your effort to revise the grievance rights of psychiatric patients in Alaska. In essence, your proposed revisions seek to ensure that psychiatric patients are afforded basic due process rights when filing a grievance.

The Disability Law Center of Alaska supports your efforts to ensure that psychiatric patients in Alaska are afforded basic due process rights. Your recommendations, including permitting psychiatric patients the right to obtain the assistance of a self-designated representative and establishing specific time frames for certain actions, are very appropriate means of assuring that rights can both be exercised and are protected.

Please let me know if there is anything we can do to assist you in this effort.

Sincerely,

DISABILITY LAW CENTER OF ALASKA

David C. Fleurant
Executive Director

MEMBER OF THE NATIONAL ASSOCIATION OF PROTECTION & ADVOCACY SYSTEMS

DISABILITY LAW CENTER OF ALASKA

ANCHORAGE
3330 Arctic Boulevard
Suite 103
Anchorage, AK 99503
(907) 565-1002
FAX (907) 565-1000
1-800-478-1234
www.dlcak.org

January 29, 2007

Andrea Schmook, Chair
Alaska Mental Health Board
431 N. Franklin Street, Suite 200
Juneau, Alaska 99801-1121

Re: Recommended Changes to API Grievance Policies and Unit Manuals

Dear Ms. Schmook:

On behalf of our agency, I am writing in support of the recommended changes to API's Grievance/Complaint policies, procedures, and practices, as well as recommended changes to API's unit manuals, that will be offered to you and the other AMHB members during this week's meeting.

We have actively participated in the development of these recommendations, as part of the API Governing Body's sub-committee, formed to address these issues. We firmly believe these changes will benefit those who receive care and treatment at API, and assist the hospital in its efforts to develop and maintain a more person-centered, recovery model of treatment. So too, these changes support and lend themselves to one of our agency's fundamental beliefs and mission – to protect and promote individual rights, dignity and ability to self-advocate.

We hope you and the other board members will add your support and any additional recommendations you may have, as these recommendations make their way to API's Governing Body for final review and consideration.

Sincerely,

THE DISABILITY LAW CENTER OF ALASKA

David C. Fleurant
Executive Director

MEMBER OF THE NATIONAL ASSOCIATION OF PROTECTION & ADVOCACY SYSTEMS

Cc: API Grievance Committee Members

3745 Community Park Loop, Suite 200
Anchorage, AK 99508
Main line: (907) 269-7960
FAX: (907) 269-7966

The Trust

The Alaska Mental Health Trust Authority

To Whom It May Concern:

Subject: Support of legislation and regulations to ensure prompt and appropriate handling of grievances that are held in inpatient facilities in Alaska.

At a full Board of Trustees meeting on September 7, 2007 the Board of Trustees of the Alaska Mental Health Trust Authority approved the following Statement of Support as follows:

The Board of Trustees of the Alaska Mental Health Trust Authority are in support of the Department of Health and Social Services and the Alaska State Legislature working with Alaska mental health advocacy groups and individuals to ensure the passage of legislation and the implementation of regulations that improves the prompt and appropriate handling of grievances/complaints from people diagnosed with serious mental illness that are held in inpatient facilities in Alaska. "Prompt and appropriate handling" at minimum, is defined by the attributes listed below.

1. *Written grievance procedures will be provided to the patient at time of admission.*
2. *A patient's written complaint will be provided to an "impartial body" without further preconditions.*
3. *The patient will be allowed an array of assistance and not be limited to utilizing representatives solely defined by the facility.*
4. *Complaints shall be addressed and resolved within specific time frames to be set out in the amended statute.*

Sincerely,

Jeff Jessee
Chief Executive Officer

STATE OF ALASKA

Sarah Palin, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

Advisory Board on Alcoholism and Drug Abuse
Alaska Mental Health Board

P.O. BOX 110608
JUNEAU, AK 99811-0608
PHONE: (907) 465-8920
FAX: 465-4410

February 1, 2007

At the January 2007 Juneau meeting of the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board a motion was made to support the revision of AS 47.30.847 and passed unanimously.

Kathryn Craft, Interim Executive Director
ABADA & AMHB

August 11th, '08

News Release

The state of Georgia recently established an Ombudsman's Office that will exclusively handle complaints by psychiatric patients. (The psychiatric patient Ombudsman's Office is modeled after the long-term-care Ombudsman's Office.)

The new Ombudsman's Office was created after a series of articles by the Atlanta Journal Constitution newspaper in which it was shown that the grievance procedure system for psychiatric patients in Georgia was ineffective and unfair. The series of articles showed that oversight by the Dept. of Human Resources (equivalent to our DHSS) was not protecting patients. DHR oversight was like the fox protecting the henhouse, according to a state official.

The new Georgia psychiatric patient Ombudsman's Office reports directly to the Governor's office.

Alaska's psychiatric patient grievance procedure system, both Behavioral Health grantee grievance procedure requirements and the state statute, is unfair to psychiatric patients.

Alaska's DHSS doesn't keep statistics of the number and type of grievances filed by psychiatric patients / clients. DHSS does not maintain an office to investigate psychiatric patient complaints, even though they are required to do so by statute. DHSS does not give their phone number to all psychiatric patients and inform patients that DHSS is required to investigate complaints. DHSS cannot delegate its responsibility to investigate psychiatric patient complaints to a non-state facility or agency.

For more information contact :

Mental Health Advocates
Faith Myers / Dorrance Collins
3240 Penland Pkwy, Sp.35
Anchorage, AK. 99508

(907) 929-0532

Faith Myers
Dorrance Collins

Cc: Open Letter

Anchorage Daily News

AP Wire Service

DHSS ---- Governor Sarah Palin

Psychiatric patients are one of the most vulnerable groups in our society. Many persons that are in acute care facilities for forced evaluations have dementia.

There must be a state office that can respond to a psychiatric patient's complaint without needing 2 to 4 weeks and writing to the Medicaid / Medicare Office in Seattle.

State of Maine, State of Georgia, etc., have established offices that can immediately respond to a psychiatric patient's complaint.

Faith Myers

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
CERTIFICATION AND LICENSING

Sarah Palin, Governor

619 E. Ship Creek Avenue Suite 232
Anchorage, AK 99501-1667
Telephone: (907) 334-2483
Fax: (907) 561-3011

January 2, 2007

Dorrance Collins
3240 Penland Pkwy, Space 35
Anchorage, AK 99508

Dear Mr. Collins:

This letter is in response to the complaint our office received from you on 11/29/06 regarding your dissatisfaction with the current grievance procedure at Alaska Psychiatric Institute. In addition, you stated that several hospitals in the state of Alaska refused to release their grievance policy to you.

In order for our office to perform an on-site investigation at a facility such as Alaska Psychiatric Institute we must first get approval from the Centers for Medicare and Medicaid Services (CMS) Regional Office in Seattle. Therefore, the documentation you provided to our office in regard to your concerns was forwarded to that office. Upon review by CMS, it was determined that there were no regulatory compliance issues identified.

In addition, you indicated in your letter that you feel the grievance procedure statute AS 47.30.847 should be changed. Unfortunately, our office is not able to assist you with this change. You may pursue that change through the State of Alaska Legislature. Alaska Psychiatric Institute administrative staff should be able to provide you with the name and contact information for their Legislative Representative or you may contact the State Legislative Department directly at (907) 465-4648.

Thank you for notifying us of your concerns. If you have any further questions you may contact me or Kathy Thomas at 334-2483.

Sincerely,
CERTIFICATION AND LICENSING

Bernadean Anselm
Program Manager

AS47.30.847—Psychiatric Patient Grievance Procedure was expressly written to protect psychiatric patients.

The Department of Health and Social Services (DHSS) has stated that the statute 47.30.847 does not apply to the new hybrid medical hospitals that contain psychiatric units.

Providence Hospital treats approximately 4000 psychiatric patients a year, including forced psychiatric evaluations. And there are numerous other hospitals around the state that treat patients/ do forced psychiatric evaluations which can last 3 to 7 days because of holidays, weekends, etc. during which the patient is in a locked facility. The present statute AS47.30.847 does not apply to many of those hospitals.

These hospitals use Joint Commission for Accreditation of Hospital Organizations (JCAHO) grievance procedure / oversight. Alaska may be the only or one of the few states that civilly commits, does forced evaluations on citizens and the state of Alaska does not write special rules to protect those patients.

Faith Myers

Reference:

"Recovery or growth begins with being able to effectively complain."

(Whether it be) "psychiatric patients—children—husband or wife—etc"

A 2008 survey of Alaska Psychiatric Institute's patients shows 21% of the patients were afraid to complain or file a grievance. Nineteen percent didn't answer the question with the possibility they were afraid to answer.

The patient's voice must be encouraged and allowed to come forward to facilitate true recovery.

Faith Myers / Dorrance Collins
(907) 929-0532

March 30 '09

PLEASE GIVE / SEND

TO: Tom Obermeyer

Attached is the testimony we will give Wednesday, April 1, 09 on SB 66.

We timed how long it will take – 5 minutes – Would you talk to Sen. Bettye Davis and try to get us that much time.

Faith Myers
Dorrance Collins

FROM: MENTAL HEALTH ADVOCATES, Faith Myers / Dorrance Collins, 3240 Penland Pkwy, Sp. 35, Anchorage, AK. 99508

(907) 929-0532

Testimony to the Senate HESS Committee, April 1, '09

Madam Chair, Senate HESS Committee members,

My name is Dorrance Collins. I support the passage of SB 66.

In the state of Maine, citizens sued their equivalent of the Department of Health and Social Services (DHSS) to force improvements in the state's psychiatric patient grievance procedures.

In the state of Georgia, the legislature in '08 stepped in and revised the grievance procedure statute after it was shown that Georgia's equivalent of DHSS was not properly investigating psychiatric patient's complaints, not writing fair rules for the grievance procedures and also not keeping statistics of the number of complaints filed by psychiatric patients.

I have in front of me a 3 page report from Alaska Psychiatric Institute (API) which is managed by DHSS. It is dated 2006. It shows 256 complaints were filed by patients in a 12 month period. Not one was considered a grievance. Not one patient had their grievance heard in front of an impartial body. Not one person received a written response, which is a Federal requirement.

The loopholes and inadequacies in the current grievance procedure statute AS47.30.847 allowed API, which is managed by DHSS, to treat all patient complaints in an informal manner; allowing API to by-pass regulations.

Just some of the patient complaints—
--54 were concerning respect and dignity,
--3 sexual abuse allegations,
--11 complaints against doctors
--17 complaints about medication
--18 complaints concerning safety,
--4 complaints concerning medical treatment, etc.

Now, under pressure, API has made some improvements. But that still leaves approximately 50 other psychiatric patient treatment locations and as of now there is nothing to stop API from going back to their old habits.

Some state officials are going to say that hospitals with psychiatric units are governed by Joint Commission for the Accreditation of Hospital Organizations (JCAHO) rules and thus there is no need to expand the psychiatric patient grievance procedure statute to cover places like Providence; which handles approximately 4000 psychiatric patients a year; some of those patients are there for forced evaluation. And then there are Fairbanks Memorial and Bartlett Juneau Hospitals, which can do civil commitments. And also there are 50 or so grantee facilities where some psychiatric patients are court ordered or court required to receive treatment.

I have in front of me a letter from Joint Commission for the Accreditation of Hospital Organizations (JCAHO) Quality Control. I'll read one sentence.

"Please be aware our current Public Information Policy precludes us from providing you (the patient) with the specific results of any complaint investigation."

A patient can file a complaint with JCAHO but cannot find out the results and that is not good enough—patients need to know the results of their grievance and appeals and that can only be done with a state appeal process.

I have testified in front of JCAHO. I've also spoken with Medicaid and Medicare Regional office in the state of Washington. Those organizations set some minimum standards for grievance procedures but they fully expect every state to develop their own comprehensive grievance procedure statute and Alaska has not done it to this day.

I also have in front of me—two five page reports from the state Ombudsman's Office. They are critical of DHSS for not keeping statistics of the number of complaints filed by psychiatric patients. In a return letter, DHSS stated to the Ombudsman's Office that they do not want to keep statistics. SB 66 will require DHSS to do so.

In the same Ombudsman's reports, it also came to light that DHSS has not investigated a psychiatric patient complaint in a number of years even though they are required to do so by AS47.30.660. DHSS cannot or should not delegate its responsibility of investigating a patient's complaint to non-state entities, but that is exactly what DHSS is doing at this time.

In closing, there is a nation-wide trend of revising and up-dating psychiatric patient's grievance procedure statutes, making them uniform to cover all psychiatric patients.

I am asking that you pass SB 66. Thank you,

Dorrance Collins
3240 Penland Pkwy, Sp. 35
Anchorage, AK. 99508

(907) 929-0532

Dorrance Collins

Cc: Open Letter

Testimony to Senate HESS Committee **April 1, '09**

Madam Chair, Senate Committee members,

My name is Faith Myers. I support the passage of SB 66 as written and amended.

The current psychiatric patient grievance procedure statute, AS47.30.847, is inadequately framed and does not protect psychiatric patients and their rights. It needs to be revised.

As a former psychiatric patient, I have been in acute-care psychiatric facilities, evaluation units and I have also received treatment as an out-patient. As an advocate, I've talked to former psychiatric patients and when producing our newsletter, which we mailed to the legislature this year, we conducted a survey of former patients. That survey is in the newsletter. The survey shows there is dissatisfaction with current psychiatric patient grievance procedures.

Ten different categories of clients receiving services from the Department of Health and Social Services (DHSS) , who are not satisfied, can file an appeal with the Department or an Administrative law judge.

Individuals in 10 prisons or jails can file an appeal with the Department of Corrections (DOC).

As of now, all psychiatric patients do not have a clear path to filing an appeal with the state or DHSS.

Alaska may be the only state not letting psychiatric patients file an appeal to a higher level, past the facility they are receiving services from. Alaska must give psychiatric patients the right to file an appeal either with DHSS or an Administrative law judge. Either one would be acceptable.

The loopholes in the current statute AS47.30.847 allow psychiatric facilities to deny patients their right to file a grievance at the time of their choosing.

Here is what is important to a person like myself, who has a mental illness, who is in a psychiatric institution or in a psychiatric E.R. or as an outpatient consumer.

--To be able to receive a written copy of the grievance procedure and associated rules.

--To get a written answer or resolution to a complaint or formal grievance.

--To be able to file a grievance when I choose, instead of having to go through the facility's informal complaint resolution process first.

(Con.)

–To receive an answer to my grievance or complaint in a timely manner, before the complaint becomes moot because I am discharged.

–To be able to appeal to a higher level of authority, hopefully impartial, when I am dissatisfied with the facility's resolution of a grievance even to appeal to DHSS.

--To have a method of urgent grievance reporting that will be looked at by more than one person within 24 hours when I have an emergency grievance.

These are rights that I or any other psychiatric patient or mental health consumer need and would benefit from and these are all rights given by SB 66 to protect the psychiatric patient.

In closing, I am asking you to support the passing of SB66.
Thank you,

Faith Myers
3240 Penland Pkwy, Sp. 35
Anchorage, AK. 99508

(907) 929-0532

Faith Myers

Cc: Open Letter

March 27, '09

PLEASE GIVE / SEND

TO:

Attached is 3 pages outlining how an individual can appeal to DHSS (10 different categories).

In fact, it should be just as simple for psychiatric patients to file for a fair hearing concerning their grievances.

Faith Myers
Dorrance Collins

FROM: MENTAL HEALTH ADVOCATES, Faith Myers / Dorrance Collins, 3240 Penland Pkwy, Sp. 35, Anchorage, AK. 99508

(907) 929-0532

State of Alaska
Department of health and Social Services
Division of Public Assistance

FAIR HEARING REQUEST

This form may be filled out by a client, his or her authorized representative, or by any Division of Public Assistance employee. **COMPLETION OF THIS FORM IS NOT REQUIRED IN ORDER TO OBTAIN A FAIR HEARING.** The Division will grant a hearing to anyone who asks for one either in writing, by phone, or in person.

Please Print

Client Name: _____

Mailing Address: _____

Telephone Number: _____ **Case Number if Known:** _____

Check the program(s) you want a fair hearing on:

- [ ] Food Stamps
- [ ] Alaska Temporary Assistance Program
- [ ] Old Age Assistance
- [ ] Aid to the Blind
- [ ] Aid to the Disabled
- [ ] Interim Assistance
- [ ] General Relief Medical
- [ ] General Relief Assistance
- [ ] Medicaid
- [ ] Energy Assistance

Briefly state why you want a hearing: _____

_____

_____

_____

Please check one box to indicate whether you want your benefits continued without change:

[ ] **Continue my benefits without making the change proposed on the notice until the hearing decision is made or my food stamp certification period ends. I understand that if the hearing officer finds that the state's action was correct, I will have to pay back any extra benefits I receive while waiting for the hearing decision.**

[ ] **Go ahead and take the action proposed on the notice. I will accept the amount stated in the notice, knowing that if the hearing officer finds that the state's action was wrong, I will be paid for any benefits wrongly denied me.**

_____ _____
Signature of Client or Representative **DPA Employee Signature**

_____ _____
Date **Date**

GEN 85 (06-3641) REV. 9/97

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE

ALL ABOUT FAIR HEARINGS

WHAT IS A FAIR HEARING?

A fair hearing provides the opportunity for you to have your case reviewed by a higher authority whenever you disagree with action taken that reduces, suspends, denies or ends your benefits. A fair hearing can be requested for any Division program.

WHO CAN REQUEST A FAIR HEARING?

You, any household member, your authorized representative, or a responsible person acting on your behalf may request a fair hearing. In many cases the Division must give you at least 10 days advance written notice for an action to reduce, to suspend, to deny, or to end your benefits. In many cases the agency does not give 10 days advance written notice because only "adequate" notice is required, not "timely" notice. This notice must include the reasons for the proposed actions and explain your right to a fair hearing and the situations under which benefits may be continued when a fair hearing is requested.

HOW MUCH TIME DO YOU HAVE TO MAKE A REQUEST FOR A FAIR HEARING?

You may request a Food Stamp fair hearing up to 90 day from the effective date of the proposed action. For all other programs, you may request a fair hearing up to 30 days from the date of the notice of action.

HOW DO YOU REQUEST A FAIR HEARING?

You, any household member, your authorized representative, or a responsible person acting on your behalf may make a request for a fair hearing in person, on the telephone, or in writing. Written requests may be hand-delivered or mailed to any Division of Public Assistance office.

WHEN CAN THE DIVISION REFUSE TO HOLD A FAIR HEARING OR DISMISS A SCHEDULED FAIR HEARING?

The division can refuse to hold a fair hearing or to dismiss a scheduled fair hearing when:

1) The request is received after the time allowed for requesting a fair hearing has expired; or

2) The request is withdrawn in writing by you or your representative; or

3) You or your representative fail, without a good reason, to appear at the fair hearing; or

4) The sole issue of the request is one of federal or state law which requires and automatic benefit reduction for classes of recipients; or

5) The issue you are presenting is not one over which the agency has jurisdiction.

WHAT HAPPENS AFTER THE DIVISION RECEIVES YOUR REQUEST FOR A FAIR HEARING?

After the request of a fair hearing is received, the Division office will send you a written notice of the place and time of the fair hearing and the name and phone number to notify if you or your representative cannot attend the fair hearing. This notice will be sent to you at least 10 days before the fair hearing so that you have time to prepare.

CAN YOU POSTPONE THE SCHEDULED FAIR HEARING?

You have the right to request and receive one postponement of the scheduled fair hearing, not to exceed 30 days.

WHAT DOES THE FAIR HEARING OFFICER DO?

The Fair Hearing officer is responsible for conducting the fair hearing and notifying you of the decision in writing. The written letter of the decision must include the decision, the reason for that decision, and the laws or regulations supporting the decision. In addition, the letter includes a statement about your rights and how to appeal the decision.

HOW LONG MUST YOU WAIT FOR A DECISION ON YOUR FAIR HEARING?

The Division must hold the fair hearing, notify you of the decision, allow you 15 days to appeal the decision to the Division Director and notify you of the appeal decision:

1) Within 60 days from the date the Division receives a Food Stamp Program fair hearing request; or

2) Within 90 days from the date the Division receives a fair hearing request for any other public assistance programs.

If the hearing is decided in your favor, the Division has another 10 days to make a required change in your benefits.

The deadlines for the hearing decision will be extended for the same number of days as the fair hearing was postponed, or otherwise delayed at your request.

WHAT ARE YOUR RIGHTS BEFORE AND DURING THE FAIR HEARING?

You have the right to all the following before and during the fair hearing:

1) Review your case file.

2) Obtain a copy of all documents and records that will be used at the fair hearing. This includes appropriate program manual sections relied on by Division employees to take the action with which you disagree. This applies only to case materials which are related to your timely request for a fair hearing.

3) Present the case yourself or be represented by an attorney, paralegal, friend, relative or any other person who may be helpful in presenting your case.

4) Bring witnesses and submit evidence to establish pertinent facts and circumstances.

5) Establish facts and arguments having to do with the issue without undue interference.

6) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

WHAT IS A PRE-HEARING CONFERENCE?

The pre-hearing conference is a voluntary meeting between you or your representative and a representative of the Division to discuss your concerns about the action taken on your case. Sometimes this discussion will help you understand the reasons for the action or reveal any agency mistakes and may make the fair hearing unnecessary. The pre-hearing conference cannot replace or cancel the scheduled fair hearing. However, if your concerns are resolved at the conference, you may decide to withdraw the request for a fair hearing.

IS THERE ANY PLACE WHICH PROVIDES FREE REPRESENTATION AT THE FAIR HEARING?

You may be eligible for free legal representation from Alaska Legal Services Corporation which has offices throughout the state. Such representation is not required, but may be to your advantage. Your caseworker can give you the phone number and address of you local Alaska Legal Services office, or you may refer to your telephone book for the phone number and address.

HOW FORMAL IS THE FAIR HEARING?

The fair hearing is NOT a trial. It will be conducted in an informal manner and will be attended by the Fair Hearing Officer, a representative for the Division, and by you or a member of your household and/or your representative. You do not have to be familiar with the rules of order. Every effort will be made to arrive at the facts in a way which makes you feel comfortable. The fair hearing will be scheduled in a place which is easily accessible to you and your representative. The fair hearing may be conducted by telephone.

DISABILITY LAW CENTER OF ALASKA

ANCHORAGE
3330 Arctic Boulevard
Suite 103
Anchorage, AK 99503
(907) 565-1002
FAX (907) 565-1000
1-800-478-1234
www.dlcak.org

April 1, 2009

Dear Senate Health and Social Service Committee Member:

I am writing you today regarding Senate Bill 66 – the mental health patient grievance procedure bill that is scheduled to be heard in the Health and Social Services committee this afternoon.

Broadly speaking, we support the concept of a better defined and more uniform grievance process. I think it safe to say that Alaska lacks any procedurally coherent process at this time. In checking with other states that have a more defined process, the genesis for their laws arose after some tragic event. I do not believe that we should wait for a tragic event to improve our grievance process. That said, SB 66 as currently written is not the vehicle for achieving the goal of a uniform grievance process.

There are several areas of concern regarding SB 66. These concerns can be organized into two general categories: concerns regarding definitions and concerns regarding the grievance procedure itself. In addition, there are several areas in which SB 66, as written, is overly confusing and unclear.

Definitions:
First, in section (b)(8), there is concern with the definition of an urgent grievance which as written allows for an urgent level of review to be provided when a grievance alleges sexual abuse, physical abuse or a denial of lifesaving treatment or procedures, lifesaving medications or basic care or human rights, as defined by the commissioner. This urgent level of review is to be provided within 24 hours after receipt.

Sexual and physical abuse are assaults and should be addressed through appropriate authorities (for example law enforcement or Adult Protective Services) and not the grievance process. If a sexual assault occurred, the grievance reporting the assault could go unprocessed for up to 24 hours. This amount of time could result in the loss of physical evidence, witnesses and other information that is critical for law enforcement or other appropriate agencies. That is not to say that an individual who experiences an assault should not be entitled to file a grievance, however, an urgent grievance is not the most appropriate avenue for relief. In addition, SB 66 does not indicate whether once a grievance is received complaining of sexual or physical abuse, does this trigger mandatory reporting under AS 47.24.010? If so, does the agency who receives the report take responsibility for the grievance or is the facility required to continue to process it despite the involvement of a potentially more appropriate agency?

There is also some concern with the very broad categories that are included in the urgent grievance process. For example, "basic care or human rights as defined by the commissioner" is so broad, that it could encompass most if not all of the

MEMBER OF THE NATIONAL DISABILITY RIGHTS NETWORK

grievances that an individual may file. It is questionable whether these categories of issues necessarily require an urgent grievance response, or are more appropriately addressed by another agency or process. Furthermore, leaving "basic care" and "human rights" undefined and at the discretion of the commissioner is questionable. These terms have much for far-reaching impact than just the grievance procedure at issue here.

In addition it would appear that a grievance is too broadly defined, including not only rights violations, but 'suggestions' and 'concerns'. We feel that such a broad use of the grievance process would dilute the efficacy of the system, and be unduly burdensome to the facility if they are required to process, at several levels, all 'suggestions' and 'concerns' they receive from patients. Perhaps a less exhaustive process could be developed to deal with this type of complaint that would not require the expenditure of resources that could be better used to process grievances involving violations of rights.

In section (j)(1) the definition of facility includes a "clinic in which mental health patients receive . . . treatment . . ." This is far broader than the scope of the rest of the bill which applies to "a public or private evaluation facility or unit or designated treatment facility or unit under AS 41.30.660 – 47.30.915." This inconsistency will cause confusion among both patients who will not know what facilities the grievance procedure applies to, and to facilities and providers who will be unsure what grievance procedure is required.

Grievance Procedure:

SB 66 as written does not outline the appeal rights for an urgent grievance. The CEO or commissioner makes a decision within 24 hours, but there is no indication whether that decision is a first level or second level review or what step in the process comes next. If it goes next to the Office of Hearings and Appeals, (OHA), OHA has 30 days to issue a recommended decision which is not very timely for an urgent appeal. If an urgent grievance goes through the three step process, in the final step, the recommended decision goes back to the commissioner who may be the individual that issued the decision in the first place. Or is the commissioner's decision on an urgent grievance the final administrative action for purposes of superior court jurisdiction?

There concern that the Office of Hearings and Appeals (OHA), who would be responsible for making findings and recommendations to the commissioner in the third level of the process has no jurisdiction over private facilities, raising concern that a level three appeal may not be available to residents of all facilities. In addition there is no guidance in the bill as to what records and information must be provided to OHA and the hearing officer when they make their findings.

In section (d), facilities would be required to designate an advocate to assist patients with grievances "or pursuing other redress for complaints concerning care, treatment and rights." This provision could be read to require the advocate required to assist the patient in filing complaints with other appropriate agencies or assist them in obtaining private counsel to pursue a lawsuit. The responsibilities assigned to this advocate seem a bit open-ended and goes beyond the intent of the grievance statute.

There are also several provisions in SB 66 which are confusing and unclear. For example:

(b)(5)(B) – "if the level-two review results in a finding of no adverse effect, no additional review is necessary . . ." Does this mean that a facility is not required to provide further review when they make a determine of no adverse effect? What does a determination of no adverse effect mean? "the written response must include a list of options . . ." What options are there beyond proceeding to a level three review? Are there additional options a patient might pursue beyond the scope of the grievance procedure?

(f) – burden of proof is on facility to prove compliance with "applicable laws and procedures." What if the grievance is about a "suggestion" or "concern" and the facility is in compliance with all applicable laws and procedures – what burden of proof is required if a facility declines to adopt a suggestion when the facility is in full compliance?

(g) – the department shall "intervene in all level three appeals." The department is making the decision on a level three appeal, so how can it intervene? When is the department required to intervene in lower level decisions? What type of intervention is appropriate or required?

We appreciate the Committee's attention to this issue, however, given the number of concerns Disability Law Center has it cannot support SB 66 as written. A member of DLC staff will be made available to testify by telephone at the hearing this afternoon. If you have any questions or concerns regarding DLC's position or the issues raised in this letter please contact me.

Sincerely,

Holly Johannknecht

Holly Johannknecht
Staff Attorney

To Senate H&SS Committee
From Donald Roberts (Kodiak, AK)
RE: SB66 Mental Health Grievance Procedures

① I support SB66 and urge its passage.

② Concerns
   ⓐ treating grievances as clinical procedures.
      - insurance companies are billed or when grievant is billed
      - records follow the grievant when records are transferred - patient is then ~~treated~~ perceived as troublesome.
   ⓑ ~~selection~~ designation of representative
      representative should be a person of the grievants choosing ~~or~~ - should not be limited to persons who are acceptable or approved by staff at treatment facility

264 Lilly Dr / Apt C2
Kodiak, AK

Sen. Bettye Davis,
And HESS Committee members,

April 2, '09

Re: Sen. Bill 66

Disability Law Center (DLC) gave us a copy of their letter concerning SB 66 (dated April 1, '09). In their letter they state, "I do not believe that we should wait for a tragic event to improve our grievance procedure." (AS47.30.847)

DLC also offered some criticism of SB66.

Basically SB 66 is good/ fair. If there is a technical problem with SB 66—Who should fix it? "We believe it should be the Senate and the House in committee."

DHSS should not be the author of SB 66. They are Providers. Also non-profits receiving grant money to investigate patient complaints or just receiving grant money from DHSS (some) may have a financial interest in killing SB 66 or rewriting it.

Thank you,

Cc: Open Letter

Faith Myers
Dorrance Collins

FROM: MENTAL HEALTH ADVOCATES, Faith Myers / Dorrance Collins, 3240 Penland Pkwy, Sp. 35, Anchorage, AK. 99508

(907) 929-0532

April 1, 2009

The Honorable Bettye Davis
Alaska State Senator
Alaska Senate
Juneau, Alaska

Dear Senator Davis:

First of all, I would like to personally thank you for the work that you do on behalf of people with mental illness and for the work you have done on SB 66 and CS for Senate Bill No. 66.

I waited on the telephone today to testify to the Senate HSS Committee on these two bills. In case I don't have an opportunity to call-in again, I wanted to write this letter to you regarding the testimony I wanted to present today.

I am the Alaska Mental Health Board representative on the API Advisory Council and I have been a patient in API. Additionally, I had a contract with API in 2003 and 2004 to establish the Office of Consumer and Family Affairs. One of the tasks of this office was to take complaints from patients in API. It was during this time that I reviewed grievance policies and procedures from other state hospitals around the country and wrote a draft grievance policy and procedure for review at API. The policy went through many reviews and rewrites, as well as review by the API Advisory Board. The API Advisory Board established a committee to make recommendations to the hospital management on the developing policy. Mental health consumers were included on the committee who were not on the Advisory Board at the time.

The Alaska Mental Health Board is very committed to support protection of patients' rights. However, API serves people who are civilly committed, or under an ex parte, and patients who are involuntarily medicated. This requires that there are extra safeguards in place for the patient population in API. It requires a higher standard than it does in community agency settings and other hospitals where people go voluntarily.

When I worked in Illinois as the Director for the Office of Consumer and Family Affairs for the State of Illinois Department of Health and Social Services, Division of Mental Health, we had 11 state hospitals and 210 community agencies. Each state hospital's grievance procedure was very different from the other hospitals, depending on whether it was rural or in the city of Chicago, or depending on the culture of the hospital and even the ethnicity of the patients being served so grievance policies and procedures needed to be different but with some similarities. The grievance policies and procedures were different too in the community agencies, and this also depended on even the size of the agency—some were small, some were large.

Currently, SB66 and CS for Senate Bill 66 requirements don't allow for flexibility so that providers can have easy to understand and accessible policies and procedures for their specific clients such as, large native populations where the policy needs to be culturally sensitive. I support the need for the Alaska Mental Health Board to work with the bills as they are written to allow for more flexibility rather than everyone meeting the high standards that are set for specific reasons that only apply to API. Not only

does API's Quality Improvement program track data from the grievances, but also data collected about the outcomes of the MHSIP surveys and data gathered on the reduction of the use of restraints and seclusion. Other hospitals and community agencies aren't required to track this data as it only applies to state hospitals so the requirements for everyone other than API need to be less rigid, more flexible and accessible, with easy to follow procedures for their clients.

While I support the intent to protect patients' rights through grievance policies and procedures, I ask that you consider allowing the Alaska Mental Health Board staff time to review and amend the bills that are being considered at this time. Once again, I want to thank you for all the work that you do on behalf of Alaska citizens with mental illness.

Sincerely,

Andrea Schmook
Member of the Alaska Mental Health Board

SB 68

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 7
Juneau, AK 99801-1182
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Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Date: 4/16/2009

To: Senator Stedman, Co-Chair
House Finance Committee

From: Senator Bettye Davis

Re: SB 68 "An Act relating to the voting rights of felons"

This is a request that you schedule a hearing on SB 68 at the earliest possible date.

Please find attached a copy of the bill, a sponsor statement, fiscal notes, and a sectional analysis. Your attention to this request would be appreciated. Thank you.

April 14, 2009

AMERICAN CIVIL LIBERTIES UNION OF ALASKA
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(907) 258-0044
(907) 258-0288 (fax)
WWW.AKCLU.ORG

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The Honorable Bettye Davis
Senator, Alaska State Senate
State Capitol, Room 30
Juneau, AK 99801-1182
Via fax 907-465-3756 and email: Senator_Bettye_Davis@legis.state.ak.us

*Re: **ACLU of Alaska – Support of SB 68***

Dear Senator Davis:

On behalf of the American Civil Liberties Union (ACLU) of Alaska and our thousands of members and activists throughout the state, as well as our Board of Directors and Staff, I am writing to express our **strong support of Senate Bill 68** seeking to enfranchise formerly incarcerated Alaskans.

We are grateful for your work in sponsoring this bill, and your historic commitment to the most fundamental of constitutional rights – the right to vote.

Thanks also to your office for responding to our inquiries regarding the details of this legislation. We appreciate the hard work of your staff in seeking to ensure that SB 68 will reduce unnecessary impediments to enfranchisement. As you know, those who participate in voting are less likely to re-offend, and reducing barriers to voting contributes to the public welfare of all Alaskans.

The ACLU of Alaska is pleased to support SB 68 and hopes to work with you towards quick passage of this legislation.

Please feel free to contact us at (907) 258-0044, or jmittman@akclu.org, if you require any additional information.

Sincerely,

Jeffrey A. Mittman
Executive Director

Sen. Bettye Davis

From: ACLU [aclu@aclu.org] on behalf of Garrett Ennis [alaskancomfort@hotmail.com]
Sent: Friday, April 10, 2009 10:27 PM
To: Sen. Bettye Davis
Subject: Ensure all Alaskans have the right to vote

Apr 11, 2009

RECEIVED
APR 13 2009

Senator Bettye Davis
120 4th Street
Juneau, AK 99801-1182

Dear Senator Davis,

As your constituent, I ask you to support SB 68, which helps keep all Alaskans safer, by ensuring that ex-offenders have the right to vote and function as responsible citizens and taxpayers.

Restricting voting? rights does not prevent crime or provide compensation to victims. Research shows that people who vote are much less likely to be re-arrested. That is why the American Probation and Parole Association, the National Black Police Association, the American Bar Association and others support full voting rights when former offenders return to their communities.

Senate Bill 68 encourages the behaviors we all wish to see and that society ought to encourage a commitment to community and participation in our democracy.

Thank you for supporting SB 68.

Sincerely,

Mr. Garrett Ennis
5432 E Northern Lights Blvd # 329
Anchorage, AK 99508-4713

AS 15.60.010 (9)

(8) "federal election" means a general, special, or primary election held solely or in part for the purpose of selecting, nominating or electing a candidate for the office of President, Vice-President, presidential elector, United States senator, or United States representative;

(9) "felony involving moral turpitude" includes those crimes that are immoral or wrong in themselves such as murder, manslaughter, assault, sexual assault, sexual abuse of a minor, unlawful exploitation of a minor, robbery, extortion, coercion, kidnapping, incest, arson, burglary, theft, forgery, criminal possession of a forgery device, offering a false instrument for recording, scheme to defraud, falsifying business records, commercial bribe receiving, commercial bribery, bribery, receiving a bribe, perjury, perjury by inconsistent statements, endangering the welfare of a minor, escape, promoting contraband, interference with official proceedings, receiving a bribe by a witness or a juror, jury tampering, misconduct by a juror, tampering with physical evidence, hindering prosecution, terroristic threatening, riot, criminal possession of explosives, unlawful furnishing of explosives, promoting prostitution, criminal mischief, misconduct involving a controlled substance or an imitation controlled substance, permitting an escape, promoting gambling, possession of gambling records, distribution of child pornography, and possession of child pornography;

(10) "general election" means the election held on the Tuesday after the first Monday in November of even-numbered years;

(11) "hand-counted ballot" means a ballot designated to be counted by hand in precincts where precinct tabulators are not available;

(12) "house district" means one of the districts described in art. VI, sec. 1, Constitution of the State of Alaska;

(13) "judicial district" means one of the districts defined in AS 22.10.010;

(14) "lieutenant governor" includes an appointed lieutenant governor, governor, or acting governor if a vacancy has occurred in the office of lieutenant governor or governor;

(15) "limited political party" means a political group which organizes for the purpose of selecting candidates for electors for President and Vice-President;

(16) "local election" means a regular or special election held by a borough, city, school district, or regional educational attendance area;

(17) "master register" means the list of all registered voters in the state which is maintained by the director of elections;

(18) "member of a political party" means a person who supports the political program of a party;

(19) "numerical identifier" means a voter's date of birth, the last four digits of a voter's social security number, a voter's Alaska driver's license number, or a voter's Alaska identification card number or voter identification number;

(20) "oath" includes affirmation;

(21) "official registration list" means the list of all voters qualified to vote at a particular election compiled in accordance with AS 15.07.125;

(22) "optically scanned ballot" means a paper ballot designed to be read by an optical scanning machine;

(23) "party district committee" means the political party committee that performs the executive function for a region representing an area larger than a precinct and smaller than the state;

(24) "political group" means a group of organized voters which represents a political program and which does not qualify as a political party;

(25) "political party" means an organized group of voters that represents a political program and

(A) that nominated a candidate for governor who received at least three percent of the total votes cast for governor at the preceding general election or has registered voters in the state equal in number to at least three percent of the total votes cast for governor at the preceding general election;

Lynda Zaugg

From: Lynda Zaugg
Sent: Monday, April 06, 2009 10:13 AM
To: 'wgreene@gci.net'
Subject: SB 68 Felon voting

Rev. Greene, SB 68 will be heard in front of Senate Judiciary on Friday 4/10 at 1:30. The teleconf # is 888-295-4546. Thank you. Lynda

To Rev. Greene
FAX # 907-337-4168

from Lynda Zaugg
465-4906

Rev. Greene, the hearing time is from 1:30 to 3:00 on Friday.
Thank you for your help
Lynda
Sen Davis' office
4/9/09

Jeff, Al, I'm just providing a heads up re voting rights for felons. Jeff, if you would be available to testify that would be great. Al, if Rev. Patterson would also be available to testify -- it would be very helpful. SB 68 has its next hearing before Senate Judiciary on Friday April 10th at 1:30. Teleconf # is 888-295-4546 or Anchorage LIO. Thanks. Lynda

email

Mindy 4/6/09

Lynda Zaugg

From: Jeffrey A. Mittman [jmittman@akclu.org]
Sent: Tuesday, March 31, 2009 11:17 AM
To: Lynda Zaugg
Subject: Contact Info: SB 68

Lynda,

It was good speaking with you.

This office is happy to work with the Senator in whatever way might be helpful to move SB 68 through the Legislature.

At some point, it might make sense to discuss local/state endorsements if we feel it will be necessary to assure a successful Senate Floor vote, House process, and gubernatorial support.

You may always reach me at (907) 258-0044, x103, or jmittman@akclu.org.

Best,

Jeffrey

ACLU
AMERICAN CIVIL LIBERTIES UNION of ALASKA

Jeffrey A. Mittman
Executive Director
ACLU of Alaska
PO Box 201844
Anchorage, AK 99520
(907) 258-0044 ext. 103
(907) 258-0288 (fax)

Not a problem. You really do not need to be present ---- I am just planning on using the numbers you provided re number of people currently with suspended voting rights due to felony convictions. This bill will tie the return of felon voting rights to release from incarceration rather then the end of probation supervision. Your Div. did not object to the bill last year so I am assuming that would still to be the case? If not please let me know. And if you are busy with your Mom – do not worry about this. Take care and thank you. Lynda

---

From: Fenumiai, Gail M (GOV) [mailto:gail.fenumiai@alaska.gov]
Sent: Monday, March 30, 2009 8:56 AM
To: Lynda Zaugg
Subject: Re: felon voting rights

I'm out of town dealing with my ailing mother. If its okay I can let you know later what time will work. Thanks.

From: Lynda Zaugg
To: Fenumiai, Gail M (GOV)
Sent: Mon Mar 30 08:31:12 2009
Subject: RE: felon voting rights
That would be great. What would be a good number to call you at? And when? Teleconf # for Tues is 888-295-4546. Thank you. Lynda

---

From: Fenumiai, Gail M (GOV) [mailto:gail.fenumiai@alaska.gov]
Sent: Saturday, March 28, 2009 6:00 PM
To: Lynda Zaugg
Subject: Re: felon voting rights

I am not in town but can give you a call on Monday sometime. If you want I can participate by teleconference.

From: Lynda Zaugg
To: Fenumiai, Gail M (GOV)
Sent: Sat Mar 28 14:12:37 2009
Subject: felon voting rights
Gail, I'll give you a call on Monday but wanted to give you a heads up re SB 68 'Felons' right to vote. A hearing has been set for Tues 3/31 at 9 am before Sen. State Affairs. Lynda

Gail, for your info, SB 68 is scheduled for a hearing before Sen. Judiciary on Friday 4/10 at 1:30. The hearing last week went just fine. No major questions. I used your numbers for the number of felons without voting rights. I'm not expecting anything different this week. Take care. Lynda

Gail Fennimore
Dir - Div of Elections
4/6/09 405-4611

Lynda Zaugg

From: Fenumiai, Gail M (GOV) [gail.fenumiai@alaska.gov] Dir Div. of Elections
Sent: Monday, March 30, 2009 10:31 AM
To: Lynda Zaugg
Subject: Re: felon voting rights

We do not object to the bill and have submitted a zero fiscal note.
If there are any questions presented by the committee let me know and I can get you the answers.
Thank you
Gail

From: Lynda Zaugg
To: Fenumiai, Gail M (GOV)
Sent: Mon Mar 30 10:25:36 2009
Subject: RE: felon voting rights

Not a problem. You really do not need to be present ---- I am just planning on using the numbers you provided re number of people currently with suspended voting rights due to felony convictions. This bill will tie the return of felon voting rights to release from incarceration rather then the end of probation supervision. Your Div. did not object to the bill last year so I am assuming that would still to be the case? If not please let me know. And if you are busy with your Mom – do not worry about this. Take care and thank you. Lynda

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Gail, I'll give you a call on Monday but wanted to give you a heads up re SB 68 'Felons' right to vote. A hearing has been set for Tues 3/31 at 9 am before Sen. State Affairs. Lynda

Lynda Zaugg

From: Fenumiai, Gail M (GOV) [gail.fenumiai@alaska.gov]
Sent: Wednesday, February 18, 2009 10:09 AM
To: Lynda Zaugg
Subject: RE: Information from elections regarding felon voters

It is defined in AS 15.60.010(9)

From: Lynda Zaugg [mailto:Lynda_Zaugg@legis.state.ak.us]
Sent: Wednesday, February 18, 2009 10:01 AM
To: Fenumiai, Gail M (GOV)
Subject: RE: Information from elections regarding felon voters

Excellent, thank you. One more question. What qualifies as a crime of "moral turpitude"? Again, thank you for your time. Lynda

---

From: Fenumiai, Gail M (GOV) [mailto:gail.fenumiai@alaska.gov]
Sent: Tuesday, February 17, 2009 11:40 AM
To: Lynda Zaugg
Subject: Information from elections regarding felon voters

Good morning Lynda,
Lauri Wilson provided me with the questions you had regarding felon voters. The division's responses to your questions are below. Please let me know if you have any other questions or need additional information.
Gail Fenumiai

(1) Number of felons we have in our system now that have lost their voting rights: 6,081

(2) What processes we have in place to obtain information from DOC for convictions and discharges:
(3) What kind of information we receive from DOC that allows us to place a voter in I/FC status:
The State Dept. of Corrections has created a weblink to their files of felony charges. Once a week our staff runs the electronic report from this website for a list of felony charges that occurred in the timeframe entered. This report is then compared to VREMS to determine if we should inactivate a voter's record for those that have been charged with a felony regarding moral turpitude. There have been occasions where the charge listed on the report does not provide enough information to determine if it's a felony regarding moral turpitude, so staff will refer to the courts website for further information or contact DOC. A voter's record is then inactivated to FC (Felony conviction) based on the date of the conviction listed on the report.

We also receive an electronic notice once a month from the Federal Courts regarding felonies of moral turpitude. This report is processed in the same manner as the state felony report. If there is a question regarding the charge we request assistance from Sarah Felix.

Once a felon has served all time associated with the charge, his rights are restored. A "Notification of Restoration of Rights" letter from corrections is sent to the Division of Elections.

We then change the voter's record from inactive FC (felony conviction) to inactive FD (felony discharge). The voter can then re-register to vote. If we do not receive a notice from DOC that the voter's rights have been restored and the voter submits a new registration form, we contact the DOC for a release date of the felony and update the voter's record. The voter becomes a new voter and his original registration date is the date of the new registration form.

(4) What we do if we don't receive notification from DOC that a person has been discharged. Do we go out on our own and research lists independently on an annual or bi-annual basis? The division does not conduct an independent review.

? does the DOC
Rep - tells them when
Reg @ end of sent
& now are not -
To do that Rep
people cannot
still not
to vote

12/30/08

SB 7 Felon Voting Rts

Jeff Mittman. ACLU-

258-0044

103

What to talk about?

Re-intro?

12/30 — ACLU to have atty's review SB 7
— " To try match B. 11 HS
— " To provide Backup on 20

Alaska State Legislature

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Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 3C
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill SB 7 **"An Act relating to the voting rights of felons."**

Tentative list of people to testify in person and by teleconference

Persons to testify telephonically from Anchorage LIO:

1. **Reverend Alonzo Patterson; phone: 907-276-6673**
2. **Rex Butler, Attorney; phone: 907-272-1497**
3. **Bill Parker –former Corrections Official; phone: 258-2702; cell: 907-748-3094**
4. **~~Vince Casey~~, NAACP, 272-8717**
5. **Reverend Greene?**
6. **~~Michael Macleod-Ball~~, Executive Director, Alaska ACLU Phone: 258-0044; cell: 230-0065; MWM@AKCLU.ORG**
7. **Denise Morris, Pres./CEO AK Native Justice Center, Anchorage. Phone: 793-3550; fax: 793-3570**

Call-in from out-of-state:

1. **Daniel Levitas, Representative, American Civil Liberties Union, Atlanta: State Legislative Strategist, Felon Disenfranchisement, Voters Right Project. Phone: 404-523-2721, ext. 213; Cell: 404-290-3214**
2. **Julie Fernandez, Attorney, Leadership Conference on Civil Rights 202-263-2856**

Persons in Juneau to testify in person

1. **~~Marilyn~~ Pugh, former Commissioner, Dept. Corrections Dept.; phone: 907-586-1598**
2. **Mike Miller, former Representative, phone: 907-586-3067; cell: 907-957-2777**
3. **Whitney Brewster, Director of Elections; phone: 465-4611, Juneau; 375-6400 Anchorage**

3800

Lynda Zaugg

From: Al Cheathon [acheathon@shiloh2000.net]
Sent: Friday, March 27, 2009 10:07 AM
To: Lynda Zaugg
Subject: RE: hearing for felon voting rights

I'll make sure the Pastor get's this information.

Have a great day.

SHILOH
MISSIONARY BAPTIST CHURCH
Al Cheathon

Al Cheathon, Office Administrator
Shiloh Missionary Baptist Church
855 East 20th Avenue
Anchorage, AK 99501
907-276-6673: Office
907-770-9811: FAX

From: Lynda Zaugg [mailto:Lynda_Zaugg@legis.state.ak.us]
Sent: Friday, March 27, 2009 9:07 AM
To: Al Cheathon
Subject: hearing for felon voting rights

Al, thank you for relaying this info to Rev. Patterson. The hearing will be Tues 3/31 at 9:00 a.m. in front of Sen. State Affairs chaired by Sen. Menard. Sen. Davis has put forth this bill last year – if passed it would allow individuals convicted of felonies to vote upon release from jail. This year the bill is SB 68. I can fax a copy of the bill and sponsors statement for your review. Or you can also download a copy from Legislative web site from BASIS. Thanks again for your help. Lynda

Lynda Zaugg

From: Deborah Prator
Sent: Thursday, March 26, 2009 3:13 PM
To: Lynda Zaugg
Subject: SB 68

Lynda – Just a quick note to let you know that I have scheduled SB 68 in State Affairs for Tuesday, March 31, 2009 at 9 a.m. Hope this works for you and Sen. Davis. Like this "Spring" we are having? ☺ Debbye Prator

Legislative Aide
Office of Senator Linda Menard
Phone: 907-465-4957
deborah_prator_@legis.state.ak.us

Alaska State Legislature

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716 W. 4th Ave
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Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Sponsor Statement

SB 68 "An Act relating to the voting rights of felons"

Across the country states handle the right to vote for returning felons differently. Two (2) states, Maine and Vermont do not take away a felons right to vote. Thirteen states (13) allow felons to vote upon release from incarceration. Twenty one (21) including Alaska allow felons to vote after they complete all parole/probation requirements while fourteen (14) states permanently disenfranchise certain felons. If our belief is that felons once released have paid their debt to society then returning their right to vote upon release from incarceration would be a positive step.

SB 68 allows felons upon release from incarceration to register to vote. This bill starts the process which allows felons to start assuming responsibility for their reintegration in their communities. We are each responsible for how our government works and we do that through voting. In Alaska, 6081* Alaskans have lost their right to vote because of felony convictions. Currently, Alaska law bars the vote to persons convicted of felonies of moral turpitude until the expiration of a post-incarceration period of parole or probation, which is often years after they have reentered society to become productive citizens and tax payers. .

Harsh sentencing laws over the past 30 years have allowed the prison population to balloon, while reducing the rehabilitative model to almost non existent. Over 4.7 million Americans or 1 in 43 adults cannot vote due to felony convictions, with 1/3 or more of them were incarcerated due to alcohol and drug offenses. In Alaska we have gone from slightly over 800 prisoners in 1984 to 5344 in 2008, an increase of 149%. Of those incarcerated in Alaska 48% are Caucasian, 36% are Alaska Native, 10% are African American, 3% are Hispanic, and 3% are Asian/Pacific Islanders.* Nationally minority felons are disproportionately disenfranchised under current law and the harm of this continued disenfranchisement after release is exacerbated by stigma and other forms of discrimination as they try to reenter society. In Alaska 52% of our incarcerated offenders are minorities.

In Alaska, we do not have a problem taking a person off the voting roles if convicted of a felony but we do not have a system that will automatically allow them to return to the voting roles upon termination of supervision. Voting is just one of many steps a returning felon must make to become a productive member of the community. This Bill will help provide a clear time for returning voting rights and provide an important right/responsibility to felons returning to their communities.

* Alaska Div. of Elections
* Alaska Dept. of Corrections "2008 Offender Profile"

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 2, 2009

SUBJECT: Sectional Summary of SB 68 (Work Order No. 26-LS0324\A)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Alpheus Bullard
Legislative Counsel

You have requested a sectional analysis of the above referenced bill. As a preliminary matter, please note that a sectional analysis should not be considered an authoritative interpretation of the bill, and the bill itself is the best statement of its contents.

Section 1. Establishes that a person convicted of a crime that constitutes a felony involving moral turpitude under state or federal law may not vote while incarcerated for that crime, and that the person upon release will be advised of voter registration requirements and procedures.

Section 2. Establishes that the voter registration of a person convicted of a crime that constitutes a felony involving moral turpitude will be cancelled while that person is incarcerated.

Section 3. Establishes that a person convicted of a crime that constitutes a felony involving moral turpitude under state or federal law is disqualified from voting while incarcerated for that crime.

Section 4. Repeals AS 15.60.010(39), a definition of "unconditional discharge."

TLAB:ljw
09-053.ljw

Alaska State Legislature

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Fax: (907) 269-0148

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Senator Bettye Davis

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3806

SB 68 allows felons upon release from incarceration to register to vote. This bill starts the process which allows felons to start assuming responsibility for their reintegration in their communities. We are each responsible for how our government works and we do that through voting. In Alaska, 6081* Alaskans have lost their right to vote because of felony convictions. Currently, Alaska law bars the vote to persons convicted of felonies of moral turpitude until the expiration of a post-incarceration period of parole or probation, which is often years after they have reentered society to become productive citizens and tax payers. .

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In Alaska, we do not have a problem taking a person off the voting roles if convicted of a felony but we do not have a system that will automatically allow them to return to the voting roles upon termination of supervision. Voting is just one of many steps a returning felon must make to become a productive member of the community. This Bill will help provide a clear time for returning voting rights and provide an important right/responsibility to felons returning to their communities.

* Alaska Div. of Elections
* Alaska Dept. of Corrections "2008 Offender Profile"

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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Date: 4/16/2009

To: Senator Stedman, Co-Chair
House Finance Committee

From: Senator Bettye Davis

Re: SB 68 "An Act relating to the voting rights of felons"

SB 68 carries a zero fiscal note from both the Dept. of Corrections and the Div. of Elections. It has been vetted in both Sen. H&SS and Sen. Judiciary. This is a request that you waive SB 68 to Senate Rules Committee at the earliest possible date.

Please find attached a copy of the bill, a sponsor statement, fiscal notes, and a sectional analysis. Your attention to this request would be appreciated. Thank you.

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Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Date: 4/1/2009

To: Senator French, Chair
Senate Judiciary Committee

From: Senator Bettye Davis

Re: SB 68 "An Act relating to the voting rights of felons"

This is a request that you schedule a hearing on SB 68 at the earliest possible date.

Please find attached a copy of the bill, a sponsor statement, a fiscal note, and a sectional analysis. Your attention to this request would be appreciated. Thank you.

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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Date: 3/23/2009

To: Sen. Menard, Chair
State Affairs Committee

From: Senator Bettye Davis

Re: SB 68 "An act relating to the voting rights of felons."

This is a request that you schedule a hearing on SB 68 at the earliest possible date.

Please find attached a copy of the bill, a sponsor statement and a sectional analysis. Your attention to this request would be appreciated. Thank you.

26-LS0324\A

SENATE BILL NO. 68

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY SENATOR DAVIS

Introduced: 1/21/09
Referred: State Affairs, Judiciary, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to the voting rights of felons."

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

*** Section 1.** AS 15.05.030 is amended to read:

Sec. 15.05.030. Loss and restoration of voting rights. (a) A person convicted of a crime that constitutes a felony involving moral turpitude under state or federal law may not vote in a state, federal, or municipal election **while incarcerated for that crime** [FROM THE DATE OF THE CONVICTION THROUGH THE DATE OF THE UNCONDITIONAL DISCHARGE OF THE PERSON]. Upon **release from incarceration** [THE UNCONDITIONAL DISCHARGE], the person may register under AS 15.07.

(b) The commissioner of corrections shall establish procedures by which a person **released from incarceration** [UNCONDITIONALLY DISCHARGED] is advised of the voter registration requirements and procedures. **The procedures established under this subsection must provide that at the time of the person's release from incarceration,**

(1) the department shall give the person a written notification of the person's restored right to vote; and

(2) the commissioner of corrections shall notify the director that the person is entitled to be reregistered as a voter.

*** Sec. 2.** AS 15.07.135 is amended to read:

Sec. 15.07.135. Cancellation of registration of incarcerated [CONVICTED] persons. (a) The director shall make reasonable efforts to obtain the names of persons convicted of a felony involving moral turpitude **and incarcerated for that crime**. Promptly after receipt of evidence satisfactory to the director that a person has been convicted of a felony involving moral turpitude **and incarcerated for that crime**, the director shall cancel the registration of the person.

(b) Upon presenting proof that a person whose registration was canceled under (a) of this section has been **released from incarceration** [UNCONDITIONALLY DISCHARGED FROM CUSTODY], the person may register. The director shall make reasonable efforts to verify the **released from incarceration** [UNCONDITIONAL DISCHARGE] of persons applying for registration under this subsection.

*** Sec. 3.** AS 33.30.241(a) is amended to read:

(a) A person who is convicted of a felony involving moral turpitude as defined in AS 15.60.010 is disqualified from voting in a state or municipal election **while the person is incarcerated for that crime** [UNTIL THE PERSON'S UNCONDITIONAL DISCHARGE].

*** Sec. 4.** AS 15.60.010(39) is repealed.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB68**
() Publish Date:

Identifier (file name): SB068-OOG-DOE-3-27-09
Dept. Affected: OOG
Title: An Act relating to voting rights of felons
RDU: Elections
Component: Elections
Sponsor: Senator Davis
Requester: Senate State Affairs Committee
Component Number: 21

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*
This legislation will have no fiscal impact on the division of elections.

Prepared by: Gail Fenumiai, Director — Phone 465-4611
Division: Division of Elections — Date/Time 3/27/09, 8:41pm
Approved by: Linda Perez, Director — Date 3/27/2009
Administrative Services

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: SB68-DOC-OC-3-27-09
Bill Version:
() Publish Date:

Identifier (file name): SB68-DOC-OC-3-27-09
Dept. Affected: DOC
Title "An Act Relating to the Voting Rights of Felons"
RDU Administration & Support
Component Office of the Commissioner
Sponsor Senator Davis
Requester Governor
Component Number 694

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CHANGE IN REVENUES ( )							
FUND SOURCE		(Thousands of Dollars)					
1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Passage of this legislation should not have a significant impact on the Department of Corrections.

Prepared by: Leslie Houston, Director
Phone 465-3339
Division Administrative Services Division
Date/Time 3/27/09 0740
Approved by: Dwayne Peeples, Deputy Commissioner
Date 3/27/2009
Office of the Commissioner

(Revised 9/10/2008 OMB)

3815

LEGAL SERVICES
DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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Mail Stop 3101

State Capitol
Juneau, AK 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 14, 2009

TO: Senator Bettye Davis
Attention: Tom Obermeyer

FROM: Patty Rose, Legal Editor
Division of Legal Services

SUBJECT: Work Order Number 26-LS0324\A
Voting rights of felons

As you requested, the enclosed work order will be prepared in final and delivered to your office the workday before session begins so that you may file it on the first day of session.

Enclosure

1st Day Intro
TSO 1/19/09

26-LS0324\A
Bullard
1/14/09

SENATE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY SENATOR DAVIS

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

"An Act relating to the voting rights of felons."

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

*** Section 1.** AS 15.05.030 is amended to read:

Sec. 15.05.030. Loss and restoration of voting rights. (a) A person convicted of a crime that constitutes a felony involving moral turpitude under state or federal law may not vote in a state, federal, or municipal election **while incarcerated for that crime** [FROM THE DATE OF THE CONVICTION THROUGH THE DATE OF THE UNCONDITIONAL DISCHARGE OF THE PERSON]. Upon **release from incarceration** [THE UNCONDITIONAL DISCHARGE], the person may register under AS 15.07.

(b) The commissioner of corrections shall establish procedures by which a person **released from incarceration** [UNCONDITIONALLY DISCHARGED] is advised of the voter registration requirements and procedures. **The procedures established under this subsection must provide that at the time of the person's release from incarceration,**

(A) the department shall give the person a written notification of the person's restored right to vote; and

(B) the commissioner of corrections shall notify the director that the person is entitled to be reregistered as a voter.

*** Sec. 2.** AS 15.07.135 is amended to read:

Sec. 15.07.135. Cancellation of registration of incarcerated [CONVICTED] persons. (a) The director shall make reasonable efforts to obtain the names of persons convicted of a felony involving moral turpitude **and incarcerated for that crime**. Promptly after receipt of evidence satisfactory to the director that a person has been convicted of a felony involving moral turpitude **and incarcerated for that crime**, the director shall cancel the registration of the person.

(b) Upon presenting proof that a person whose registration was canceled under (a) of this section has been **released from incarceration** [UNCONDITIONALLY DISCHARGED FROM CUSTODY], the person may register. The director shall make reasonable efforts to verify the **released from incarceration** [UNCONDITIONAL DISCHARGE] of persons applying for registration under this subsection.

*** Sec. 3.** AS 33.30.241(a) is amended to read:

(a) A person who is convicted of a felony involving moral turpitude as defined in AS 15.60.010 is disqualified from voting in a state or municipal election **while the person is incarcerated for that crime** [UNTIL THE PERSON'S UNCONDITIONAL DISCHARGE].

*** Sec. 4.** AS 15.60.010(39) is repealed.

26-LS0324\A
Bullard
1/2/09

SENATE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

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BY SENATOR DAVIS

Introduced:
Referred:

A BILL

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26-LS0324\A
Bullard
12/31/08

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TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY SENATOR DAVIS

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Referred:

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Alaska State Legislature
716 West 4th Ave.
Anchorage, A 99501
907-269-0144-office
907 269 0148 fax
From the Office of Senator Bettye Davis

To: Legislative Legal Services **Fax:** 465-2029

From: Tom Obermeyer, Legis. Asst. to Senator Bettye Davis **Date:** December 30, 2008

Re: Request for 3 work orders **Pages:** __11__ pages including cover

CC:

Urgent **[X] For Review** **☐ Please Comment** **Please Reply** **☐ Please Recycle**

To whom it may concern:

Senator Davis would like to start work orders for three additional bills in the 26th Legislature:

1) CSSB 7(STA), 25-LS0100\K, or a later draft - Felon Voting rights. Any changes to be considered will be forwarded as soon as possible, probably in the next week.

2) Senate Resolution to enact a "New Deal for Higher Education" to rebuild access for students to our nation's public colleges and universities. Refer to attached California HR 4 which calls for:

a) a federal program for higher education in the amount of $70 billion, or 10% of federal stimulus packages;

b) establish college-going grants, including increased Pell grants to lower income students and grants similar to the WWI era G.I. Bill of Rights; and

c) student loan debt forgiveness for all students who take jobs in public service. Note: I will draft some additional language and statistics which are pertinent to Alaska, some of which are attached in ADN article: *Our View: Higher Education*

3) A bill to re-establish the Alaska Commission on the Status of Women which I understand was consolidated with the Alaska Commission on Children and Youth in 1993 by Governor Hickel's Executive Order #84 (and may never have been implemented). See attached letter from Jan Angvik dated November 30, 2008.

statenews

Vol. 51, No. 7 | The Council of State Governments | August 2008

growth behind bars

Adapting to Climate Change | *Auto Industry in the South Faring Well* | *Affordable Higher Education*

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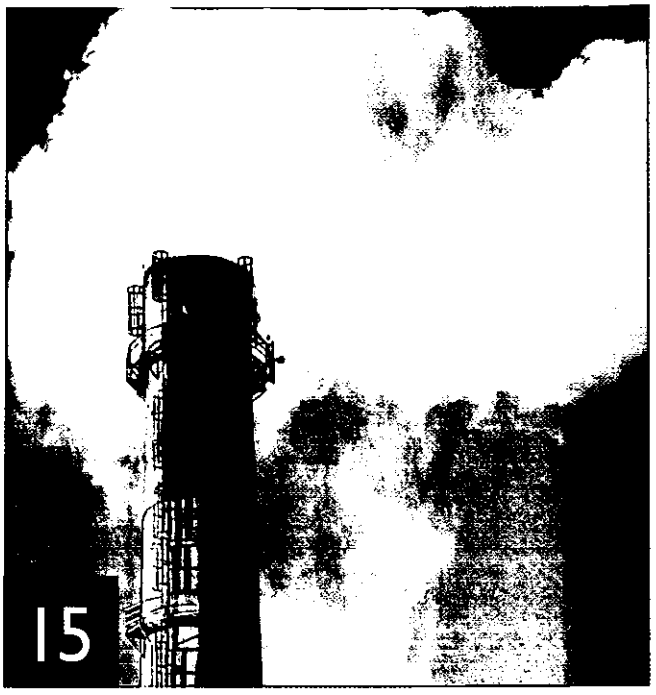

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csg WEB

States' prison populations are expected to grow in the next decade and prison costs are projected at almost too much to afford. You can read about efforts of some states in the article on Page 19, and share your experiences on Capitol Comments. E-mail *mchavers@csg.org* and we may feature your programs and efforts dealing with the growing prison population on our blog, Capitol Comments.

Several states are working hard to make higher education more affordable for residents as tuition costs skyrocket. Read about some of those efforts on Page 30, and check out Capitol Comments for more details about Indiana's 21st Century Scholars program and Oklahoma's Promise. You can also get advice about steps to affordability and learn more about state 529 programs on the blog.

Alan Sokolow, director of The Council of State Governments' Eastern Regional Conference, is retiring after more than four decades with CSG. Read the interview on Page 11 and hear more from Sokolow at Capitol Comments.

And don't forget to check Capitol Comments for updates from the ERC meeting in August, as well as the previous regional meetings held in July.

NEW

state capitol comments

This month's issue of *State News* includes a new indicator that alerts you to more information about a particular topic at Capitol Comments. Look for it throughout the magazine, then check CSG's blog for special Web-only features.

capitol trivia

Question:

What are the three states that employ the most people to operate state government? Which state has the fewest state employees?

To find the answer, log onto CSG's Web site at www.csg.org!

$1 MILLION EVERY MINUTE OF EVERY DAY

By Daniel Sullivan

By the time you finish reading this, Canada and the United States will have traded well-over $1 million. That's $1 million every minute of every day. Canadians and Americans produce things together. We create jobs together. Trade with Canada supports 7.1 million American jobs—that's one in 25.

As Canada's representative in New York, New Jersey and Connecticut, in June, I shared the importance of the Canada-U.S. economic relationship with members of Congress. The message? Think North American competitiveness. Think jobs in your state. Think Canada.

Canada buys four times more from the United States than does China. Canada, not China. Thirty-five states, including New York, New Jersey and Connecticut, sell more to Canada than to any other country in the world. All 50 states sold $250 billion to Canada last year alone.

In fact, for every $1 of New York's goods that China buys, Canada buys more than $5.25. And in New Jersey, Canada buys nearly $7 to China's $1 purchase.

Incredibly, Connecticut exports more goods to Canada than to the United Kingdom, Japan, Mexico and Australia combined.

The jobs supported by U.S.-Canada trade are equally impressive—207,000 jobs in New Jersey are linked to U.S.-Canada trade, 469,000 jobs in New York and 90,250 Connecticut jobs.

Take Montreal-based Bombardier, a leader in the production of aircraft, trains and other transport systems. Facilities in Québec produce rail car shells destined for urban and suburban transport systems in the U.S. These shells are finished in Plattsburgh, N.Y., using a process that employs 800 workers. A new rail car system at JFK International Airport will utilize Bombardier rail cars, a project that has enabled its contractor, Total Transit Systems of Pittsburgh, to bring 100 jobs to New York.

And consider, Unison, a GE subsidiary with a manufacturing plant in the town of Brookhaven, N.Y., that employs 115 people and manufactures aviation components while providing maintenance and support services. Unison enjoys an extensive supply-management relationship with Canada that includes both purchasing component pieces from Canadian suppliers and then selling finished aviation products to clients, such as Bombardier.

And Campbell Soup Company, founded in Camden, N.J., is one of many international firms that depend on the fluid exchange of goods between the U.S. and Canada. Campbell relies on a highly integrated North American supply chain organized around 23 facilities in 14 states and Ontario. In 2007, Campbell shipped nearly 4,500 truckloads from Canada to the United States containing its premium soups and frozen foods. Meanwhile, 3,500 truckloads entered Canada, bringing microwavable soups from the company's largest plant, located in northwest Ohio, as well as Pepperidge Farm snacks from Connecticut, Pennsylvania and other sites.

The movement of goods across the U.S.-Canada border is key to the competitiveness of companies like Bombardier, Unison/GE and Campbell Soup Company whose operations are integrated across North America.

Canadians and Americans are in this together. We depend on one other to compete globally. Deal makers and job creators—that's who we are.

—Daniel Sullivan, who was appointed consul general of Canada in New York in October 2006, will speak at The Council of State Governments' Eastern Regional Conference in August.

3828

Inaugural
Henry Toll Fellowship
Class of 1986

Location: Lexington, Ky.

Building Leadership REACHING OUT

In founding The Council of State Governments, Colorado Sen. Henry Toll displayed his exceptional leadership skills by recognizing a national need and taking the steps to fill that need.

In recognition of its founding father and his leadership, CSG in 1986 started the Henry Toll Fellowship Program with an eye to equipping state leaders with the tools, knowledge and skills necessary to be the statesmen and women of tomorrow—leaders in the mold of Toll himself.

Twenty-two years later, the Toll Fellowship Program is one of the nation's foremost leadership development programs. Graduates have gone on to serve

Twenty-two years later, the Toll Fellowship Program is one of the nation's foremost leadership development programs.

as governors, secretaries of state, chief justices and as members of the United States Congress. Just as CSG is the only organization serving all three branches of state government, each year the Toll Fellowship Program brings together representatives of all three branches from across the country. A key goal for the Toll program is to assist state leaders in working successfully across party lines, across branches of state government and across state borders to make creative policy and solve key problems.

Annually, 40 of the nation's most promising state leaders come to Lexington, Ky., for a five-night, six-day "intellectual boot camp." CSG routinely brings in some of the nation's top lecturers on a variety of topics that have included effective political communication techniques, time management, crisis management, state governance transformation and generational communication styles. Dynamic team building and leadership exercises are important components of the Toll program.

Since its inception, the Toll Fellowship Program was designed to provide a broad foundation of leadership skills. While CSG's committees and task forces focus on specific policy issues, the Toll Fellowship Program strives to provide the skills with which its alumni can tackle the policy problems facing the states. In addition, one of the program's most beneficial outcomes is the creation of a national, multi-branch network. The relationships forged during the Toll Fellowship Program provide an opportunity for sharing policy ideas and solutions with leaders from other states and branches of government. Recognizing the importance of such networking, the Toll Fellow Alumni network meets regularly at CSG spring and annual meetings allowing these new bonds to spread between classes as well.

CSG Associates Program

Also in the 1980s, CSG began to reach out to members of the corporate community and established the Associates Program in 1984. Since then, the program has provided three key elements to government relations professionals:

- access to key decision-makers in all three branches of state government;
- participation in discussions on policy development and emerging trends in the states; and
- opportunities to network and exchange ideas on cutting edge issues.

Members of the CSG Associates Program include Fortune 100 and Fortune 500 companies as well as trade associations. As partners with CSG, the Associates participate in CSG's committee and task force deliberations and participate actively in CSG's 21st Century Foundation decision-making process. In addition to providing their perspectives on state trends, the Associates also make significant contributions to CSG's meetings and international exchanges.

Founding members of the Associates program are 3M, Altria, American Chemistry Council, AT&T, Avon, Eastman Kodak Company, PhRMA, R.J. Reynolds and The Proctor & Gamble Company.

Associates members are encouraged to be actively involved in CSG's task forces and committees that help establish CSG policy and programs. CSG's Associates Awards program recognizes Associates for public-private programs that benefit the states.

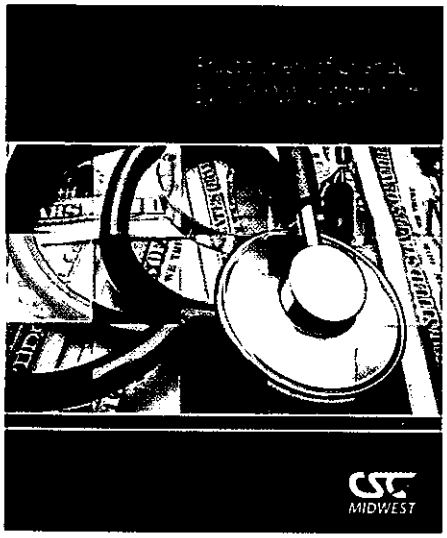
1980 • 1981 • 1982 • 1983 • 1984 •

S

- **1980** Frank H. Bailey named executive director of CSG
- **1983** Carl W. Stenberg named executive director of CSG
- **1983** National Association of Secretaries of State re-affiliates with CSG
- **1984** National Association of State Personnel Executives (NASPE) affiliates with CSG
- **1984** CSG Associates Program established
- **1986** The Toll Fellows Program established
- **1986** Midwestern Legislative Conference moves its office from Chicago to Lombard, Ill.
- **1987** National Association of State Facilities Administrators (NASFA) affiliates with CSG
- **1987** American Probation & Parole Association (APPA) affiliates with CSG
- **1989** Daniel M. Sprague named executive director of CSG

toolbox

New CSG Midwest Report Examines Health Care Reform in Region



As the price of health care increases and states face myriad budget challenges, reducing costs and ensuring quality health care for all is a top concern of lawmakers and their constituents.

Last month, The Council of State Governments' Midwestern Office released a report exploring recent health reforms in the region.

"Practitioners of Change: Regional Case Studies in State Health Care Reform and Cost Containment" was unveiled in July at the Midwestern Legislative Conference Annual Meeting in Rapid City, S.D.

Using 11 case studies—one from each Midwestern state—the report examines key policy issues in health care and highlights innovative efforts in the region to control costs and reform state health systems.

The case studies are based on interviews with Midwestern state officials, legislators and experts, as well as studies and data from the nation's top sources in health policy.

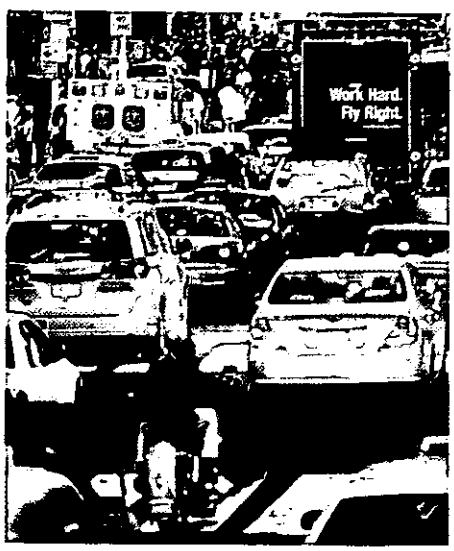
The report also includes an appendix on cost-containment strategies in the Canadian provinces.

The project was completed as part of the 2008 MLC chair's agenda of South Dakota Sen. Tom Dempster.

To read the report, visit *www.csgmidwest.org*.

statesource

States Look to Save on Gasoline Bills



As prices at the pump continue to hover around $4 a gallon this summer, several states are considering options to cut costs.

In July, Kentucky State Police announced a plan to scale back patrols and set up at least 200 checkpoints to reduce the amount of gas used, according to *The Courier-Journal*.

The new policy began July 4 and is expected to continue through Labor Day, according to the Louisville newspaper. Kentucky State Police spent $132,000 more for gasoline in May than the agency did in May 2007, according to *The Courier-Journal*.

State Police Capt. Tim Lucas told the newspaper the plan was an effort to "let traffic come to us instead of us seeking traffic."

And in June, Utah became the first state to mandate four-day workweeks for the majority of its state employees. Many Utah state employees will work from 7 a.m. to 6 p.m. Monday through Thursday, and 1,000 of the 3,000 Utah state buildings will close on Friday, according to *Stateline.org*.

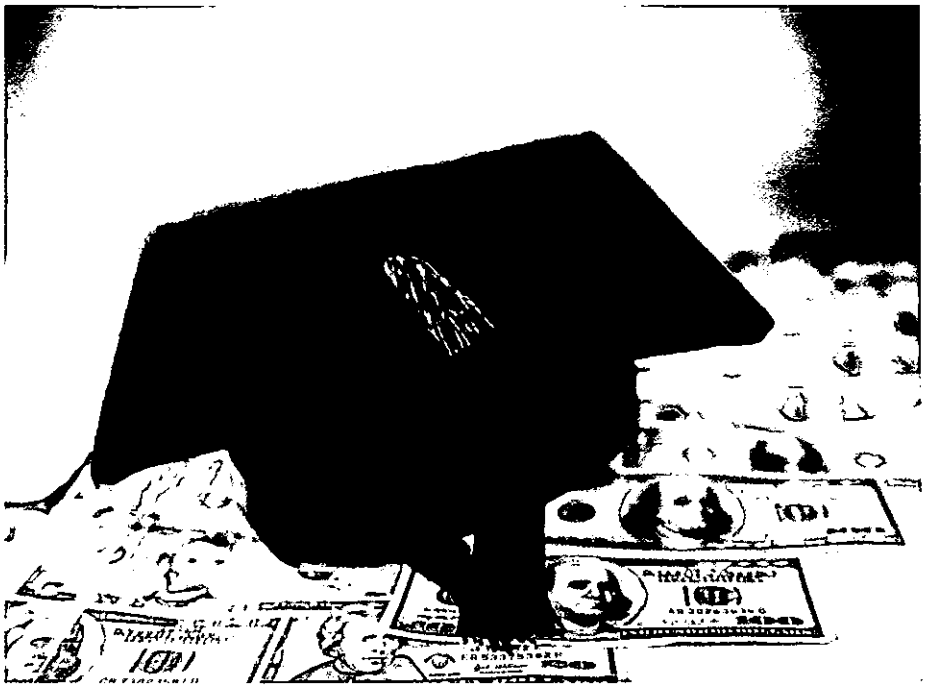
"Utah is the only state to mandate a four-day workweek for most of its state government employees and no other state currently has plans to mandate a four-day work week, although a number of states are going to be keeping a close eye on Utah's effort," said Leslie Scott, executive director of the National Association of State Personnel Executives, an affiliate of The Council of State Governments.

In Michigan, Gov. Jennifer Granholm announced in July that her office is considering work-schedule alternatives to save fuel. In New Mexico, Gov. Bill Richardson ordered state agencies to adopt policies for telecommuting and alternative work schedules by Sept. 1.

Kentucky and South Carolina are also offering shorter work weeks to state employees this summer, according to *Stateline.org*.

"Many states are promoting the greater use of already existing alternative work schedule and telecommuting policies to be used whenever possible," Scott said. "Some states are in the process of updating their policies, which may have been written decades ago. The handful of states that didn't already have telecommuting and/or flexible work schedule policies are creating them."

Ohio Gives Veterans, Families In-State Tuition



> "It delivers real support to veterans while helping strengthen Ohio's strategic plan for higher education, which calls for attracting and keeping talent in the state."
>
> —*Ohio Gov. Ted Strickland*

To combat rising higher education costs, all military veterans, their spouses and dependent children can now attend Ohio colleges and pay the in-state tuition rate, according to *The Plain Dealer* in Cleveland.

"This is a great benefit for veterans, as well as for Ohio," Gov. Ted Strickland said in a press release after signing an executive order July 8. "It delivers real support to veterans while helping strengthen Ohio's strategic plan for higher education, which calls for attracting and keeping talent in the state. Who better to have as part of Ohio's colleges and universities, work force and communities than the veterans who have served, led and protected our country?"

State officials hope the plan will help more veterans and their families attend the state's 13 colleges and universities and 23 community and technical colleges, according to *The Plain Dealer.*

"We think we have an incredible value," Ohio Board of Regents Chancellor Eric Fingerhut told the newspaper. "We hold the University System of Ohio as second to none."

In addition to the in-state tuition for all veterans and their families, the executive order will also:

- Establish The Ohio GI Promise Council;
- Launch The Ohio GI Promise Hotline and Web site;
- Schedule a University System of Ohio systemwide conference on veterans services;
- Expand the use of Ohio National Guard Scholarships; and
- Designate Ohio colleges and universities "Servicemember Opportunity Colleges."

Read more about what the states are doing to help make higher education more affordable in the story, "Funding the Future" on page 30.

States Testing New 9-1-1 System

Public safety agencies—including those in Montana and Indiana—have spent weeks testing a new 9-1-1 system, a project organized by the U.S. Department of Transportation.

The current 9-1-1 system is designed around telephone technology and cannot handle the text, data, images and video that are increasingly common in the way people communicate and are critical to the future, according to the U.S. Department of Transportation Web site. The Next Generation 9-1-1 initiative, nicknamed NG 9-1-1 by the federal government, "will establish the foundation for public emergency communications services in a wireless mobile society," according to the Department of Transportation.

Joining Indiana and Montana as testing sites are three cities: Rochester, N.Y., Seattle, Wash., and St. Paul, Minn.

The testing began June 16 and the initiative aims to improve 9-1-1 access for deaf or hearing-impaired users, such as through text messaging, according to *The Journal Gazette* of Fort Wayne, Ind.

The initiative also aims to improve how the 9-1-1 system tracks callers, regardless of whether the 9-1-1 call is made from a landline or from a wireless phone or using Voice over Internet Protocol, according to the newspaper.

For more information on the new initiative, visit the U.S. Department of Transportation's Web site at *http://www.its.dot.gov/ng911/index.htm.*

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statesnapshots

Cash for Corrections

Some States Spend More on Corrections than on Higher Education

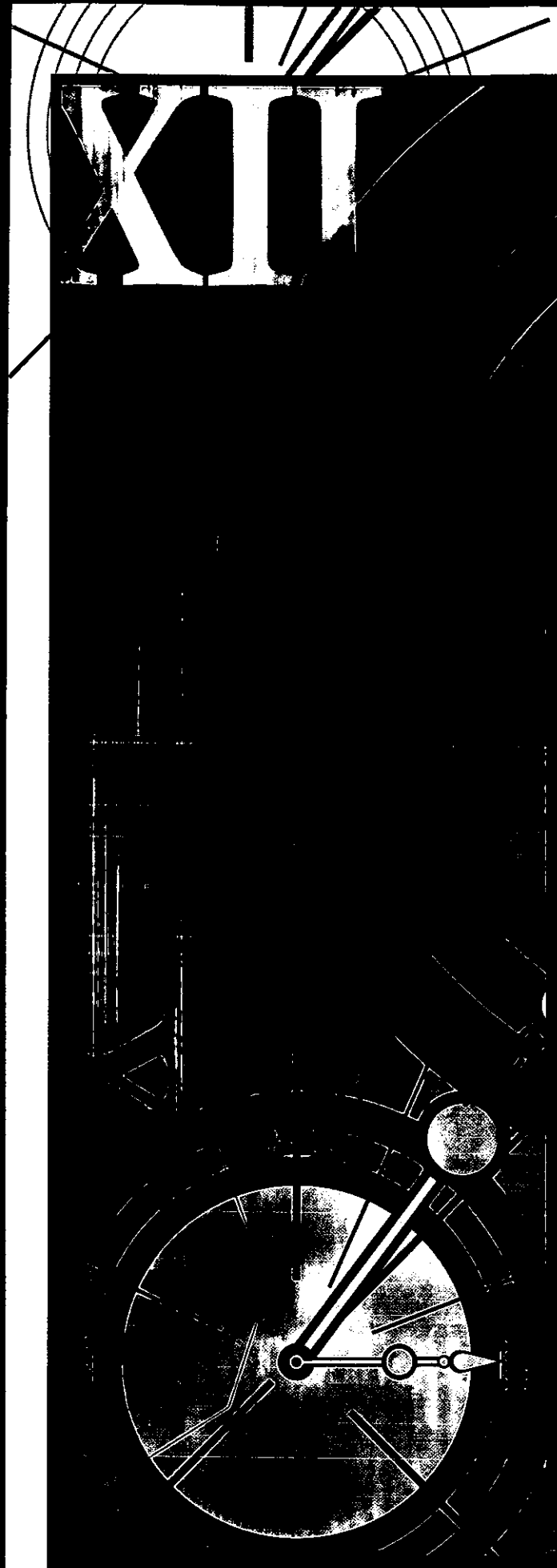
State	How Much Corrections Cost the State (2007)	Ratio of Higher Education Spending to Corrections Spending (2007)
Alabama	$388 million	$1:$0.23
Alaska	$227 million	$1:$0.77
Arizona	$895 million	$1:$0.77
Arkansas	$314 million	$1:$0.46
California	$8.795 billion	$1:$0.83
Colorado	$599 million	$1:$0.78
Connecticut*	**$661 million**	**$1:$1.03**
Delaware	$240 million	$1:$1
Florida	$2.719 billion	$1:$0.66
Georgia	$998 million	$1:$0.50
Hawaii	$205 million	$1:$0.31
Idaho	$179 million	$1:$0.56
Illinois	$1.125 billion	$1:$0.51
Indiana	$649 million	$1:$0.40
Iowa	$313 million	$1:$0.38
Kansas	$312 million	$1:$0.40
Kentucky	$454 million	$1:$0.35
Louisiana	$552 million	$1:$0.46
Maine	$122 million	$1:$0.49
Maryland	$1.084 billion	$1:$0.74
Massachusetts	$1.139 billion	$1:$0.98
Michigan*	**$2.063 billion**	**$1:$1.19**
Minnesota	$438 million	$1:$0.17
Mississippi	$227 million	$1:$0.30
Missouri	$586 million	$1:$0.67

State	How Much Corrections Cost the State (2007)	Ratio of Higher Education Spending to Corrections Spending (2007)
Montana	$142 million	$1:$0.81
Nebraska	$172 million	$1:$0.28
Nevada	$222 million	$1:$0.43
New Hampshire	$92 million	$1:$0.73
New Jersey	$1.468 billion	$1:$0.67
New Mexico	$241 million	$1:$0.32
New York	$2.622 billion	$1:$0.73
North Carolina	$1.083 billion	$1:$0.33
North Dakota	$55 million	$1:$0.24
Ohio	$1.766 billion	$1:$0.69
Oklahoma	$461 million	$1:$0.51
Oregon*	**$684 million**	**$1:$1.06**
Pennsylvania	$1.638 billion	$1:$0.81
Rhode Island	$157 million	$1:$0.83
South Carolina	$444 million	$1:$0.49
South Dakota	$74 million	$1:$0.41
Tennessee	$619 million	$1:$0.41
Texas	$3.292 billion	$1:$0.51
Utah	$324 million	$1:$0.41
Vermont*	**$111 million**	**$1:$1.37**
Virginia	$1.136 billion	$1:$0.60
Washington	$832 million	$1:$0.55
West Virginia	$171 million	$1:$0.36
Wisconsin	$890 million	$1:$0.73
Wyoming	$82 million	$1:$0.23

** These states spend more on corrections than on higher education.*

SOURCE: The Pew Center On The States Report: "One in 100: Behind Bars in America 2008"

For more on how the states are dealing with rising prison populations and escalating corrections costs, see the story on page 19. For more on higher education funding, see the story on page 30.



CHANGING TIMES

Longtime ERC Director Reflects on His Tenure as Retirement Nears

Alan Sokolow, director of The Council of State Governments' Eastern Regional Conference in New York City, will retire in December after 41 years. Sokolow, 65, began as a field representative and became director of the ERC in the fall of 1972. The Brooklyn native, who now lives in Montclair, N.J., spoke recently with *State News* about his tenure and the successes of CSG, as well as the changes he's witnessed in state government operations. Here are highlights of that interview.

By Mary Branham Dusenberry

As you look back on your tenure at CSG, what do you see as your most significant accomplishment?

"I think I've kind of sent the message to the whole organization of always trying to have us work as a team and believe in the esprit and treat colleagues as part of the family. I think I've also been successful in doing that with the Eastern leadership over the years so that their investment is deeper than just being a member of an organization, but feeling a significant commitment to its work and to its staff.

Alan Sokolow, left, who is retiring from The Council of State Governments after 41 years, is pictured with New York Sen. Hugh Farley, center, and Wendell Hannaford, who will take over as ERC director upon Sokolow's retirement.

Specific things that we've accomplished over the years: One that we've grown the office in member jurisdictions. ... We have now 10 states, the U.S. Virgin Islands, Puerto Rico and six Canadian provinces. We have gone from 11 to 18 over this period, so that's been very exciting growth for us.

Secondly, in the late 90s, we had an active program through our criminal justice project that was focusing on issues of over-representation of minorities in the prison system of the Northeast. It attracted a number of key Hispanic legislators who were part of National Hispanic Caucus of State Legislators. That had been in existence for about 10 years but had fallen on harder days, and had a very minimal budget, no full-time staff, just struggling to survive. Four of the members ... approached me at one of our annual meetings in 1998 to see whether I would be willing to help them re-energize the organization. It was a real joy and labor of love."

ERC has also created a number of affiliate organizations. Can you discuss those?

"We're the only one that has a regional trade group of state trade directors that the states fund and we staff through this office. It was really the work of that regional group since 1999 or 2000, that created the decision by the national organization, SIDO (State International Development Organizations), to join CSG as an affiliate member.

In the late 90s ... we created a regional agriculture project that is also being funded primarily by our member states, called the Northeast States Association for Agricultural Stewardship. That's provided a really significant support system for rural legislators in the region who are interested in northeast agriculture not only surviving, but growing. It was an uphill battle because we didn't have the leverage or strength compared to other regions of the country where the powerful agriculture interests are based ...

On the criminal justice front I'm beyond thrilled about how the regional effort led by Mike Thompson has grown so phenomenally and astoundingly over the last 10 years and turning it into the Justice Center for national CSG. I'm very, very proud of the major accomplishments they've made in serving all of state government and being a wonderful example of our mission and purpose and providing very exciting and important technical assistance to the states."

You have worked with state governments for 40 years. What has been the biggest change in state government operations or funding during that time?

"I would say the biggest change is the growth of partisanship and ideology in the political process. When I started, Republicans and Democrats could fight like cats and dogs over substantive issues in legislation, but when the debate on the floor was over,

they would get together and socialize and enjoy each other's company. There was a respect for the institution to support it.

I think over the years ... you see the parties separating both politically and socially. You see the use of the press to point the finger at the other side. It plays out for us in a very big way when participation in conferences becomes a political issue between the parties. Everyone gets very insecure to travel no matter what the value of the event is. So I think that's probably been the biggest—the loss of mutual trust and camaraderie in the legislative houses over the years. It's the big states and small states as well. It just poisons the atmosphere.

I've also seen the amazing growth of the influence of lobbyists in state capitals. It's a huge industry. That's certainly had an impact. Responding to that, at least in this region, is the growth of the conflict of interest and ethics laws and rules to challenge too cozy relationships. But all of that lends itself to people looking over their shoulders and not being as open with each other about working on things in a bipartisan fashion. You just rarely see that these days, which is really a shame."

What challenges are states facing that they may not have faced 40 years ago?

"I think one of the most significant challenges now is that there is not a federal government committed financially to the federal system in terms of domestic spending. It's a terrible struggle for the states to handle all the issues that they're confronted with without a strong federal presence, whether it's health care, education, transportation. ... The federal government continues to try to promulgate rules to have control over these areas but they've backed away because of, currently, the war or because of deficit and debt issues. Also, I guess, ideologically opposed to what's called big government, there has been a real shift of federal resources away from domestic spending, which has made it so difficult for the states.

The second, I think, is just the power of the anti-tax agenda that has made it impossible for state government, federal government to probably face the bigger challenges of the financial cost of doing domestic programs as needed, whether it's health care, infrastructure, education ... kind of starving themselves by not being able to raise taxes when necessary. I think that's a very difficult problem for our whole government, state and federal, local. There's still a demand for valued services, but no willingness to be taxed to get that done.

I think the other is the continuing view by the media of government as almost the enemy, not the friend—the assumption that federal officials and state officials are venal and on the take and that less government is better. I think all of those themes still play large."

We are in the midst of another energy crisis, similar to the one in the 1970s. What is different about how states are responding this time as opposed to the 1970s?

"I think the states are doing everything they possibly can, particularly to protect the poorest of the poor, through the Low Income Home Energy Assistance. ... A lot of families in this region, particularly in New England, get their heat through home heating oil and kerosene, so there've been efforts by the states to supplement the federal spending. (While states are working on energy efficiency issues) the realities are without a very deep and committed federal program, it's very hard for the states to deal with this; and they have no control over the cost of gas or foreign oil. They can plug away at trying to do the right thing, but without a federal commitment to alternative fuels and auto efficiency standards and climate change. ...The states are trying but you probably make difference at the edges, I think, without a major national leadership to make this a high priority, almost like a Marshall plan decision at becoming energy independent. The resources at the states are limited and they need the federal government resources to make a significant difference."

How has the relationship between the state and federal governments changed over the years?

"In the Nixon administration there was a great deal of commitments to the federalism idea and the grants programs domestically and trying to work through the regionalization of the federal agencies to support the states and work as teams. I think that was a highlight until, when the Reagan administration came in, there was less ambition to do so. I think to this day, there seems to be greater effort by the feds to have a much bigger say in education than it ever had and yet not providing the resources to make the kind of changes that were contemplated.

I'm not sure where the Supreme Court is going to go on the 10th amendment. Losing the Sandra Day O'Connors of the world is a tough hit for the states because she was very supportive of states' rights in the best sense of that phrase. I'm not sure that's going to continue with the court.

And in the transportation area, the Bush administration is basically on a path to privatize or turn over the responsibilities of transportation to the states and probably with a grants program that is not enough for the states to do the job. There's not a belief in the national transportation system. When you think back to the '50s with Eisenhower and the interstate highway system, it's kind of turned on its head. There's much less investment or perception that there's a national system and that it needs to be invested in and protected by the national government."

Is there a particular policy issue that creates more challenges for state government than other issues?

"I think we're not going to get to the bottom of our domestic needs without a committed federal government that's in much better economic shape to support the states. I think it's going to be an ongoing struggle to make change, but I think it's going to be on the edges and incremental and never get to the bottom of how to deal with this. Whether it's housing or transportation, we're losing ground."

—Mary Branham Dusenberry conducted the interview and is managing editor of State News.

Alan Sokolow discussed the growth of The Council of State Governments Eastern Regional Conference's jurisdictions, as well as the ERC associates program and changes in the relationships between the national CSG headquarters and the regions, in greater depth. Visit Capitol Comments, CSG's blog, for more from the interview.

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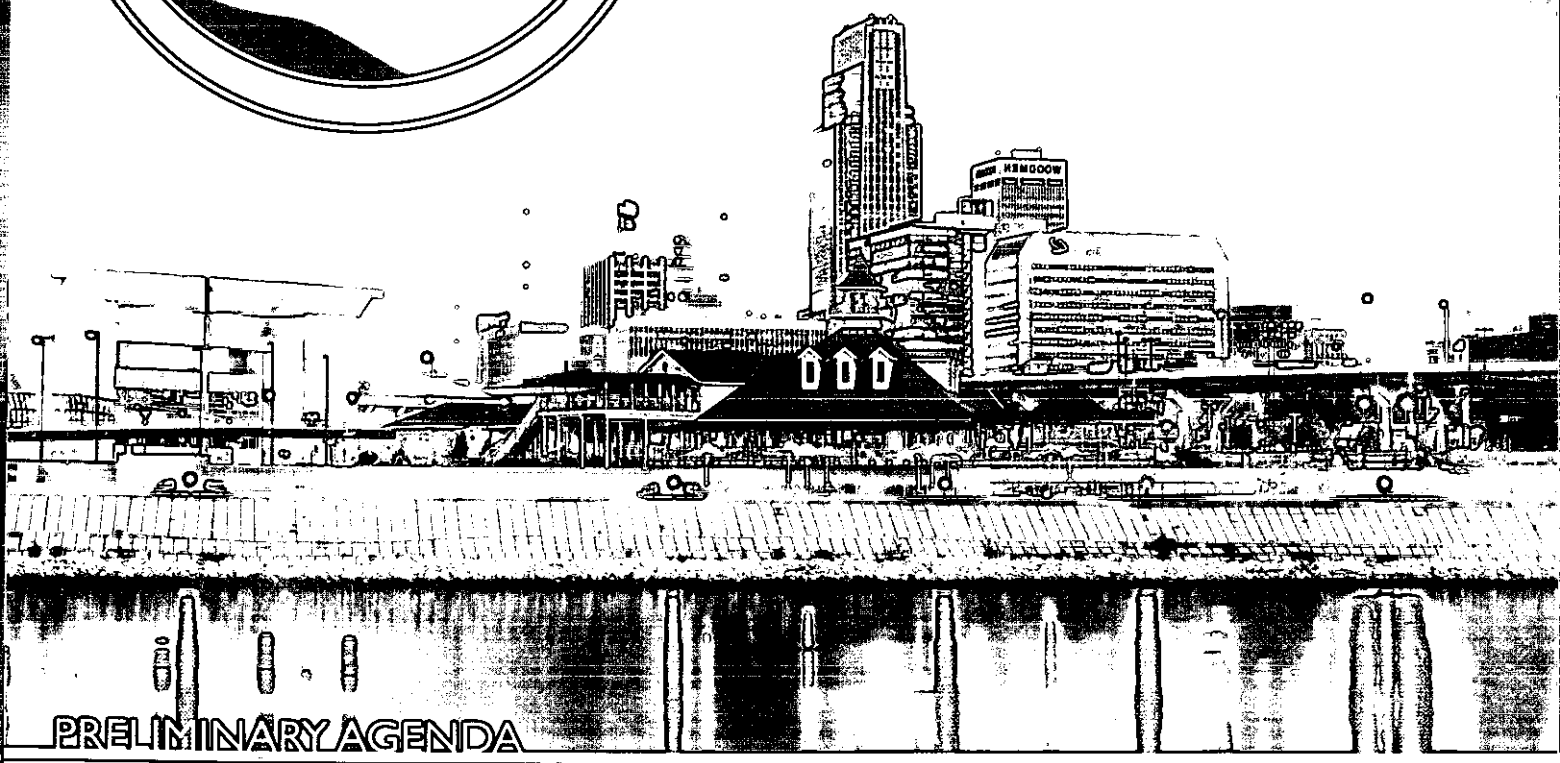


PRELIMINARY AGENDA

Thursday, Dec. 4

Noon	Registration Opens
Noon–4 p.m.	Guest Program
1:30–3 p.m.	Interbranch Working Group
1:30–3 p.m.	Technology Working Group
1:30–3 p.m.	Investment Subcommittee
3:30–5 p.m.	Financial Services Working Group
3:30–5 p.m.	Transportation Advisory Group
3:30–5 p.m.	Finance Committee
3:30–5 p.m.	Associates Advisory Committee
5–5:45 p.m.	New Members Reception
6–8 p.m.	Opening Reception *Holland Performing Arts Center*

Friday, Dec. 5

7–9 a.m.	Breakfast Tabletop Policy Discussions
9–12:15 p.m.	Strategic Planning Committee
9–4 p.m.	Guest Program
9–4:30 p.m.	CSG Exhibit Show
9–12:15 p.m.	Energy & Environment Policy Task Force
9–12:15 p.m.	Education Policy Task Force
9–12:15 p.m.	Health Policy Task Force
9–12:15 p.m.	Public Safety & Justice Task Force
12:30–2 p.m.	Lunch Plenary
2–3:45 p.m.	International Committee
2–3:45 p.m.	Annual Meeting Committee
2–5 p.m.	Suggested State Legislation (I)
2–5:30 p.m.	Technical Tours
5:30–6:45 p.m.	Regional Receptions
9–Midnight	SGAC Late Night Event

Saturday, Dec. 6

7:30–8:30 a.m.	Breakfast Tabletop Policy Discussions
7:30–10:15 a.m.	Suggested State Legislation (II)
8:30–4:30 p.m.	CSG Exhibit Show
8:30–10:15 a.m.	Intergovernmental Affairs Committee
8:30–10:15 a.m.	21st Century Foundation
8:30–10:15 a.m.	Policy Workshop
9–4 p.m.	Guest Program
10:30 a.m.–Noon	Plenary II
Noon–2:00 p.m.	Awards Luncheon *Qwest Center Ballroom* *Speaker: Mark Shields*
2:30–4 p.m.	Policy Workshop: Health
3–5 p.m.	Governing Board/ Executive Committee Meeting
6–9 p.m.	Omaha Host State Dinner *Joslyn Art Museum*

Sunday, Dec. 7

7:30–8:30 a.m.	Breakfast Tabletop Policy Discussions
8:30 a.m.	Conference Adjourns

KEYNOTE SPEAKER

Mark Shields

Mark Shields is a nationally known columnist, commentator with unmatched credentials as an analyst of the U.S. political system. He is best known for his work as moderator on CNN's *Capital Gang* where he debated policy issues with Robert Novak, Al Hunt, Kate O'Beirne and Margaret Carlson. He currently serves as an analyst on *The NewsHour with Jim Lehrer* on PBS, seen every Friday and during primaries, national conventions and elections.

Since 1979, Mark Shields has been writing his column on national politics for the *Washington Post*. The column is now distributed nationally by Creators Syndicate.

adapting to SURVIVE

States Prepare for the Health Effects of Climate Change

In the absence of federal action, a number of states and localities are stepping up to the plate to address issues surrounding climate and health.

By Sean Slone

3838

"I think everyone's focus originally was on mitigation but there is a clear understanding now that we have to look at adaptation. The fact is (climate change) is already here and to ignore steps that need to be taken, I think, you do at your own peril."

—Maryland Sen. Paul Pinsky, Chair of the Environment Subcommittee

With its relatively mild temperatures and persistent drizzle, Seattle isn't usually the first city that comes to mind when discussing the effects of climate change. But rising global temperatures could mean more frequent, more intense and longer lasting heat waves, even for the land of Starbucks. The city could see heat waves like the ones responsible for hundreds of deaths in the United States in recent years.

In addition, increased smog and fine particulate matter, combined with a longer pollen season, could mean more respiratory problems for many of Seattle's 580,000 residents, according to the Climate Impacts Group at the University of Washington. Rising temperatures and flooding in the Emerald City could also contribute to higher numbers of communicable diseases spread by rodents, shellfish and mosquitoes.

Washington state is one of a handful of states trying to address both the causes of climate change and its probable impacts. Gov. Christine Gregoire in 2007 charged the directors of the state departments of ecology and community, trade and economic development with determining steps the state should take to prepare for impacts to five sectors—public health, agriculture, the coast line, forestry and infrastructure. The directors formed several preparation and adaptation working groups to develop recommendations for the governor.

Anne Biklé, a former Seattle-King County Public Health Department official, was a member of the working group on human health.

"When the (work group) came up, we at the health department were very excited about it because we felt like finally there (would) be a place to talk about what our changing climate means for people," said Biklé, who now works for the National Wildlife Federation.

Biklé's working group issued a series of recommendations that included enhancements to public health tracking of diseases, emergency preparedness and response, and community design policies to reduce driving.

The group also recommended the state departments of health and agriculture collaborate on improving monitoring of diseases spread by animals and insects. It called for establishing long-term laboratory capacity, funding for disease identification and testing, and increased training of veterinarians in reporting these diseases. The group also called for the state departments of health and ecology to collaborate on outdoor air quality surveillance and health risk communication strategies.

In the area of emergency preparedness and response, members recommended creating a heat emergency task force and called on the Washington Military Department's Emergency Management Division to help improve the state's ability to respond to heat wave emergencies.

The working group also included a series of recommendations for local governments to make communities more walkable and pedestrian friendly.

"If we are building communities and engaging in new developments, are we siting them in a way that means people have to drive every time they want to try to accomplish some part of their daily routine?" Biklé said. "Or are we designing things in a way that we minimize the primary generating source for greenhouse gas emissions? We also want more walkable, livable communities so people can get more physical activity to help reduce rates of overweight and obesity."

A bill introduced in the 2008 session of the Washington legislature would have directed the state department of ecology to develop a report using the recommendations of the human health and other work groups. Though the Senate approved the bill, the House

failed to pass it, due largely to budgetary concerns. But state Rep. Dave Upthegrove, who chairs the House Ecology and Parks Committee, expects a similar proposal to be introduced next year. "There was great interest," he said.

States' Mitigation and Adaptation Plans

Washington isn't the only state tackling both the causes of climate change through mitigation of greenhouse gas emissions and its probable impacts through adaptation policies. The Pew Center on Global Climate Change reports that 33 states have created or are in the process of creating climate action plans, most of which deal primarily with reducing greenhouse gas emissions.

While reduced emissions may help, climate scientists say global warming will be a reality for decades, so states will also need to adopt strategies to adapt to the probable impacts of climate change. While six states—Arizona, Colorado, New Hampshire, North Carolina, Utah and Vermont—include adaptation within the scope of climate action plans, six others—Alaska, California, Florida, Maryland, Oregon and Washington—address adaptation with parallel, stand-alone efforts. These adaptation plans, which are in various stages of implementation, address the health effects of climate change to varying degrees.

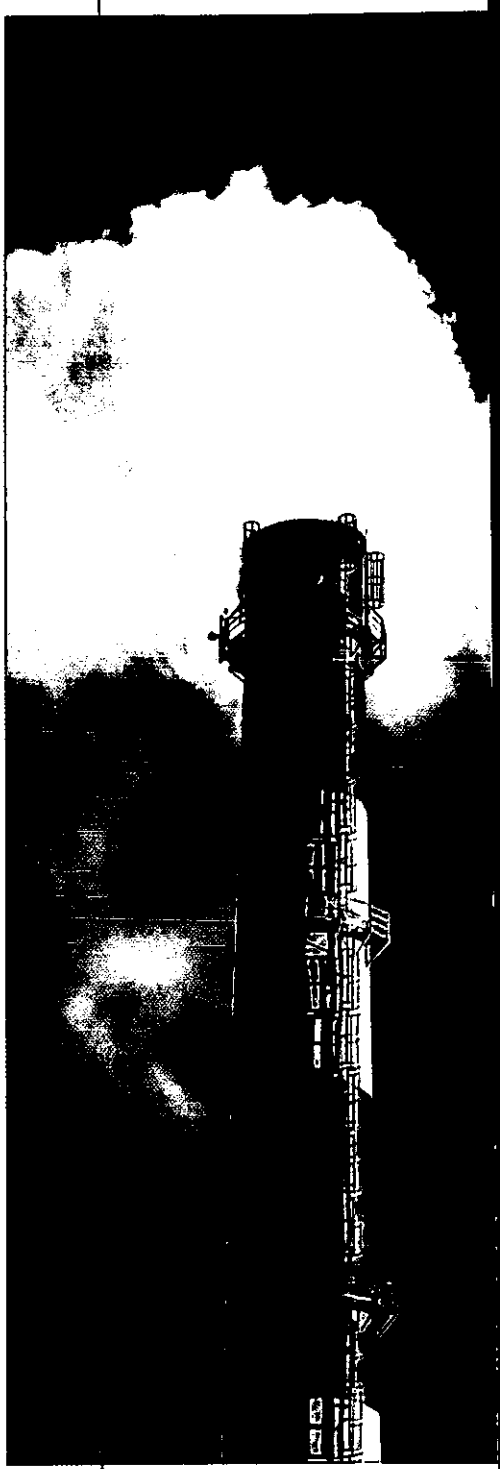
In Florida, a 2007 executive order by Gov. Charlie Crist calls for the Governor's Action Team on Energy and Climate Change to issue legislative recommendations for "adaptation strategies to combat adverse impacts to society, public health, the economy, and natural communities in Florida" by Oct. 1, 2008.

In 2006, Oregon Gov. Ted Kulongoski established the Climate Change Integration Group by executive order. The group's final report, issued in January, offered 10 recommendations, which include incorporating the public health implications of climate change into state policy, planning and preparation. It promotes recognizing the public health benefits of many climate change mitigation, preparation and adaptation activities, and encourages watching for unintended public health consequences of these activities.

In California, the secretary of the state environmental protection agency is required to report to the governor and the state legislature biannually on the impacts of global warming on the state, including impacts to public health, and to report on mitigation and adaptation plans to address them.

In Maryland, a 2007 executive order by Gov. Martin O'Malley established the Maryland Climate Change Commission, which is charged both with developing an action plan to address the causes of climate change and preparing for the likely consequences and impacts of climate change. The commission's Web site, www.mdclimatechange.us, includes an analysis of policy options, several of them health-related.

Maryland Sen. Paul Pinsky is a member of the commission and chairs the Environment Subcommittee in the state Senate. "For the state of Maryland, which has the Eastern Shore just a couple of feet above sea level, with tourism and agriculture and with the Chesapeake Bay, (climate change) has significant implications," he said. "I think everyone's focus originally was on mitigation but there is a clear understanding now that we have to look at adaptation. The fact is (climate change) is already here and to ignore steps that need to be taken, I think, you do at your own peril."



Preparedness of the Public Health Work Force

The success of states in adapting to the health effects of climate change may hinge on personnel and resources, public health officials believe.

"The public health system will be a frontline responder to potential emergency conditions caused by climate change," Dr. Georges Benjamin, executive director of the American Public Health Association, told the U.S. House Select Committee on Energy Dependence and Global Warming in April. "As a frontline protector and communicator to communities, the public health community plays a key role in helping to mitigate and adapt to climate change. As such, the public health community must have the tools, skills, training and education and resources to fulfill this role," he said.

But a 2008 national survey of local public health departments revealed some cause for concern about the preparedness of the public health community for dealing with the health

effects of climate change. Three-fourths of local health directors surveyed by the Environmental Defense Fund, George Mason University and the National Association of City and County Health Officials (NACCHO) said they lacked the expertise to assess local health impacts of climate change in their region or to craft adaptation plans. Moreover, they said their state departments of health also lacked expertise in crafting such plans. The directors also believed they lacked the necessary resources to address climate-related health threats and specifically cited a need for additional funding and staff.

"The response doesn't surprise me at all," said Dr. Dennis McBride, health director for the Milford, Conn., Health Department and chairman of NACCHO's Environmental Health Committee. "I think there's a set of skills ... that health departments have to be brought up to speed on. Most of us in public health rarely use climate as something we have to take into account. There's also the expertise on the interface of human ecology with other ecologies, which to me involves a whole different set of skills that are not there in public health."

NACCHO and the Trust for America's Health reported last year that even as state and local health agencies work to meet public health preparedness goals, funding has declined by more than 25 percent since 2005, threatening the sustainability of new emergency preparedness programs. The Trust also reported that 12 states lack an electronic disease surveillance system compatible with the national system and nationwide disease monitoring remains disconnected from monitoring of related health, behavioral and environmental factors.

Another disconnect between human and animal health agencies prevents quick responses to climate-related emerging diseases that can be transmitted between animals and humans. Moreover, the Centers for Disease Control and Prevention this year said that public health departments and state public health laboratories have reported difficulty recruiting and retaining qualified epidemiologists and laboratory scientists.

The Climate Change Health Challenge

Two University of California-Berkeley researchers earlier this year recommended several adaptation strategies for states to consider. Richard Jackson and Kyra Naumoff Shield in the *Annual Review of Public Health* recommended that states:

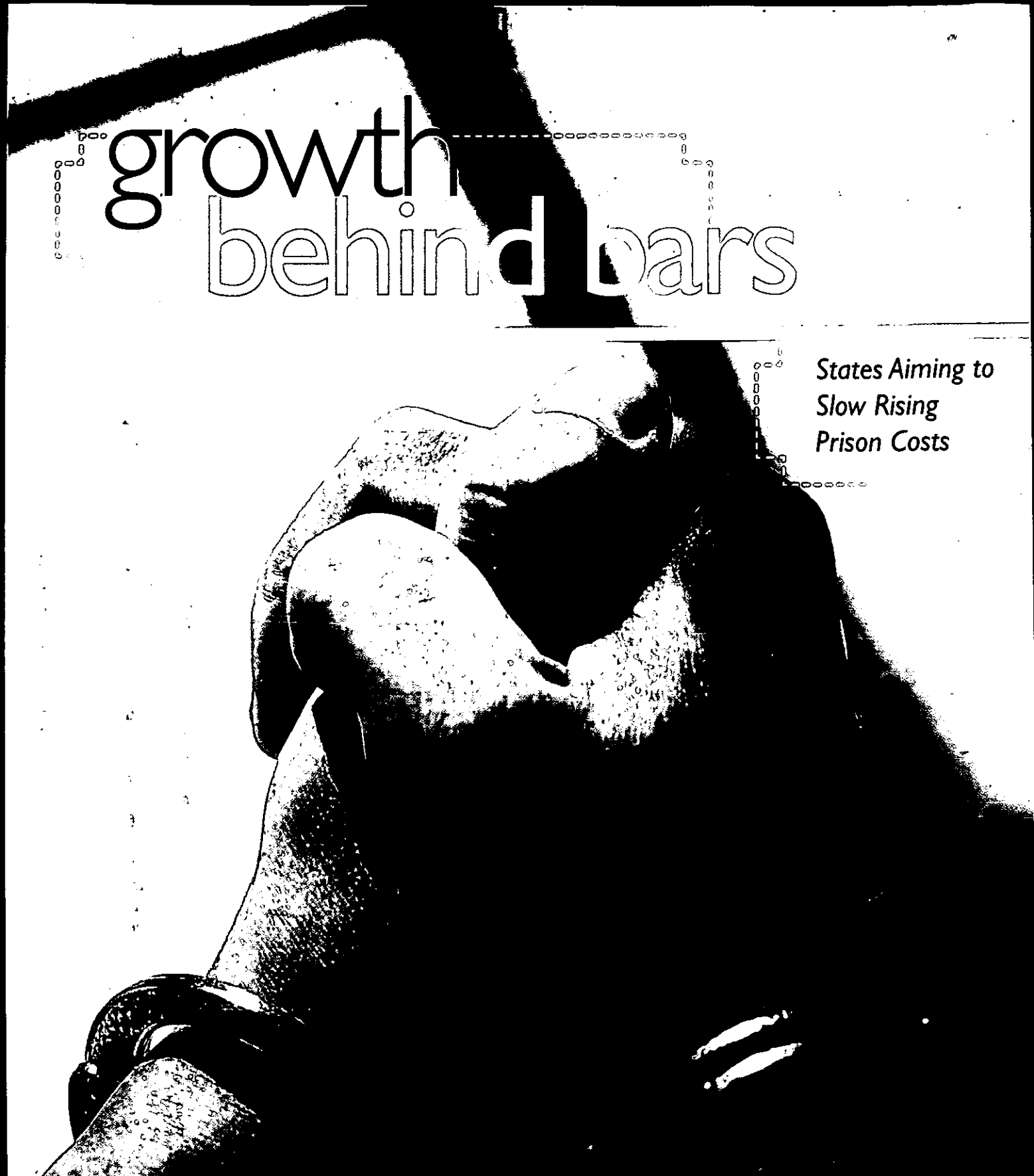
- Create a multidisciplinary leadership team to lead state adaptation and mitigation scenario planning;
- Develop partnerships with other government agencies, the private sector, nongovernmental organizations and universities to more effectively address health aspects of climate change;
- Support training programs in universities and other settings to develop the interdisciplinary experts needed to confront the broad spectrum of climate and health issues;
- Encourage state health departments to implement asthma tracking and control programs with a view toward instating similar programs at the local health department level; and
- Explore opportunities for the detection of real-time heat stress-related conditions by tracking electronic medical records.

Jackson and Naumoff Shield also wrote: "As the impact of climate on health is expected to vary by location and given the level of leadership shown on this issue by the U.S. government, it is important to address issues at the state level rather than wait for federal agencies to respond."

—Sean Slone is a health and transportation policy analyst at The Council of State Governments.

growth behind bars

States Aiming to Slow Rising Prison Costs



States' prison populations are expected to grow in the next decade and prison costs are projected at almost too much to afford. With so many people behind bars, some states are employing strategies to keep people from returning to prison and spending money on treatment programs, while some states face a future of building expensive jails.

By Mikel Chavers

In 2006, Kansas, like many other states, was feeling the pressure of a corrections system that was ready to bust at the seams. Legislators feared the state would need to handle an influx of inmates projected at far more than the state could afford to lock up.

The Kansas prison system was staring a dismal future in the face—it would need an additional $500 million by 2016 to house an inmate population projected to increase by 22 percent, according to The Council of State Governments' Justice Center.

In fact, according to a new Pew Center on the States report, "One in 100: Behind Bars in America 2008," released in January, for the first time in history more than one in every 100 Americans is locked up in prison.

And like Kansas, many state departments of corrections' budgets are feeling the crunch.

But prisons are expensive to build.

In Texas, for example, it costs $250 million to $300 million to build a medium security prison housing 2,200 to 2,500 inmates and another $40 million a year to staff and operate the facility, according to Texas Rep. Jerry Madden, who is also the chair of the Texas Corrections Committee for the legislature.

Last year, states spent more than $49 billion on corrections, up from $11 billion 20 years earlier, according to the Pew report.

"The stakes here truly are high," Jake Horowitz, senior associate with the Public Safety Performance Project of the Pew Center on the States, told an audience at CSG's spring meeting in Lexington, Ky., in May. "If we don't do our job well in this field, people get hurt and taxpayer dollars can get squandered."

Kansas Takes Action

Kansas officials decided a better use of taxpayer dollars would be to curb prison spending and reinvest those dollars in programs targeting the root of the problem.

Partnering with the Justice Center, Kansas officials worked to uncover the multiple factors driving the prison population growth.

At the root of the problem, for one, were individuals whose parole or probation was revoked—landing them back in prison. Those individuals accounted for 65 percent of prison admissions and took up 27 percent of prison capacity in the state, according to the Justice Center.

Ninety percent of those who lost their probation or parole in Kansas in 2006 went back to jail because they violated the terms of their parole or probation. Thirty-two percent broke parole or probation with alcohol or drug use, the Justice Center reports. And 58 percent of the people who lost their parole or probation demonstrated a need for substance abuse or mental health treatment, according to the Justice Center.

In May 2007, Kansas lawmakers came up with a plan to solve all that—Senate Bill 14.

The bill "was designed to give (the corrections depart-

> "... We ought to look at some programs that keep people either from returning to prison or from coming there in the first place that do not endanger public safety."
>
> —*Texas Rep. Jerry Madden*

ment) funding to kick-start risk reduction programs," said Margie Phelps, director of Re-entry Services in the Kansas Department of Corrections.

Kansas risk-reduction programs are designed to keep people from relapsing and coming back to prison once they get out. And legislators in Kansas believe in these programs.

Lawmakers are seeing that risk reduction programs that are a few years old are reducing return rates, the number of people absconding is going down, and crimes committed by parolees are going down, Phelps said.

With Senate Bill 14, lawmakers in Kansas basically provided an additional $7 million in funding to special risk reduction programs in the prisons and provided incentives to get more offenders to participate in those programs. Those measures and others in the bill are expected to avert $80 million in state spending over the next five years, according to the Justice Center.

As a result of the new law, state officials changed prison population projections. Instead of a 22 percent increase, state officials are expecting a much lower 4 percent increase in Kansas' prison population over the next 10 years.

Of the treatment programs receiving additional funding, therapeutic communities—an extreme Kansas program that seeks to change risky behaviors in specific groups of the prison population—are receiving additional funding. In the yearlong program, inmates with similar issues are literally housed together in a specific satellite unit or prison facility and they learn to function socially within that community.

"It's uncomfortable," Phelps said. "Think about the behavior that you have had that most bothers you and that it's a habit that you've had for the longest time in your life and you're trying to change that—that's what we're dealing with here."

But it can be difficult to get inmates to sign up for such a life-changing and behavior-breaking experience.

When staff in the Kansas Department of Corrections asks offenders to work with the risk reduction staff and join one of these therapeutic communities or other treatment programs, "one out of three will say no," Phelps said.

But with the new legislation, inmates can qualify to get out of jail 60 days early if they participate. "So the 60-day credit is just one incentive in their toolbox now," Phelps said. "If you're in a yearlong or 22-week program, you come to some spots where you just want to chuck it—again, that's very common in our population. I think this will be a chance to say, 'are you sure you want to chuck it? Look how far you've come, and remember you can get these 60 days of credit.' It will just be a part of the conversation."

The first offenders eligible for the 60-day credit are those whose offenses occurred after Jan. 1—and to date, no inmates are eligible, according to Phelps.

Prison Beds No Longer for Rent

Virginia, like Kansas, is also feeling the budget crunch in the department of corrections. To make up a budget shortfall in the department, state lawmakers OK'd a plan to rent prison beds to out-of-state inmates. But Virginia Gov. Timothy Kaine halted that plan in June.

"The issue there is we all had budget cuts. Every agency had budget cuts and (are) getting ready to go through some more," said Barry Green, deputy secretary of Public Safety in Virginia. "So for the Department of Corrections it was $19.2 million a year."

The plan to rent the prison beds was supposed to make up that money.

"That way they'll be able to keep all of their existing prisons open," Green said. "But with a $19.2 million reduction—and if you had to take that in cuts—they'd have to close something."

The governor put a stop to the plan after several sheriffs complained that Virginia was leasing space in its prisons to out-of-state prisoners while Virginia inmates remained in local jails funded with local tax dollars, according to *The Virginian-Pilot*.

The state is currently housing 300 Wyoming inmates—generating $7.2 million a year for two years, according to Green, but won't take in any other states' inmates, although more may come from Wyoming.

"So how they're going to make up that budget cut is still up in the air," Green said.

That shortfall is an estimated $12 million a year, according to Green. That means a new 800-bed expansion to a Virginia state prison will not open because the state doesn't have the money to operate it, Green said.

And further adding stress to the budget, Virginia's prison population is expected to grow by 1,000 prisoners a year, Green said. "It would take a prison a year to meet that forecast," he said. "If it's necessary to protect public safety, we'll find the money."

Delegate David Albo agrees. "We usually don't have a problem finding communities for prisons, because they provide good jobs," he said.

The newest project is a prison in Charlotte County, which could be a privately run prison, although that decision is not final, Green said. The new prison could house another 1,500 to 2,000 beds, he said.

"There's a lot of stuff that we're trying and I can't tell you that it hasn't made a difference. I can just tell you that we continue to have a reasonable amount of (prison population) growth—or unreasonable amount of growth as you might call it," Green said.

Texas Says Prisons Cost Too Much

Texas, some might say, used to be in a similar spot as Virginia.

Back in 2005 when Texas Rep. Madden became chair of the Texas Corrections Committee, the speaker of the state House gave him one charge: Don't build any prisons—they cost too much, he said.

"We had the projection going into the last legislative session that by 2012 we would be 17,000 plus prison beds short in the state of Texas," Madden said. "We had facing us what would have amounted to a big building project that would have cost us lots of money."

The dilemma for Texas was how to keep from spending billions of dollars in construction costs.

Then in May 2007, the Texas legislature passed a package of criminal justice legislation that included funding to expand treatment and diversion programs as well as new policies and procedures for probation and parole.

The biggest part of that package, according to Madden, was in the appropriations act where slightly less than $250 million was included to expand existing programs. Those programs include:

- 800 new beds in a residential substance abuse program for people on probation;
- 3,000 slots for outpatient substance abuse treatment for people on probation;
- 1,400 new beds in intermediate sanction facilities, diverting probation and parole technical violators from prison;
- 300 new beds in halfway houses;
- 500 new beds in a treatment facility targeting drunken drivers;
- 1,500 new beds for an in-prison intensive substance abuse treatment program; and
- 1,200 slots for intensive substance abuse treatment programs in the state jail system, according to the Justice Center.

"Here's a group of things we should spend money on and oh by the way, it's a lot less expensive than this other option of putting down a lot of concrete and a lot of bars and doing the things that you have to do to build a prison," Madden said.

Some of the programs got an early start after the funds became available Sept. 1, 2007. However, the programs that required new facilities are still in the planning stages, Madden said.

Texas is still several months away from measurable results, Madden said. But with the new funding and policy changes in place, the statistical evidence is enough to make Texas lawmakers proud.

"They came out with our new projection in January of this year as to what our prison needs are and what the prison population needs will be in 2012," Madden said.

"The number of prison beds we have to build is zero."

—Mikel Chavers is associate editor of State News *magazine.*

KEEPING TRACK

Updated Compact Keeps Juvenile Offenders from Falling Through the Cracks

After more than five years, a new Interstate Compact for Juveniles is expected to soon be official. The compact, which is designed to keep juvenile offenders from falling through the cracks of the justice system, needed passage in 35 states before becoming effective.

By Mikel Chavers

Updated Compact Adds Accountability, Enforcement

Every year thousands of juvenile offenders cross state lines and are lost in the system. Often left to fend for themselves and disconnected from social services and the help they need, some young offenders who would otherwise be supervised commit violent and nonviolent crimes.

But the new Interstate Compact for Juveniles seeks to change that.

First written in 1955, the compact is an agreement among states to track young offenders. The Council of State Governments' National Center for Interstate Compacts took on the challenge of rewriting the outdated compact in 2001 and advocating for its passage. The first state introduced the compact in 2003. In order to take effect, 35 states must sign the compact into law.

The new Interstate Compact for Juveniles significantly updates the agreement for tracking and supervising juveniles who move across state borders. The new language provides enhanced accountability, enforcement, visibility and communication and seeks to update a tool for ensuring public safety as well as preserving child welfare.

Now fully updated from the 1955 version, changes in the new Interstate Compact for Juveniles include:

- The establishment of an independent compact operating authority to administer ongoing compact activity, including a provision for staff support;
- Gubernatorial appointments of representatives for all member states on a national governing commission (The commission would meet annually to elect the compact operating authority members, and to attend to general business and rule-making procedures);
- Rule-making authority, provision for significant sanctions to support essential compact operations;
- A mandatory funding mechanism sufficient to support essential compact operations (staffing, data collection, training/education, etc.); and
- Language to compel collection of standardized information on juvenile offenders.

For up-to-date information on the passage of the compact in the 35th state, go to *www.csg.org* and click on the Capitol Comments link. For more information on the new compact, visit CSG's National Center for Interstate Compacts Web site at *http://www.csg.org/programs/ncic/default.aspx*.

On Sept. 18, 1998, the bodies of Gordon and Barbara Erickstad were found in a desolate area near Selfridge, N.D.—they had been stabbed. Earlier that day, police searched the couple's bloodstained home in Bismarck and found knives in the kitchen sink, according to North Dakota Supreme Court records.

The police investigation focused on the couple's adopted son and his friend from Texas. The two were later picked up in Texas and extradited to North Dakota where they faced charges of murder and other offenses, according to the court documents.

"It was just a horrific deal from one end to the other," said North Dakota Rep. Duane DeKrey. "When it was all done and said, we found out that the Texas kid was under supervision in Texas but had come to North Dakota, and Texas had absolutely no idea where this guy was or what he was up to."

With such a horrific murder involving youth lost in the system fresh in their minds, the North Dakota legislature became the first state to pass a special agreement for tracking and monitoring juvenile offenders designed to update an old, broken system.

"With this murder at the backdrop and the success of the adult compact, we were able to get it adopted," DeKrey said.

Back in March 2003, North Dakota was signed onto the new Interstate Compact for Juveniles. And after a more than five-year effort, the compact is expected to become official soon.

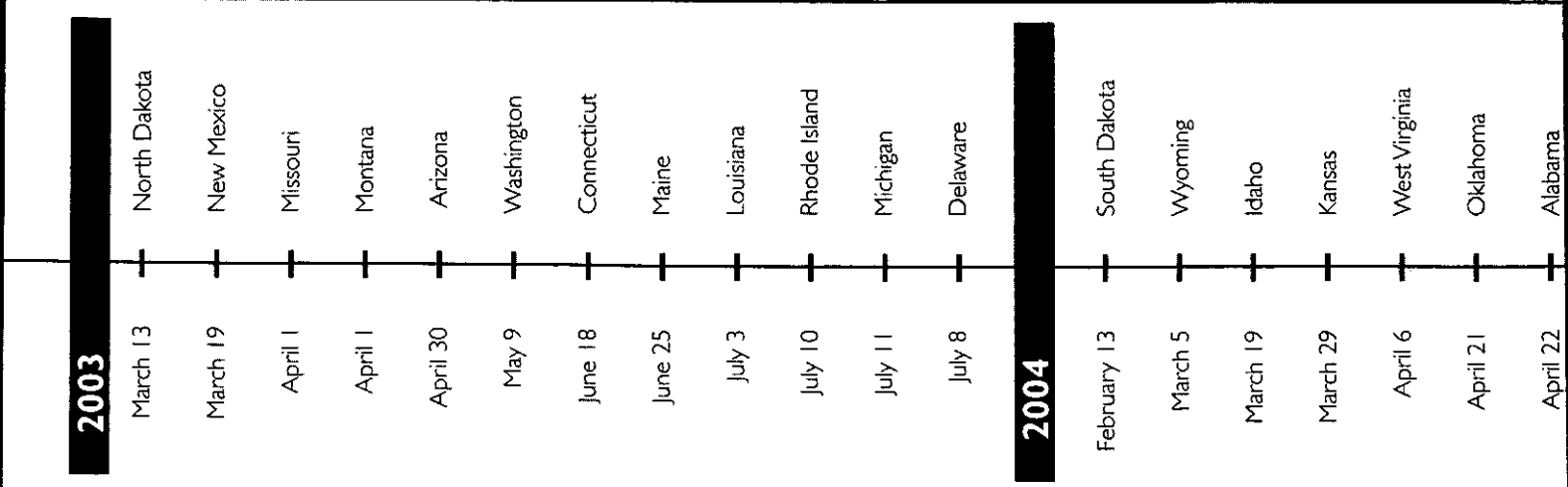
Illinois became the 35th state to pass the agreement when the legislature approved the compact and sent it to the governor for his signature in late June. As soon as the governor signs it there, the new compact will take effect nationwide. EDITOR'S NOTE: *At the time* State News *went to press, Illinois Gov. Rod Blagojevich had not yet signed the compact. Check The Council of State Governments blog, Capitol Comments, for the latest update.*

Fixing a Broken Compact

After taking on the project in 2001, The Council of State Governments' National Center for Interstate Compacts has stayed the course with the updated compact. "NCIC has devoted significant time and resources to making sure that 2008 did not end without something to show for our efforts," said Keith Scott, director of the center, which is based at CSG's Lexington, Ky., headquarters.

When 2008 began, Scott and his staff were faced with the predicament of having four states that had carryover legislation for the compact from 2007. The center began discussions with sponsors

Passing the Interstate Compact for Juveniles *(date compact passed)*



of the carryover legislation in an effort to jumpstart the bills for the 2008 session, according to Scott. At the same time, the center began intensive discussions with potential sponsors in the other respective legislative chambers.

"Fortunately we were successful on both counts in Illinois and Tennessee," Scott said. "Consequently, Tennessee has now enacted the compact into law and Illinois is on the verge of doing the same if the governor signs the bill."

And the old version compact was in dire need of an update, said Ray Wahl, a juvenile court administrator in Utah.

"First of all the compact language was antiquated; it hadn't been updated for quite some time," Wahl said of the original compact, which was written in 1955.

"Then there was this problem that there were three amendments to the original juvenile compact that some states signed on to (and) some states didn't sign on to them," Wahl said. "So it became very confusing for states to know which states were on board with certain stuff and not on board with certain stuff."

And because of the outdated compact, children were falling through the cracks, as in the case of the Bismarck murders. States were literally losing track of their young offenders when they crossed state borders.

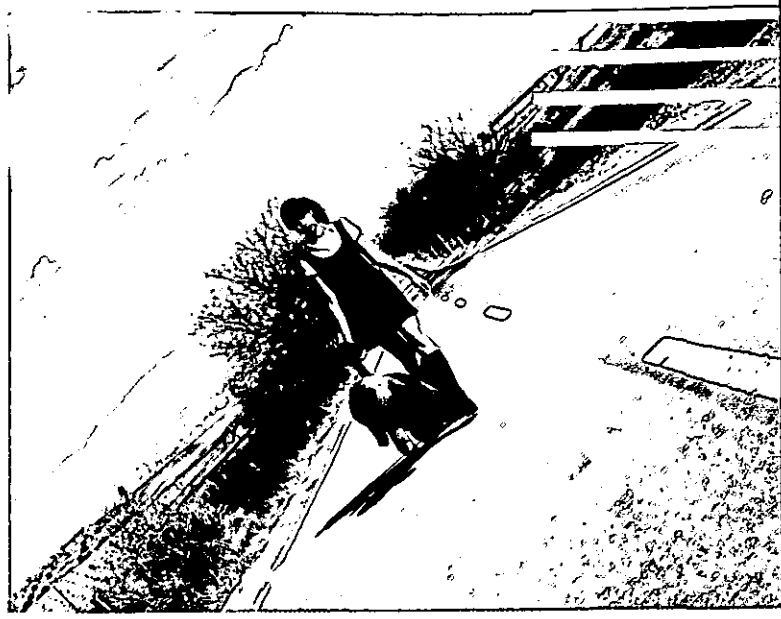
"Another big deal is there was really no authority anywhere to promulgate rules about this compact so whatever policies or rules that existed weren't promulgated with the proper authority—and that was part of the reason why they were unenforceable," Wahl said.

So, in effect, even though the old compact is still in place, there's no real way to settle disputes through the compact, Wahl said.

"So you have these rules that some states were complying with and some states weren't complying with but when a state didn't comply with the rules, there was no way to get a grievance, if you will, or a complaint heard about that," Wahl said.

But the new compact seeks to change all that with a built-in system to review complaints. The juvenile compact language took much the same form as the Interstate Compact for Adult Offender Supervision's language (the compact's equivalent for adult offenders), in that a national commission serves as a rule-making authority.

"And then there are the state councils and the state councils file complaints to this national commission for review and there's a process by which you resolve those," Wahl said.



The new juvenile compact was written with this in mind.

"The new compact was specifically designed to fill in those types of holes," Scott said. "Everyone has recognized for quite some time that enforcement was lacking. They have also realized that disputes between states have arisen with little in the way of structured resolutions. The current compact, with its interstate commission structure, is specifically set up for the purposes, among others, of providing just such a means of reliable enforcement and conflict resolution between jurisdictions."

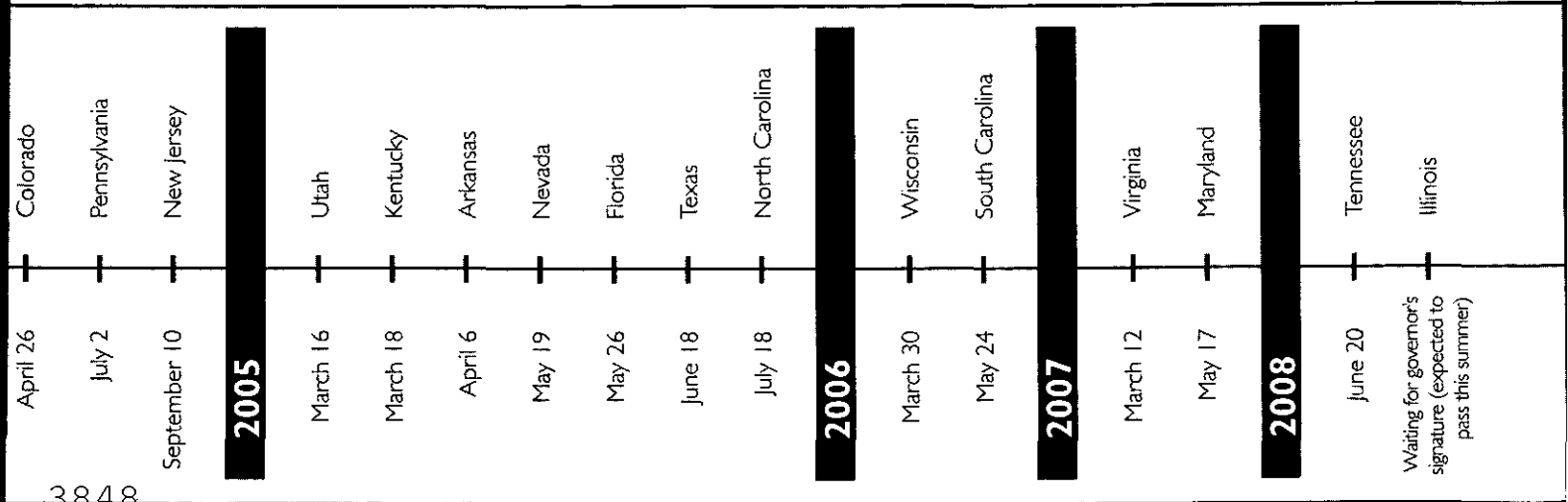
The Next Steps

When Illinois officially enacts the compact, member states can implement the changes they intended when they passed the compact into law, Scott said. The states will all participate in, and develop, the transition from the old compact to the new one, he said.

And states such as Utah and North Dakota realize the benefit of getting in on the ground floor—participating in the transition from the old compact to the new one.

"I think its going to be something that is really going to be important in the juvenile area," Wahl said.

—Mikel Chavers is associate editor of State News *magazine.*



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ANALYSIS: PAVING THE ROAD TO PROSPERITY

Auto Industry in the South Faring Well in Contracting National Economy

In stark contrast to the difficult fiscal positions states such as Michigan and Ohio face—primarily as a result of the decreasing automobile sector there—the auto industry continues to flourish in the South, generating billions of dollars in economic impact and creating thousands of direct and indirect jobs.

By Sujit M. CanagaRetna

The auto industry's drive to move South is paving the road for prosperity in the region, even while the U.S. economy inches toward recession.

The auto industry continues to prosper and play a dominant role in the economic calculations of the South with the advancement of several foreign automakers at a time when the industry's domestic Big Three—Chrysler, Ford and General Motors—face wrenching problems. As the U.S. economy experiences a great deal of tumult with a serious slowdown in growth, the automobile industry in general and the industry in the South in particular, have received an additional boost from the depreciating U.S. dollar—increasing auto exports of autos and other goods.

As a result, the industry's drive to move South continues, unabated and with renewed vigor.

A Growing Industry in the South

The South has attracted an impressive roster of foreign automakers in the last 25 years or so. Researchers attribute the success to a number of factors:

- the ability to construct new manufacturing facilities—incorporating all the latest technologies—more efficiently and effectively at a Southern location, than reconfiguring older assembly plants in the Midwest;
- the economies of scale created by the cluster effect with the growing number of automobile assembly plants and thousands of auto parts suppliers in close proximity to each other;
- the low or nonexistent rates of unionization and the negligible level of interest among Southern autoworkers to unionize;
- the attractive incentive packages—including tax breaks, worker training programs, an abundant labor pool and the ability to train a work force that has not worked in the auto industry previously—proffered by Southern states; and
- the extremely cost-effective intermodal transportation network in the region, spanning railways, highways, airports and, most importantly, ports.

Other attributes make the South attractive for automakers. The weather, reduced cost-of-living, lower or no personal income taxes, free or inexpensive property to build assembly plants, along with other attractive quality of life attributes, all make Southern locations very enticing. In addition, the cutting-edge research being conducted by two high-end research facilities—the Advanced Vehicle Research Center in Garysburg, N.C., and Clemson University's International Center for Automotive Research in Clemson, S.C.—confirms that the automotive industry in the South now extends far beyond assembly operations.

The region's success in attracting automakers has helped the South in the growing economic slowdown.

The ominous signs of a slowdown in the national economy apparent in several parts of the country by mid-2007, were made clearer in early 2008 with the release of recent gross domestic product figures, as well as weakening consumer spending, mounting inflation rates, tightening credit, rising unemployment, falling home prices and surging foreclosure rates.

But even with the gloomy economic news affecting both the national and individual state economies, the auto industry in the South has continued its upward trajectory in the last year. One factor driving this trend has been the rapidly depreciating U.S. dollar.

Automotive Exports from the South Increase

In the last year or so, the deteriorating economic situation in the U.S. was precipitated by the collapse in the housing and construction sectors in many areas of the country—propelled by the unraveling of the subprime mortgage sector—along with an unprecedented rise in energy prices and severe tightening in the credit

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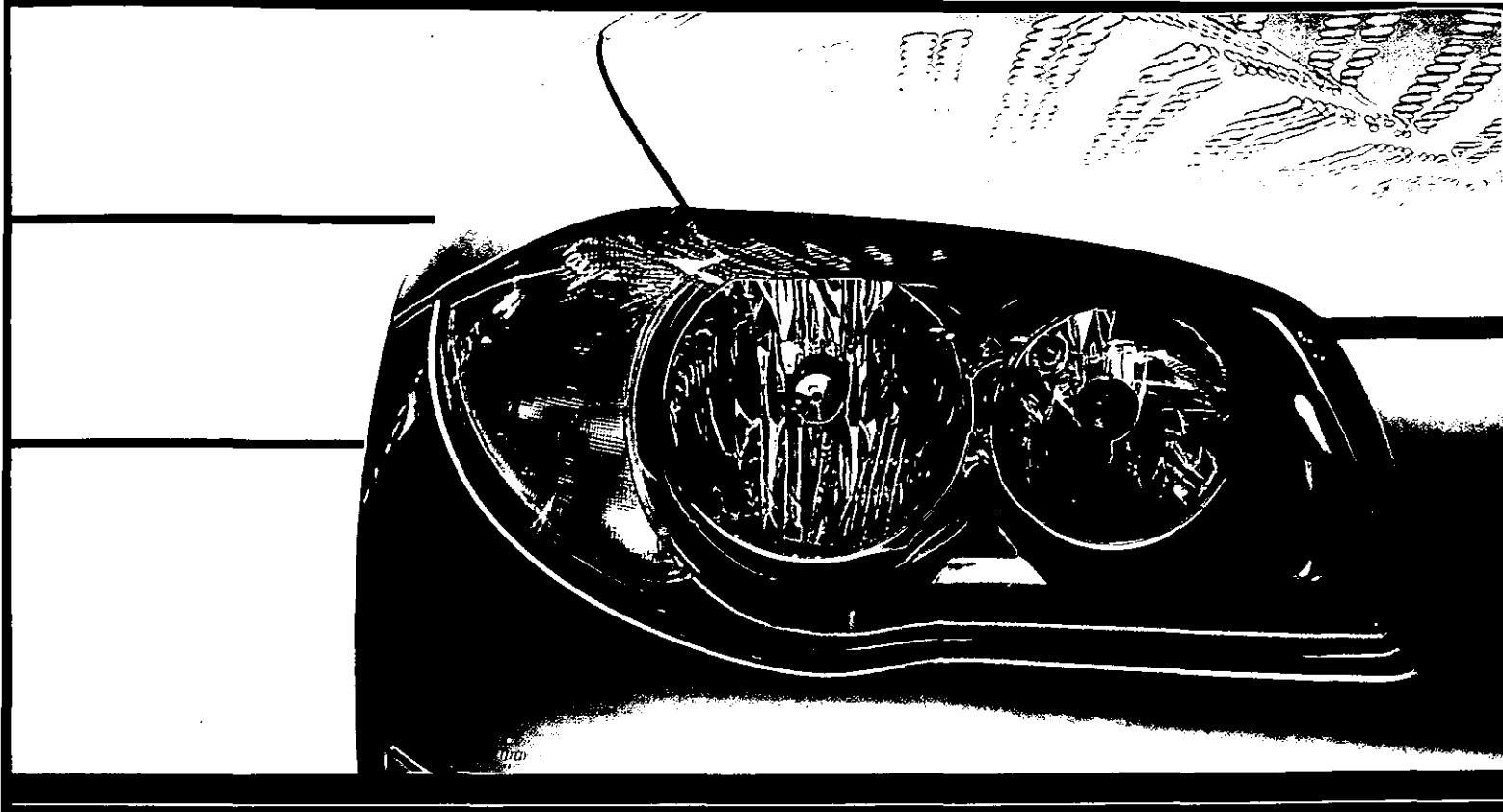

markets. But in the midst of all this economic doom and gloom, the nation's export sector has been the one bright spot.

Not only did exports increase twice as fast as imports in 2007, which narrowed the U.S. trade deficit for the first time since 1995, but the increased level of trade is keeping the economy afloat. The impetus for the blossoming export sector has been the depreciating U.S. dollar.

On a year-to-year basis for the past seven years or so, the U.S. dollar has depreciated steadily, thus providing a sizable boost not only to American exports but also in attracting foreign direct investment into the country. The automobile sector in general and the South in particular, have benefited tremendously from both developments.

A depreciating dollar makes U.S. exports much more competitive with exports from other countries. Similarly, purchasing or investing in America becomes relatively less expensive compared to times when the dollar's value is rising.

The dollar depreciated by 79 percent between 2002 and 2008. In April 2001, a single Euro cost 90 U.S. cents; by April 2008, a single Euro cost $1.57 in U.S. currency. (See Table 1) The critical role played by a depreciating dollar in stimulating exports is apparent in U.S. trade flows of road motor vehicles between 2002 and 2007. (See Table 2)

Motor vehicle exports increased by impressive levels, both in terms of value and units, from 2002 to 2007, with the exception of 2003 when there was a nearly 3 percent drop in units exported. In 2007, in particular, when the depreciation of the dollar was significant, road motor vehicle exports increased by more than 22 percent in terms of value and more than 18 percent in terms of units, a trend that reinforces how the depreciating dollar promoted vehicle exports.

Even in terms of the 16 states is The Council of State Governments' Southern Legislative Conference, the impressive growth in U.S. transportation equipment exports—including motor vehicles and motor vehicle bodies and parts—to the world is apparent from a review of federal export statistics: Between 2002 and 2007, these exports expanded on average in these Southern states by nearly 97 percent, with Mississippi (279 percent), Alabama (141 percent) and North Carolina (132 percent) leading the way. In terms of the value of transportation equipment exports in key Southern states in 2007, Texas led the way with $16.3 billion, followed by Kentucky with $7.7 billion, Florida with $7.1 billion, Alabama with $5.9 billion, and South Carolina with $5.6 billion.

Previous SLC research noted how Southern ports rank at the highest level of significance from a national trade dimension—more than two-thirds of all U.S. exports and imports transit through a Southern port. Recent data from the ports of Baltimore, Md., Jacksonville, Fla., Charleston, S.C., and Savannah, Ga., document the significant number of automobiles handled by these Southern ports—more than any other set of ports in the country.

In 2007, Baltimore surpassed Jacksonville as the nation's top vehicle exporter—with an 80 percent increase from the previous year, to nearly 294,000 units—as the weakening dollar propelled a surge in auto exports. Jacksonville still handled an imposing 614,647 vehicle units in fiscal year 2007, while Charleston saw a 67 percent jump in BMW vehicle exports from its terminals in 2007. Savannah's growth in automotive exports over the five-year period from 2003 to 2007 amounted to a staggering 183 percent, including a 52 percent expansion between 2006 and 2007.

Foreign Investment in the South Grows

Along with the surge in automobile industry exports, particularly from the South, the atrophying U.S. dollar also resulted in sizable foreign investment in the industry in the region. In March 2008, BMW announced it would spend $750 million and

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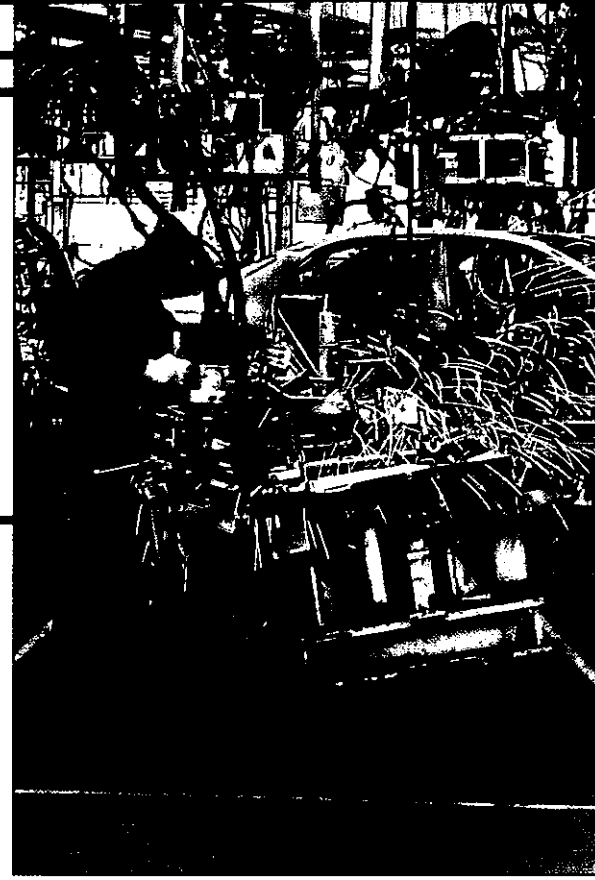
The Council of State Governments' Southern office, the Southern Legislative Conference, continues to focus on the economic impact of the automobile industry in the South. In November 2003, the SLC released a report titled The Drive to Move South: The Growing Role of the Automobile Industry in the Southern Legislative Conference Economies. *This 148-page report featured an in-depth review of the auto industry in the South. The SLC has also published articles further clarifying the growing importance of the automobile industry in the South in Global Corporate Expansion. Visit* www.slcatlanta.org *to read the publications.*



hire 500 workers in an expansion that will transform its Greer, S.C., plant into one of its largest facilities. While increasing production by 50 percent at the South Carolina plant by 2012, BMW will slash 7.5 percent of its German work force in the next two years.

Then, Volkswagen, which relocated its North American headquarters from Michigan to Virginia in 2007, announced it would build "a high-volume auto factory in the USA to escape the currency exchange pinch from a weak dollar and a strong Euro." Once again, a number of Southern states—Alabama, Kentucky, South Carolina and Tennessee—top the list of prospective locations for the plant, which will begin producing up to 250,000 vehicles and employ about 2,000 people by 2011. Also, in April 2008, Nissan announced it would invest an additional $118 million in its Canton, Miss., facility to build three new models of light commercial vehicles by June 2010.

On the auto parts supplier front, more news confirmed the continuing importance of the South in the auto industry. In Tennessee, 948 auto suppliers operate in 194 communities across the state; in total, the industry employs 125,000 Tennesseans, including the assembly workers at the Nissan plants in Smyrna and Decherd, the GM plant in Spring Hill and the Peterbilt truck plant in Madison.

After considering two other states, the Indiana-based automotive supplier PK chose to invest $35 million and build a facility in Senatobia, Miss., to make stamped and welded steel parts for the $1.3 billion Toyota manufacturing plant that will open in nearby Blue Springs in 2010. Also in preparation for the new Mississippi Toyota plant, auto parts supplier Vuteq plans a $31 million facility that will employ 630 people in New Albany, Miss., to manufacture molded plastic pieces and components. Another supplier, Toyoda Gosei, will establish a $19 million plant creating 120 new jobs in Batesville, Miss., to build injection-molded plastic parts for the Toyota Highlander. Mississippi has more than 90 automotive manufacturing, distribution and supplier companies.

In Georgia, Kia auto parts supplier Daehan Solutions revealed plans to open a $35 million facility creating 300 new jobs in Harris County, Ga., near the proposed Kia manufacturing facility in West Point.

—Sujit M. CanagaRetna is a senior fiscal analyst in The Council of State Governments' Southern office, the Southern Legislative Conference.

Table 1:

Value of Euro to U.S. Dollar, *April 1998 to April 2008*

Year	Value of Euro to Dollar	Percentage Change in Dollars
April 8, 1998	1.0882	-
April 7, 1999	1.0835	0
April 7, 2000	0.959003	11%
April 9, 2001	0.901404	6%
April 8, 2002	0.874998	3%
April 8, 2003	1.0684	-22%
April 8, 2004	1.2088	-13%
April 7, 2005	1.29231	-7%
April 7, 2006	1.2109	6%
April 9, 2007	1.3367	-10%
April 8, 2008	1.5705	-17%

Table 2:

U.S. Road Motor Vehicles Exports to the World, *2002 to 2007*

	Value *(in Billions of Dollars)*		**Units**	
	Amount	Change	Amount	Change
2002	$27.405	14.9%	1,644,831	9.5%
2003	$30.388	10.9%	1,601,019	-2.7%
2004	$33.973	11.8%	1,766,186	10.3%
2005	$40.939	18.4%	2,051,858	8.6%
2006	$46.307	13.1%	2,197,429	7.1%
2007	$56.596	22.2%	2,597,845	18.2%

Table 1: Source: http://www.x-rates.com/cgi-bin/hlookup.cgi

Table 2: Source: U.S. Department of Commerce, Office of Aerospace and Automotive Industries

How many bills were passed during the 2006 state legislative sessions?

Which states have the most legislators?

How much do state officials earn each year?

How many voting districts are in each

Which states will hold legislative elections in 20

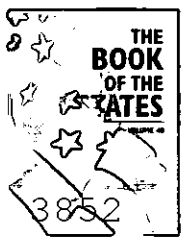
Which states have legislative term limits?

How many judges sit on each state supreme

What do *you* need to know?

Which states have legislative term limits?

Who was the first woman to serve as a governor in the United States?



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States Strive to Make Higher Education Affordable

As tuition increases at sometimes double-digit rates across the country, states are looking for ways to help students from low-income families pay for higher education. Some states are providing full tuition at in-state public universities, while others give scholarships based solely on academic performance.

By Mary Branham Dusenberry

When she was an Indiana eighth grader, Joy Martin-Day made a decision: She would go to college, regardless of the obstacles she might face along the way.

Like many students, one of her biggest obstacles was the ability to pay tuition and all the costs associated with higher education. Another was getting her mother to buy into the education dream.

"Parents, their mindsets are more on 'I'm trying to plan our meal for tonight. If you look in our cupboard, there's not much there, and how can you plan for college and there's nothing in the house to eat,'" Martin-Day said.

Indiana's 21st Century Scholars program changed that attitude, and convinced both Martin-Day and her mom that a college education was within the youngster's reach.

Seana Murphy, director of the 21st Century Scholars, said a first step in the program's success was changing people's perceptions about the ability of low-income students to afford college.

"The initial thought behind it was how do you change student aspirations so that they believe themselves capable of going to college, with the understanding that the affordability issue was one of the primary barriers to students in that income percentile even thinking about going to college," Murphy said.

That's why Indiana's scholarship program is about more than just money. It strives to educate parents and students about the whole college experience. But the financial worry was a major hurdle, even with Indiana's robust need-based aid program. The assurance of additional scholarship money to help pay the growing college costs, Martin-Day said, "is like a pillow ... easy to sleep at night."

Costs of Education Rising

As tuition and other college costs skyrocket, more states are looking at programs to make college more affordable.

Measuring Up 2006—the latest report card available from the National Center for Public Policy and Higher Education judging state performance on such issues as affordability, participation and benefits of higher education—said college tuition and fees rose 375 percent between the 1982–84 baseline to 2005. That's more than the increases in the cost of medical care, which increased 223 percent, the consumer price index, which increased 95 percent, and family income, which increased 127 percent.

But Patrick Callan, the center's president, advises state officials to not look past their own borders to determine whether their residents can afford college.

Each state's report card, he said, is based neither on the perceived value of higher education nor on what other states are charging. Instead, it's based "in terms of family income in your state—what portion of that income it would take to send someone to a two-year public, a four-year public or a four-year private college or university," he said. "Of course, the whole country has gone south dramatically."

In fact, Measuring Up 2006 gave only seven states passing scores for affordability, and their grades were Cs and Ds.

In Indiana, for instance, the cost to attend a public university would take, on average, about 30 percent of annual family income—but that's up to 69 percent of annual

income for those in the lowest income category, according to the 2006 report. Even after financial aid is factored in, those with the lowest income would still pay more than 44 percent of their income for higher education. While Indiana received an F for affordability, it did get good marks for state investment in need-based aid, and the 21st Century Scholars is just one program that ensures college is within reach.

By contrast, in Utah—which, with a C-, had the best grade on affordability—families would need to pay an average 18 percent of their income for college expenses, the report said. The range was from 7 percent for the highest income earners to 40 percent for those with the lowest income.

The need for increased family contribution comes as states have decreased the amount given to colleges and universities, and is also at a time when colleges and universities are increasing tuition costs.

While state funding for higher education has fared well in good years, it's been cut more severely than other programs in the bad years, Callan said. "You have this roller coaster effect which spills over, unfortunately, into tuition," he said. "So we end up cutting budgets and raising tuition the most when the economy is down, when it's harder on students."

That often comes at a price for states: "The bottom line is that in states with citizenry that have a higher likelihood of having a degree, per capita, income is higher. The higher the educational attainment is, the higher per capita tax revenues flow back to state coffers," said Dan Hurley, director of state relations and policy analysis for the American Association of State Colleges and Universities.

The need for better educating the nation's younger work force is heightened by the retirement of baby boomers, which, Callan said, comprise not only the biggest generation but the most educated one as well. To fill the gap left by those retirements, states will need to educate a larger portion of subsequent generations, and for that reason, he said, states should set a goal for higher education attainment, and find funding to meet that goal.

States Offer Programs

Several states have done just that. Oklahoma, for example, includes educational excellence, along with strengthening the economy, among its top priorities. Increasing the number of college graduates is a key to meeting both those goals.

"The states that have a higher percentage of their citizens with college degrees are the states with higher per capita income and a stronger economy," said Glen D. Johnson, chancellor of the state's Board of Regents. "I think we've made the case that there's not an entity in state government that helps the state reach its goals quicker or more comprehensively than higher education."

That case has helped state regents to secure permanent funding for the Oklahoma's Promise scholarship program, which pays the full tuition for students who meet eligibility criteria. "The state of Oklahoma, through our legislature and governor, is saying that the top priority in state government is funding the Oklahoma's Promise program," Johnson said. "They literally fund that before they fund anything else in state government."

The scholarship is available to students from families with less than a $50,000 annual income. Students must also maintain a 2.5 grade point average and take college preparation courses in high school, and agree to "stay out of trouble," said Johnson.

Bryce Fair, associate vice-chancellor for scholarships and grants, said the $50,000 income limit takes in about half of Oklahoma's families.

Fair said the income eligibility was much lower when the program began in 1992. He said the program had a stigma because it was limited to families earning under $24,000, and therefore had fewer students interested in participating. With the change to $50,000 in 2000, "it instantaneously became a broad-based program ... the sensitivity about being identified as an Oklahoma's Promise student dropped dramatically," Fair said.

More than 20,000 students have received the scholarship to date. By 2010, Johnson said, more than 20,000 students will be participating in the program in any given year. The scholarship is available to students on top of other traditional need-based and merit-based aid.

Not all educational assistance programs being developed by states are need-based. Kentucky, for instance, funds scholarships for students based on grades and test scores.

Former Gov. Paul Patton believes states should also provide assistance to middle and upper income students who make the grade. Patton spearheaded higher education reform in Kentucky in 1997, and was recently appointed to the state's Council on Postsecondary Education.

Part of the reform effort, Patton said, was to get more money for scholarships. The Kentucky Lottery funds need-based college aid, but a portion also goes to the Kentucky Educational Excellence Scholarship. The popular program—commonly known as KEES—is based on a student's grade point average in each of the four years of high school as well as the ACT or SAT score. It's not an all or nothing proposition, Patton said, because the amount earned is based on performance in individual years.

"What KEES does is give parents the opportunity to sit down with their child as a freshman in high school and start talking about the college education," he said. "They can start saying, it's your responsibility to earn part of the cost of your education."

That additional tuition assistance has helped to offset the annual increases in the cost of higher education, Patton said. When he was elected, the state offered $15 million worth of scholarships, but by the time he left office after his second term, scholarship investment had grown to about $150 million, he said.

Like Kentucky, Arkansas is considering a lottery to fund scholarships. Lt. Gov. Bill Halter is backing a constitutional amendment to allow the state to operate a lottery with the restriction that all net proceeds be used for college scholarships. Arkansas residents will vote on the amendment in November. Halter said some estimate the proceeds could reach $100 million a year for scholarships. He believes more funding for college scholarships is imperative for Arkansas.

"We are 49th out of 50 states with the percentage of the adult population with a college degree. We need to be competitive in the 21st century economy and we need to change that," he said.

"Higher education has never been more important to the economic success of the individual or the states and at the same time, it's never been more expensive," said Halter. "The initiative we have underway is designed to bridge that gap."

529s Bridge the Gap

States across the country are striving to bridge similar gaps in the affordability of higher education for their residents. And

some states have been offering a tax-free way for parents to save for their children's higher education costs since 1988.

Similar to 401(k) retirement plans, the 529 savings plans grow depending on the investment options selected by parents. Michigan and Florida started the first two college savings plans in 1988, and now 10.5 million accounts exist in 49 states and Washington, D.C., according to Kevin Johnson, communications manager for the National Association of State Treasurers, with which the College Savings Plan Network is affiliated.

"All the earnings in these plans are exempt from federal taxes as long as they're used for qualified education expenses," Johnson said.

"Higher education has never been more important to the economic success of the individual or the states and at the same time, it's never been more expensive."

—Arkansas Lt. Gov. Bill Halter

Some states previously offered prepaid tuition plans through the 529 program, but these plans are not as common as the savings plan, Johnson said.

"States saw this problem of families not being able to afford college, so these plans address that need and they also make it affordable for most families to do it," Johnson said.

Anything states can do will help, Hurley, of the American Association of State Colleges and Universities, said. "We need to seek collectively to elevate higher education as a major public policy priority," he said. "Otherwise, that whole middle class is going to continue to erode further and faster."

—Mary Branham Dusenberry is managing editor of State News *magazine.*

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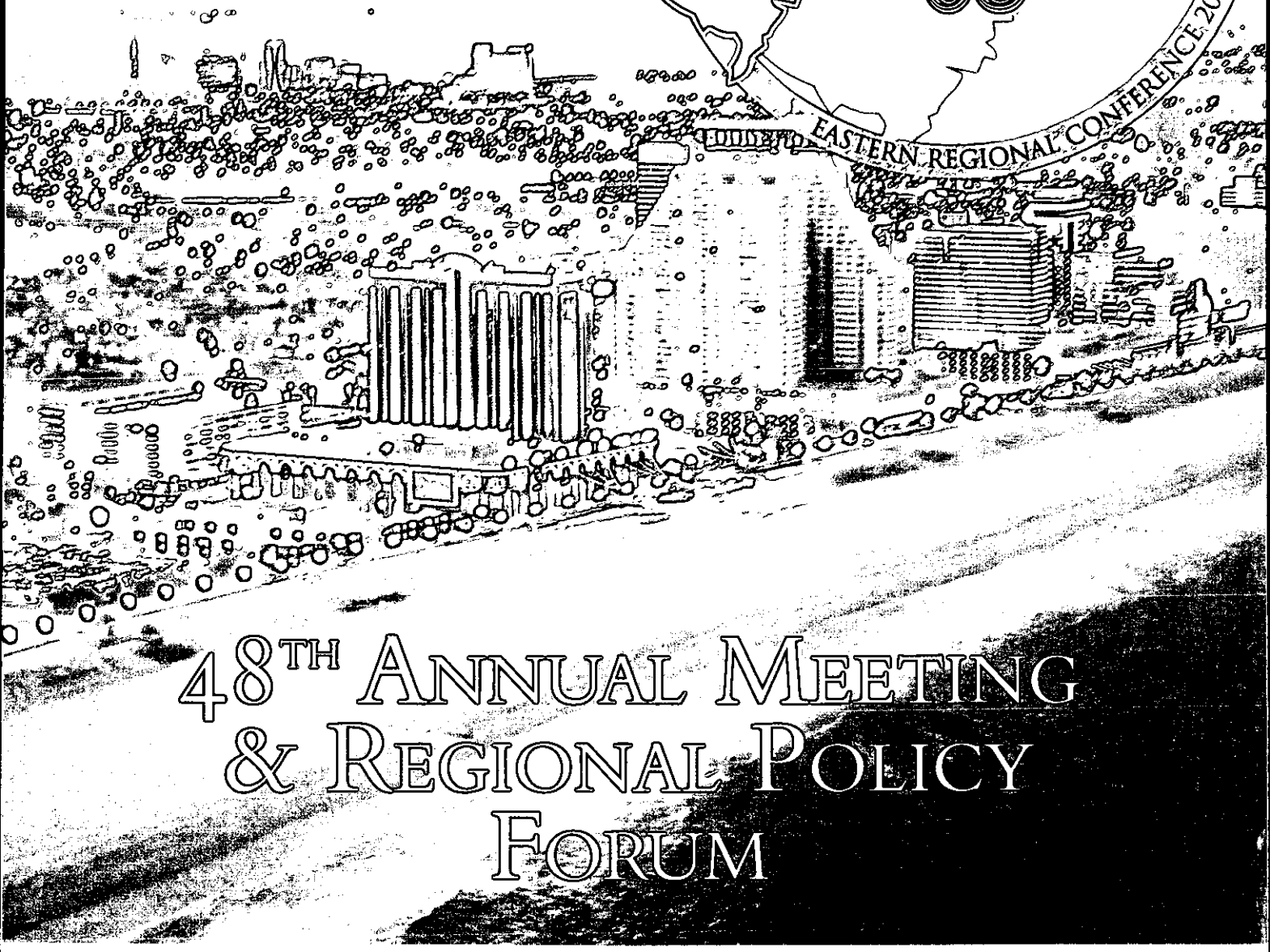

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3857

CSG Initiative Aims to Reduce Childhood Obesity

SCORE team members visited Osceola High School to view their anti-obesity efforts while attending the Southern Collaborative on Obesity Reduction Efforts Leadership Summit in May in Orlando, Fla. Dr. Veronica Gunn, from left, Tennessee's chief medical officer, talks to Susan McKay, physical education/health specialist at Osceola High School. Kentucky state Rep. Addia Wuchner discusses physical education programs with Principal Charles Paradiso. Photo by Jennifer Ginn.

How can states fight childhood obesity? Who needs to be involved? What type of policies can be implemented, and how do you get the public to buy in to these new ideas?

Those were just a few of the questions facing policymakers during the Southern Collaborative on Obesity Reduction Efforts—known as SCORE—Leadership Summit in Orlando May 8–10. A new Council of State Governments' initiative, SCORE is a two-year program funded by the Leadership for Healthy Communities aimed at reducing childhood obesity through policymaking in six Southern states.

The conference brought together teams from Kentucky, North Carolina, South Carolina, Tennessee, Texas and West Virginia to share ideas and begin planning how each state will tackle childhood obesity.

Dr. Robert Cluck, a physician and mayor of Arlington, Texas, said the best part of SCORE is that the teams bring together a wide array of people from each state—legislators, representatives of the departments of education, health and agriculture, mayors and even local educators. The time to talk to other states during the meeting also helped form new ideas, he said.

"There's no need to reinvent the wheel," Cluck said. "A lot of the states are doing innovative programs."

Each state is eligible for a $10,000 grant to be awarded this fall. The grants will be targeted toward helping the team advance its work of reducing childhood obesity in its state.

"Every state appears to be at a different level," said Lynn Hoggard, state director of child nutrition services at the North Carolina Department of Public Instruction. "For North Carolina, this allows us to continue the momentum. ... The meeting gave us new ideas, different ways of approaching this epidemic."

CSG Launches New Transportation Advisory Group

A new panel to address the increasing importance of transportation policy in state governments met for the first time during The Council of State Governments' Spring Conference in Lexington, Ky. CSG's movement into this policy area comes at a critical time, as Congress prepares to debate the future federal role in transportation financing.

"The debate over transportation needs and how government meets them in the next generation is fundamental," said Tennessee Senate Majority Leader Mark Norris, the group's chairman. "The Transportation Advisory Group assures CSG a voice in that debate and an opportunity to provide an additional forum ... not only to represent the interests of our stakeholders in the defense of states' rights but to assure fairness within our federal system as funding is reauthorized."

The advisory group was assembled based on the recommendations of staff from the CSG regional offices. Its initial membership includes two legislators and one executive branch official from each of the four regions. Sens. Carlene Walker of Utah and Yvonne Miller of Virginia were elected as vice-chairs during the Lexington meeting.

At its initial meeting, the group passed a resolution in support of transportation initiatives that incorporate increased intergovernmental participation, a multi-modal and regional approach, environmental and economic development concerns, as well as preservation of the federal-state partnership in transportation funding. The resolution also calls on Congress to take immediate steps to ensure the Highway Trust Fund does not reach a negative balance and to pass legislation establishing a reliable and predictable long-term funding source for transportation.

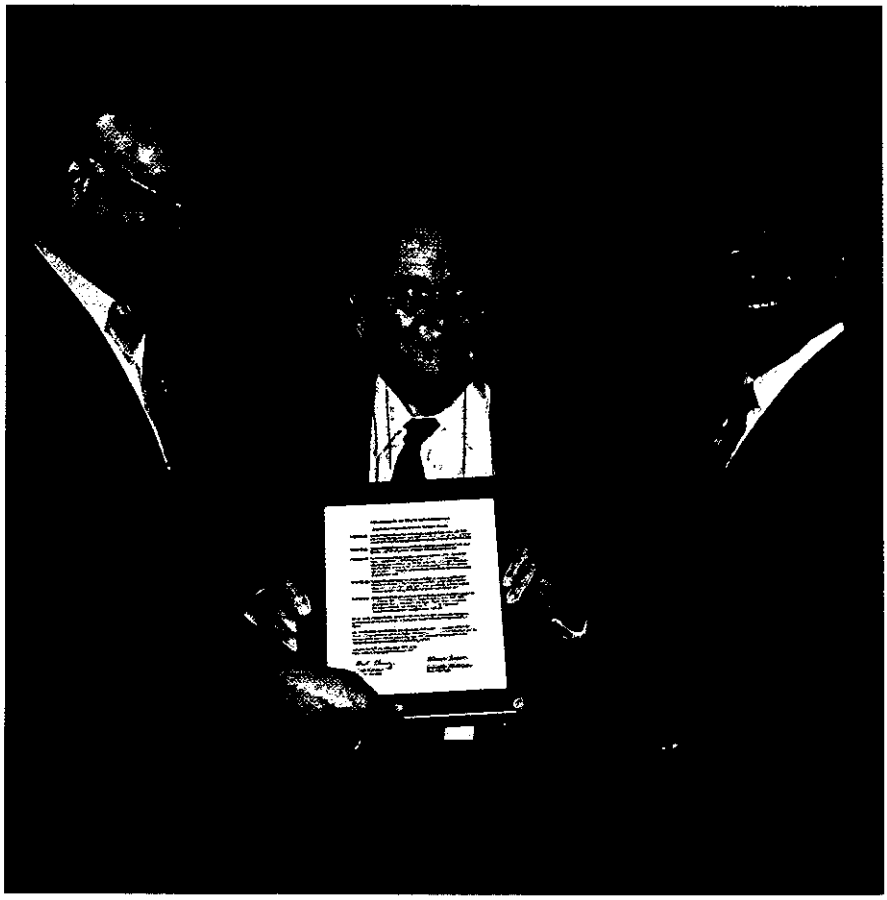
Norris said the enthusiasm of members and panelists during the Lexington forums was very high. "Everyone is eager to be a part of the advocacy," Norris said. "There is a sense of urgency about this with the realization that the lifeblood of liberty flows through our transportation network, and it is in jeopardy."

CSG hopes to eventually expand the membership of the Transportation Advisory Group and to convene in the future as a full working group.

"I am honored to chair the advisory group at this critical time and value the wisdom of my colleagues and resources of CSG," Norris said. "They will be invaluable in meeting the challenge we face."

3858

Guardian of Federalism Award Named for Tennessee Sen. Douglas Henry



State Sen. Douglas Henry of Tennessee, center, was presented a resolution renaming the Guardian of Federalism Award in his honor at CSG's spring conference in Lexington, Ky., by Kentucky Senate President David Williams, left, and CSG Executive Director Daniel M. Sprague. The award is now the Douglas Henry Guardian of Federalism Award. Photo by Jack Penchoff.

The annual Guardian of Federalism Award, presented each year by The Council of State Governments to members of Congress who demonstrate outstanding efforts on issues concerning states' rights, is now named in honor of Tennessee state Sen. Douglas Henry.

Each year CSG presents the awards to one member of the U.S. House and one member of the U.S. Senate who during the past year most actively defended federalism and the interests of states.

The Senator Douglas Henry Guardian of Federalism Awards were announced Saturday, May 31, at the CSG 75th Anniversary Spring Conference in Lexington, Ky. Sen. John D. Rockefeller of West Virginia and U.S. Rep. Tom Davis of Virginia were recognized with the award this year.

Following the announcement, CSG Vice Chair David Williams, president of the Kentucky State Senate, said Henry's "fidelity to the cause of federalism has provided the crucial contribution advancing CSG's participation in amicus briefs filed by the State and Local Legal Center before the U.S. Supreme Court defending state sovereignty and the core principles of federalism."

Henry is a past chairman of The Southern Legislative Conference of CSG and serves on CSG's national governing board and intergovernmental affairs committee, of which he is past chairman.

David Eisenhower Returns to Midwestern Leadership Institute

Prominent author, historian and political scientist David Eisenhower will return for a second year as the keynote speaker at the Bowhay Institute for Legislative Leadership Development, the leadership training program hosted by The Council of State Governments Midwestern Legislative Conference.

Eisenhower is director of the Institute for Public Service at the University of Pennsylvania's Annenberg Public Policy Center. His biography of his grandfather, *Eisenhower: The War Years, 1942–45*, was a runner-up for the Pulitzer Prize in history. Eisenhower has a unique perspective on the workings of American politics, and will discuss the meaning of public service and his insights as part of a family legacy of public service with this year's BILLD Fellows.

In May, the BILLD Steering Committee met to award this year's BILLD Fellowships. Thirty-seven lawmakers from the Midwestern states and Canadian provinces will gather in Madison, Wis., Aug. 8 for five days of intense leadership training, professional development seminars and policy workshops. A complete list of this year's BILLD class can be found on the CSG Midwest Web site at *www.csgmidwest.org*.

Each year, fellowships are awarded to Midwestern legislators through a competitive, nonpartisan selection process overseen by the MLC BILLD Steering Committee. Iowa Rep. J. Scott Raecker and Illinois Rep. Elaine Nekritz serve as the committee's co-chairs and Minnesota Rep. Laura Brod and Michigan Rep. John Moolenaar are the panel's vice chairs.

3859

Wilson Wins Rooney Award

Sara Redding Wilson was selected as the winner of the 2008 National Association of State Personnel Executives Eugene H. Rooney Jr. Leadership Award.

Wilson was appointed director of the Virginia Department of Human Resource Management in April 1998 and is the first person since 1974 to be reappointed twice to that position. During her tenure, Wilson was instrumental in re-engineering human resource programs statewide and introducing technological solutions to human resources initiatives.

She is a former executive vice president, general counsel and corporate secretary for Signet Banking Corporation and served as a member of the management committee. She is a graduate of Hamilton College and the University of Richmond School of Law. Wilson served as NASPE president from 2006 to 2007 and hosted the association's 2007 Annual Meeting in Williamsburg, Va.

Delaware's DelaWELL and the Delaware Employment Link share honors as winners of the 2008 Rooney Award for Innovative State Human Resource Management Program. Louisiana's Retiree Rehire Database received the Award of Merit. Visit NASPE's Web site at *www.naspe.net* to see the winning submissions and other entries. The winning submissions were recognized in July during the awards banquet during NASPE's 2008 Annual Meeting Strategic HR: The New Frontier, in Oklahoma City.

The Rooney program was established in memory of Eugene H. Rooney Jr., who served as NASPE president at a time of great growth for the organization. This awards program recognizes innovative state human resource management practices that ensure access and equity while enhancing productivity and service delivery. It also recognizes individuals who exemplify the character, qualities and influence Rooney had on state personnel administration.

New Member Orientation Featured at Joint Legislative Service Agency Meeting

New member orientation was at the top of the agenda for legislative service agency directors from around the U.S. when they gathered in Lexington, Ky., May 29–30.

Staff leaders from Virginia, Ohio, Louisiana and Wyoming opened the discussions on new member orientation. In a second session, lawmakers from Kentucky, Idaho and Connecticut were invited to tell participants what works and what doesn't from legislators' perspective.

Participants in the meeting also enjoyed a morning spent in teamwork training offered by the University of Kentucky.

In addition, participants were invited to optional policy briefings on interstate compacts, health and criminal justice at CSG national headquarters as well as to meetings on Selected State Legislation and financial services.

Hosted by the Southern and Western regions of The Council of State Governments, the joint meeting was an opportunity for legislative staff directors to share best legislative management practices across their respective regions. This was the first joint meeting of CSG's regional staff groups in 10 years.

Limited copies of new member orientation agendas from the Southern and Western regions of CSG are available by calling 404-633-1866 and 916-553-4423 respectively.

3860

conferencecalendar

This calendar lists meetings as designated by CSG's Annual Meeting Committee. For details of a meeting, call the number listed. "CSG/" denotes affiliate organizations of CSG. Visit *www.csg.org* for updates and more extensive listings.

Other meetings have value to state officials. Purchase a meeting listing by calling (800) 800-1910 or by e-mailing *sales@csg.org*. Announce your meetings to thousands in the state government market through an advertisement or a Web listing.

August 2008

Aug. 3–6 **CSG/American Probation and Parole Association—33rd Annual Training Institute**—Las Vegas, NV—Rio All-Suite Hotel. Contact Kris Chappell at (859) 244-8204 or visit *www.appa-net.org*.

Aug. 8–12 **CSG/Midwestern Legislative Conference—14th Annual Bowhay Institute for Legislative Leadership Development (BILLD)**—Madison, WI—Fluno Center of Executive Education. Contact Laura Tomaka at (630) 925-1922 or *ltomaka@csg.org*, or visit *http://www.csgmidwest.org* for more information.

Aug. 9–11 **CSG/Southern Governors' Association—SGA Annual Meeting**—White Sulphur Springs, WV—The Greenbrier. Contact Liz Purdy Porter at (202)624-5897 or *sga@sso.org*.

Aug. 10–13 **CSG/ERC 48th Annual Meeting and Regional Policy Forum**—Atlantic City, NJ—Sheraton Hotel. Contact Pamela Stanley at (212) 482-2320 or *pstanley@csg.org*.

Aug. 18–21 **National Association of State Treasurers (NAST) Annual Conference**—Rockport, ME—Samoset on the Ocean Resort. Contact Adnée Hamilton at (859) 244-8174 or *ahamilton@csg.org*.

Aug. 23–27 **National Association of State Technology Directors (NASTD) 31st Annual Conference & Technology Showcase**—Boston, MA—Seaport Hotel & World Trade Center. Contact Pamela Johnson at (859) 244-8184 or *pjohnson@csg.org*.

September 2008

Sept. 8–11 **CSG/National Emergency Management Association—NEMA Annual Conference**—Portland, OR—Contact Karen Cobuluis at (859) 244-8143 or *kcobuluis@csg.org*.

Sept. 8–11 **Interstate Commission for Adult Offender Supervision (ICAOS) Annual Business Meeting**—Palm Springs, CA—Wyndham Palm Springs Hotel. Contact Barno Saturday at (859) 244-8235 or *bsaturday@csg.org*.

Sept. 20–24 **CSG/Southern Legislative Conference—Center for the Advancement of Leadership Skills (CALS)**—Norman, OK—University of Oklahoma and the Carl Albert Congressional Research and Studies Center. Contact Lori Jones-Rucker at (404) 633-1866 or *ljones-rucker@csg.org*.

Sept. 25–27 **XVIII Border Legislative Conference**—Santa Monica, CA. Contact Edgar Ruiz at (916) 553-4423 or *eruiz@csg.org*.

Sept. 27–Oct.2 **CSG—Henry Toll Fellowship Program**—Lexington, KY—Hilton Suites at Lexington Green. Contact Krista Rinehart at (859) 244-8249 or *krinehart@csg.org*.

December 2008

Dec. 4–7 **CSG 75th Anniversary Celebration—Annual Conference**—Omaha, NE. Contact registration at (800) 800-1910 or *registration@csg.org*.

Dec. 8–11 **National Association of State Treasurers (NAST) Treasury Management Conference & Exposition**—Addison,TX—InterContinental Hotel Dallas. Contact Adnée Hamilton at (859) 244-8174 or *ahamilton@csg.org*.

Fall 2008

CSG/State International Development Organizations—SIDO China Market Research Missions. Contact Chris Whatley, Director of International Programs, at *cwhatley@csg.org* or (202) 624-5460.

May 2009

May 16–19 **CSG 2009 Spring Conference**—Coeur d' Alene, ID. Contact registration at (800) 800-1910 or *registration@csg.org*.

July 2009

July 10–14 **CSG/Midwestern Legislative Conference—15th Annual Bowhay Institute for Legislative Leadership Development (BILLD)**—Madison, WI—Fluno Center of Executive Education—Contact Laura Tomaka at (630) 925-1922 or *itomaka@csg.org*.

August 2009

Aug. 9–12 **CSG/Midwestern Legislative Conference—64th Annual Meeting**—Overland Park, KS. Contact Cindy Andrews at (630) 925-1922 or *candrews@csg.org*, or visit *www.csgmidwest.org* for more information.

Aug. 15–19 **CSG/Southern Legislative Conference—Annual Meeting**—Winston-Salem, NC. Contact Elizabeth Lewis at (404) 633-1866 or visit *www.slcatlanta.org* for additional information.

Aug. 22–24 **CSG/Southern Governors' Associationg (SGA) Annual Meeting**—Williamsburg, VA. Contact Liz Purdy Porter at (202) 624-5897 or *sga@sso.org*.

October 2009

Oct. 5–8 **CSG-WEST Annual Meeting**—Santa Fe, NM. Contact Cheryl Duvauchelle or Lolita Urrutia at (916) 533-4423 or *csgw@csg.org*.

November 2009

Nov. 12–15 **CSG 2009 Annual Conference**—Palm Springs, CA. Contact Registration at 800-800-1910 or *registration@csg.org*.

July 2010

July 31–Aug. 4 **CSG Southern Legislative Conference—64th Annual Meeting**—Charleston, SC. Contact Elizabeth Lewis at (404) 633-1866 or *elewis@csg.org*.

August 2010

Aug. 8–11 **Midwestern Legislative Conference—65th Annual Meeting**—Toronto, ON, Canada. Contact Cindy Andrews at (630) 925-1922 or *candrews@csg.org*. Visit *www.csg.midwest.org* for more information.

Aug. 22–24 **CSG/Southern Governers' Assocation (SGA) Annual Meeting**—Williamsburg, VA. Contact Liz Purdy Porter at (202) 624-5897 or *sga@sga.org*.

3861

Although the federal government tends to get more attention, state officials are often on the front lines of cutting-edge trends and issues. On the other hand, sometimes in the community of state governments, the more things change, the more they stay the same.

In print since 1958, *State News* (formerly *State Government News*) has chronicled many of the changes ... and continuities.

Here's what we reported on:

40 years ago—August 1968

Lieutenant Governors Call for Educational Change

The National Conference of Lieutenant Governors—now known as the National Lieutenant Governors Association, an affiliate of The Council of State Governments—called for a major re-examination of the 12-year system of public education, according to an article in the August 1968 *State Government News*.

The lieutenant governors, in their eighth annual meeting, adopted a resolution suggesting the Department of Health, Education and Welfare, in cooperation with the Education Commission of the States, meet with state representatives to consider compressing the present education system into a shorter time-span, improving the curricula and improving flexibility.

Update

Many state education systems were reformed in the past few decades, and state legislatures are constantly looking for ways to improve the schools in their states. However, the 12-year system of education has actually been expanded, with many states adding kindergarten and preschool as educational opportunities for children.

25 years ago—August 1983

States Pursue High-Tech Jobs

As early as 1983, states were going after high-tech jobs, and governors focused their messages on proposals to attract such industries, according to an article in the August 1983 *State Government News*. While experts at the time said the Silicon Valley of California, the Research Triangle in North Carolina and the Boston area accounted for most of the high-tech jobs, they expected a shift to the Midwest, South and Plains states because of the availability of labor. The problem, they said in 1983, was education. The shortage of math and science teachers at the time raised concerns about those areas' ability to educate the labor force.

A panel of governors, business and education leaders said strengthening all levels of education is imperative for the U.S. to be able to compete with countries such as Japan for high-technology and energy-related industries. A National Governors Association survey of state initiatives in high-tech industries, found many governors had appointed task forces or boards to recommend overall state policy on high tech.

Update

States are still learning to compete in the global marketplace. Check out the analysis of the auto industry in the South on page 26, and learn what some states are doing to increase the education level of residents on page 30.

10 years ago—August 1998

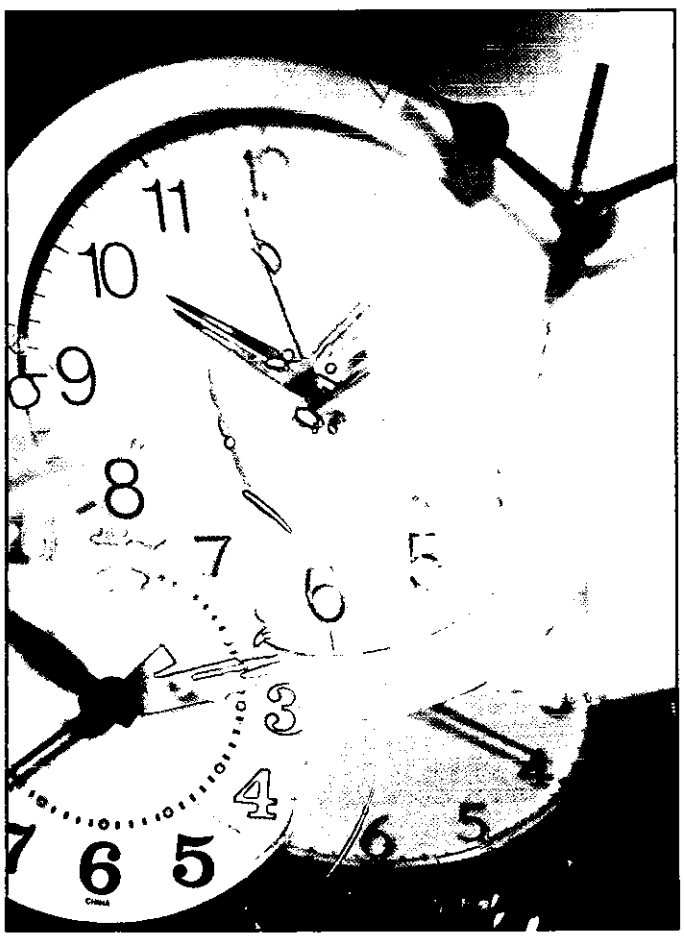
Increasing Numbers of College Graduates

An article in the August 1998 issue of *State Government News* predicted a surge of college-age students in the coming decades. Enrollment in the nation's elementary and secondary schools reached an all-time high in 1996. And the U.S. Department of Education predicted in the mid-1990s that about 3 million more children would be enrolled in the nation's schools than at that time. That means more students would be enrolling in postsecondary education, wrote Robin Zuniga, then a research associate at the Western Interstate Commission for Higher Education.

Zuniga suggested in the article that state leaders would be forced to decide how to make room for every student who wants a postsecondary education and is eligible for admission.

Update

States today are trying to figure out how to get even more students into higher education. Because of the changing global economy, states are recognizing that if they are to remain competitive, they need to increase the rates of people attending and graduating from college. To that end, many states are focusing on programs to make college more affordable, especially for students from the lowest-income families. Read the story on page 30, and check out the CSG blog, Capitol Comments, for more on what states are doing to address college affordability issues.



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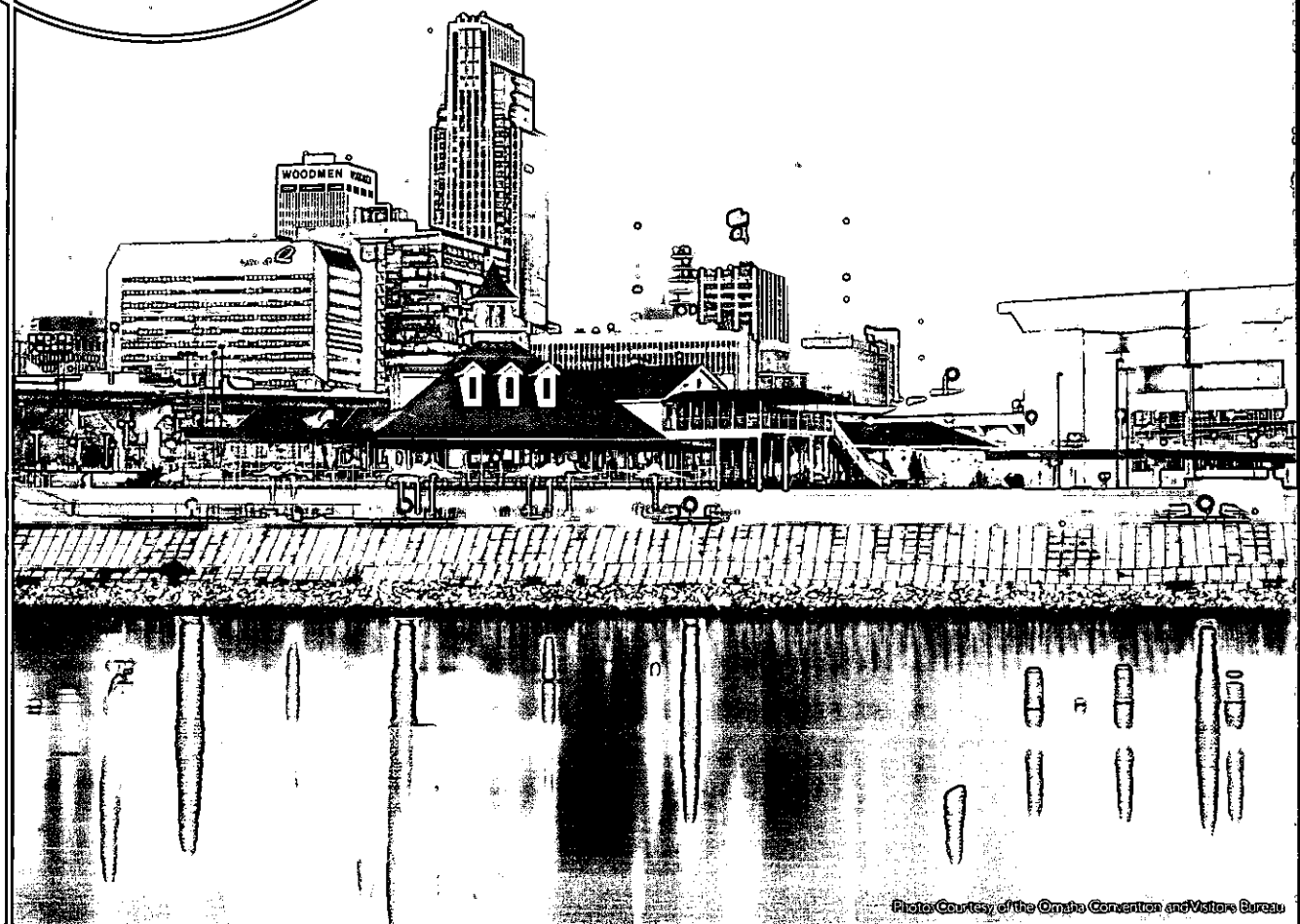

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State executive, legislative and judicial officials from across the country will come together in Omaha to help CSG commemorate 75 years of sharing capitol ideas. You won't want to miss this opportunity to get your message to these key decision-makers. Complete expo kits are available online at *www.csg.org*. For more information, call (800)800-1910 or email *karnold@csg.org*.

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The TRUST
The Alaska Mental Health Trust Authority

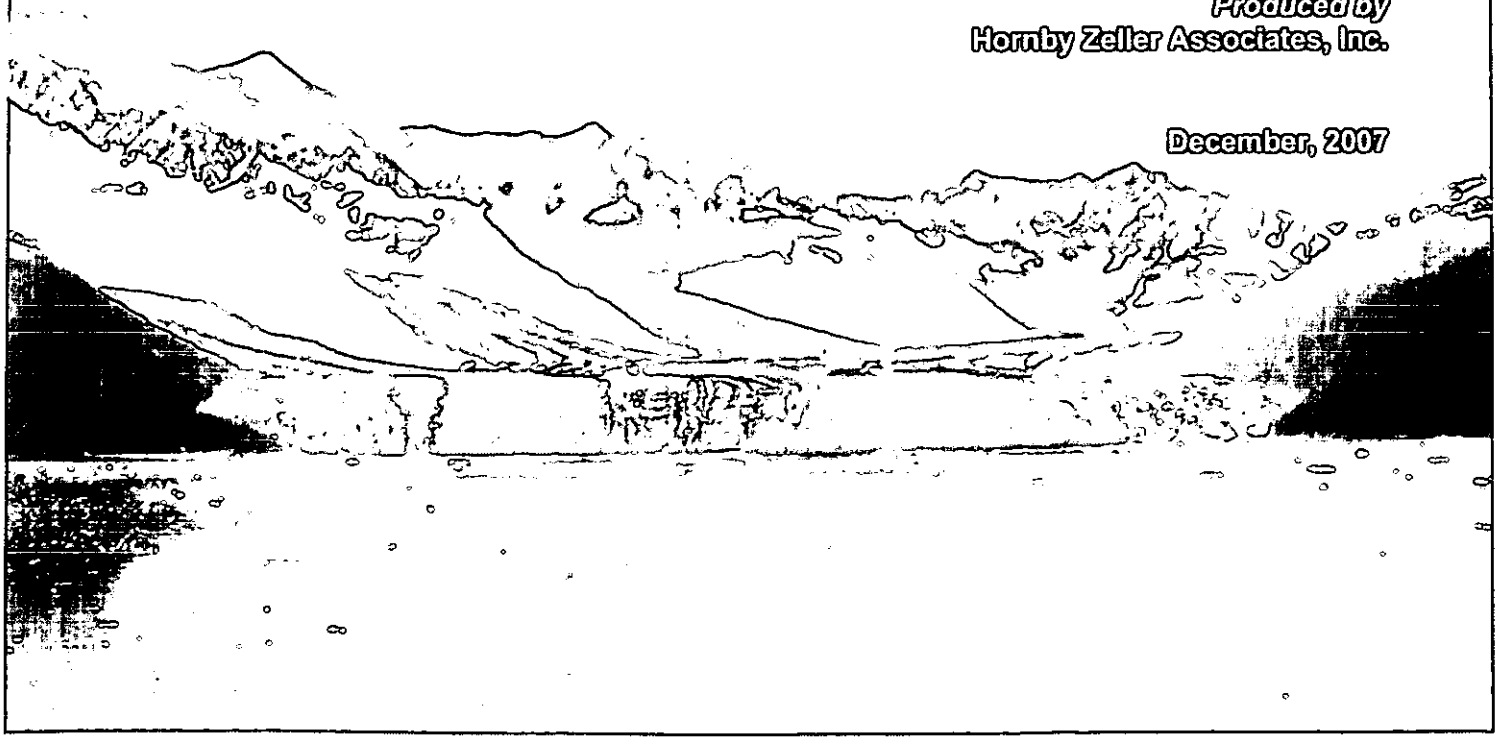
A Study of Trust Beneficiaries in the Alaska Department of Corrections

Funded by
The Alaska Mental Health Trust Authority

Produced for
The Alaska Department of Corrections

Produced by
Hornby Zeller Associates, Inc.

December, 2007



A Study of Trust Beneficiaries in the Alaska Department of Corrections

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This project is funded by the Alaska Mental Health Trust Authority under contract with the Alaska Department of Corrections. Colleen Patrick-Riley from the Alaska Department of Corrections and Steve Williams from the Mental Health Trust Authority served as the primary officials involved in the study. Its contents are the sole responsibility of the authors and do not represent the opinions of the funding agency.

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Executive Summary

People with mental illness and cognitive impairments are over-represented in the correctional system compared to their prevalence in society. This has been shown in previous research. However, the impact of over-representation both on the correctional system itself and on the individuals affected remained largely unexplored. Therefore, the Alaska Mental Health Trust Authority (AMHTA) in conjunction with the Alaska Department of Corrections commissioned this study to obtain a more in-depth and comprehensive understanding of the experiences of this population. They wanted answers to questions such as: Are people with mental illness and cognitive impairments more or less likely to be incarcerated than others who commit similar crimes? Are they identified and treated while incarcerated? Do they stay longer? Do they recidivate more? What kinds of mental illnesses and cognitive impairments do they have and how do these relate to the kinds of offenses committed? How long does it take for them to get services in the community once they are released? Are there particular service models that have been shown to be effective and could reduce recidivism?

Performed by Hornby Zeller Associates, Inc. (HZA), the study examines four years of data using a unique methodology which matches information from multiple agencies and information systems within Alaska. The sources include Medicaid data from the Alaska Department of Health and Social Services, Division of Health Care Services (DHSS), psychiatric history from the Alaska Psychiatric Institute (API) and correctional history from the Alaska Department of Corrections (ADOC). The methodology allows, for the first time, the identification of individuals who were known to have a history of mental health treatment but who may not have been identified as needing treatment by ADOC during their period of incarceration. It also provides the ability to track Medicaid funded and hospital services received in the community during periods of diversion or post-incarceration.

Results of the study provide the State of Alaska with a unique opportunity to explore a critical and yet largely neglected dimension in correctional research — the impact of those with mental illness[1] or cognitive impairments on the statewide correctional systems as well as the impact of state services and correctional detainment on the individual. More importantly, the report provides key baseline information from which changes in the system can be assessed.

The report reveals the consequences of not adequately treating the needs of Trust Beneficiaries[2] in the community. It costs the State of Alaska millions of dollars each year in added prison costs and loss of Federal entitlements to have people recycle through the corrections system. Many Trust Beneficiaries are not identified as having mental health or substance abuse problems while incarcerated; as a result, a large proportion of these individuals are not receiving the mental health and behavioral health-related services they need upon release. For others there is a delay in time to resume Medicaid-funded services upon release. Consequently, Trust Beneficiaries as a whole are far more likely to return into the custody of ADOC and stay in custody longer than other offenders in the general population.

Additional correctional resources, improved systems integration, and better linkages with community health care providers will undoubtedly assist in alleviating the burden of care for Trust Beneficiaries on Alaska's criminal justice system. Should the State of Alaska invest in more diversionary strategies and implement

[1] As defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). See Appendix C for the list of multi-axial classifications.

[2] Trust beneficiaries are those experiencing: 1) mental illness; 2) developmental disabilities; 3) chronic alcoholism with psychosis; and, 4) Alzheimer's disease, related dementias and other cognitive impairments. See Appendix B for a more complete definition of Beneficiaries that fall under the purview of the Alaska Mental Health Trust Authority.

more evidence-based service programs, the State should ultimately realize net institutional savings while at the same time improving public safety and generating better quality-of-life outcomes for Trust Beneficiaries in Alaska's communities.

Major findings from the study indicate that approximately 42 percent of all inmates in custody ADOC are Beneficiaries of the Alaska Mental Health Trust Authority. Among those identified, Trust Beneficiaries are more likely to recidivate, recidivate sooner and spend more time in custody of the ADOC than other inmates.

The following highlights other key findings presented in the report:

- Over a four year time frame, a total of 11,631 people within the ADOC were identified as Beneficiaries of the Alaska Mental Health Trust Authority.

- On June 30, 2006, of the 3,628 people who were in the custody of one of Alaska's thirteen correctional institutions, 1,524 people (42 percent) constituted AMHTA Beneficiaries[3].

- Approximately 62 percent of Trust Beneficiaries in the Alaska Department of Corrections were identified from sources provided by the Department of Health and Social Services as opposed to databases maintained by the ADOC. Most of these had Axis I substance-related disorders and generalized mood disorders such as depression. Only a small proportion of Trust Beneficiaries with severe mental disorders such as schizophrenia or other psychotic disorders were identified as not having been known to both agencies.

- With the exception of those with more severe mental illnesses, there was an overall decline in mental health service utilization among previously Medicaid-funded Trust Beneficiaries exiting the ADOC. Medicaid-eligible Trust Beneficiaries with more severe mental illness (e.g., schizophrenia and other psychotic disorders) received more services after exiting the ADOC than they did prior to entry.

- The overall rate of recidivism for the Trust Beneficiary population is 1.6 times higher (36.2%) than for other offenders released from the ADOC (21.9%). Trust Beneficiaries are significantly more likely to re-enter the ADOC sooner than others released who did not have a mental illness. On the whole, Trust Beneficiaries with severe mental illness were less likely to recidivate than Trust Beneficiaries with mild mental illness or substance-related disorders who had a far higher rate of recidivism.

- Trust Beneficiaries who are either Alaska Native or Black are significantly more likely to recidivate than Whites or other races.

- Trust Beneficiaries with Axis I disorder(s) and Axis II personality disorder(s) are 1.6 times more likely to recidivate than Trust Beneficiaries who do not have both disorder.

- Trust Beneficiary populations most likely to recidivate are young, Black or Alaska Native males who have Axis I disorder(s) and Axis II personality disorder(s) but not an adjustment disorder.

- Trust Beneficiary populations least likely to recidivate are older, white females presenting mild mental health disorders who do not have Axis I disorder(s) and Axis II personality disorder(s).

[3] This does not include individuals in custody of the ADOC either in community residential centers or the contracted facility in Arizona.

- Sixty-one percent of Trust Beneficiaries with a psychiatric admission in the year preceding entry into the ADOC were re-admitted to a psychiatric facility in the one-year period following release from the ADOC.

- More than half of Trust Beneficiary clinical recidivists had at least two Axis 1 mental health disorders and nearly three-quarters had a co-occurring substance-related disorder.

- Trust Beneficiaries who receive mental health services upon release from the ADOC have a lower rate of recidivism than Trust Beneficiaries who did not receive any mental health services.

As a result of the major findings presented throughout the report, HZA encourages the Alaska Department of Corrections and key Stakeholders within the State to consider the following recommendations:

Recommendation 1:
Review and revise screening and assessment protocols for mental health to capture a higher, more accurate portion of the population.

Approximately two-thirds of all Trust Beneficiaries incarcerated within the Alaska Department of Corrections were identified by administrative data sources not maintained by the ADOC. Although the clinical characteristics of these unidentified Beneficiaries constitute mostly those with alcohol, drug and mild mental disorders such as anxiety or depression, the ADOC should consider reviewing its screening and assessment protocols because many of these Beneficiaries are continually recycling in and out of its correctional institutions. Current DOC screening provides identification of individuals with severe or obvious mental illness, but relies on self report to identify other Beneficiaries. It would be useful to develop screening tools to systemically identify moderate mental illness, brain injury, fetal alcohol spectrum disorder (FASD) and other brain disorders. Better identification will enable the ADOC to increase the number of potential Beneficiaries appropriate for referral to substance abuse or other institutional programming or for diversion into community-based services, thereby reducing recidivism and related costs while at the same time preserving public safety.

Recommendation 2:
Consider replacing the CONCON system with one that is more standardized, would allow entry of information pertaining to clinical screens and would be online so that contracted service providers in remote areas could also have access to it.

The Alaska Department of Corrections database (referred to as CONCON) used to maintain records on the Trust Beneficiary population it serves is antiquated, designed largely for qualitative purposes and the information it contains cannot be quantified without reading narrative summaries and hand counting, a particularly onerous task for staff within the ADOC as there are thousands of records maintained in that system.

In addition, information pertaining to the Trust Beneficiary population is entered into the CONCON database only for those individuals who assessed positively for a mental illness while in custody at one of Alaska's 13 correctional facilities. If an individual received a positive *screening* for mental illness but was released from the ADOC before he or she could receive a full assessment, the information would not be captured (screening results exist on paper copy only.)

There is also missing information in the CONCON database about Trust Beneficiaries being served among the remote facilities where the ADOC uses contractors to provide clinical services. These service providers do not enter information into the CONCON database; rather, they maintain assessment and clinical information on paper copy form only.

The number of Trust Beneficiaries identified by the ADOC without an electronic version of their clinical assessment in the CONCON database is estimated to be 1,124 people.
For these reasons and others, the ADOC should consider replacing the system with one that is more standardized, would allow entry of information pertaining to clinical screens and would be online so that contracted service providers in remote areas can also have access to the system. The new system should also include the ability to identify specific Trust Beneficiary populations particularly those with traumatic brain injury, fetal alcohol spectrum disorder, borderline intellectual functioning, and mental retardation, to name a few. This system should also identify and track individuals appropriate for or participating in diversion programs, therapeutic courts, and DOC mental health release programs.

This new system should also be designed in such a way to facilitate cross-referencing against DHSS systems to identify current or former clients of the behavioral health system. As previously noted, the cross-referencing activity in this study yielded a significant number of Trust Beneficiaries who were not identified by the Department of Corrections. Although it is recognized that this cross-referencing activity will not identify every inmate with a mental illness (e.g., an inmate who received private, grant, or other public or federally funded mental health care), it does represent a starting point from which to gather more reliable baseline data. Alaska would benefit from exploring other ways of exchanging information between DHSS divisions and DOC so as to best identify and serve the Trust Beneficiary population.

Recommendation 3:
Identify Trust Beneficiaries entering the ADOC who are Medicaid-eligible so that upon release assistance can be provided to help ensure continuity of care. Use ADOC liaisons with local Social Security and State Medicaid offices to facilitate reinstatement of Federal disability benefits (SSI, SSDI, Medicaid) for a broad diagnostic population of Trust Beneficiaries just prior to their release.

Individuals can qualify for Medicaid-funded mental health services in one of four ways, either through a qualifying mental health diagnosis that meets the Social Security definition of disability, as a side treatment for a qualifying physical disability that meets the Social Security definition of disability, as a side treatment for individuals who qualify for Medicaid because they are age 65 or older, or as a side treatment for individuals who qualify for Medicaid as the caretaker relative of a family with dependent children. While the primary reason for initial eligibility was not available, the study found that many Medicaid-eligible Trust Beneficiaries who were receiving mental health services prior to entering the ADOC, 28 percent were not receiving any Medicaid-funded mental health services after release. Among those not re-engaged in services, the State of Alaska is potentially losing the equivalent of an eight percent match in supplemental federal funds that might otherwise be used to pay for additional mental health services. As a result, there needs to be better identification of Trust Beneficiaries entering the ADOC who were receiving Medicaid or are Medicaid-eligible so that upon release assistance can be provided to help ensure continuity of care.

Since 2004, there has been a Memorandum of Understanding in place with the ADOC, the Social Security Administration and the Alaska Division of Public Assistance that allows the ADOC to facilitate Pre- and Post-Release Applications for severely mentally ill Trust Beneficiaries. ADOC mental health has a 100 percent approval rate for SSI/SSDI applications. ADOC could expand this working relationship to provide application assistance to individuals with other eligible diagnoses with additional staffing resources.

Recommendation 4: Implement more evidence-based services such as Forensic Assertive Community Treatment Teams or Forensic Intensive Case Managers (FACT/FICM) for the severely mentally ill Trust Beneficiary population exiting the ADOC.

Alaska's criminal justice system currently diverts Trust Beneficiaries from incarceration through a variety of avenues such as therapeutic mental health and addictions courts and some specialized release programs. The

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ADOC should continue to sustain and expand the existing APIC Reentry and other DOC mental health release programs for misdemeanors and felons. The ADOC should also consider expanding its partnership with community agencies to divert more Trust Beneficiaries from incarceration by implementing additional evidence-based services targeted to the population most at risk.

For example, national evidence-based best practice research suggests that Forensic Assertive Community Treatment (FACT) and Forensic Intensive Case Management (FICM) are the most promising approaches to managing correctional populations with severe mental illness. The main difference between the two FACT/FICM models largely surround organizational structure. FACT operates within the domain of a self-contained team providing direct services whereas FICM has case managers with individual caseloads who refer out to psychiatric treatment services in the community. Both models have generated positive results for correctional populations with severe mental illness.

Improving its efforts to ensure that Medicaid eligibility is sustained upon release and implementing evidence-based services (such as Forensic Assertive Community Treatment Teams or Forensic Intensive Case Managers (FACT/FICM) for the high-risk Trust Beneficiary population, the State would ultimately realize net institutional savings while at the same time improving public safety and generating better quality-of-life outcomes for the seriously mentally ill Trust Beneficiary population.

While there is clear and convincing evidence that incorporating diversion and best practice models does promote success, it is important to carefully identify appropriate candidates for diversion. Some individuals require a period of incarceration before release to appropriate programs in the community. Others could effectively be diverted pre or post charge.

Recommendation 5:
Expand more culturally sensitive programs for Alaska Natives.

Alaska Native Trust Beneficiaries receiving mental health care services after release from the ADOC have the highest rate of criminal recidivism. When compared to the general population of Alaska, the prevalence of Alaska Native Trust Beneficiaries sentenced to the ADOC (36%) is significantly higher than their prevalence in the general population (16%). While there are a number of other factors that are associated with the disproportionate arrest and detainment of Alaska Natives, the ADOC and community health care providers should consider introducing more culturally sensitive programming into the services they provide. The State of Alaska could partner with Alaska Native Tribal organizations to improve the design and delivery of behavioral health services.

Recommendation 6:
Develop more community-based mental health, substance abuse treatment and support services for Trust Beneficiaries exiting the Alaska Department of Corrections.

There is a general lack of community-based mental health and substance abuse treatment services for the growing number of Trust Beneficiaries exiting the Alaska Department of Corrections. In addition, safe and sober housing is inadequate to meet the current needs of the Trust Beneficiary population. The State should consider allocating additional funding for community-based alternatives to incarceration and increase capacity to deliver essential services to Trust Beneficiary probationers and parolees, including co-occurring substance abuse treatment. Developing an appropriate spectrum of community housing will be critical to Beneficiary success, ranging from independent to supportive living situations to structured options all with an emphasis on sobriety and consumer and public safety. Key stakeholders within the criminal justice system should work closely with mental health consumers, families and advocacy groups to improve services, develop new initiatives and involve all relevant agencies.

To obtain a copy of the complete report, visit the Alaska Mental Health Trust's web site:
http://www.mhtrust.org/documents/12-07%20Final%20DOC%20Trust%20Beneficiary%20Study.pdf

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Should Convicted Felons Have Voting Rights?

by Bryan Knowles
Friday, June 9, 2000

As federal and state prison populations continue to swell and the 2000 elections are fast approaching, the issue of voting rights for convicted felons has gained increasing attention from candidates and the media. With the exceptions of Maine, Vermont and Massachusetts, the remaining 46 states and the District of Columbia prohibit inmates serving felony convictions from voting in any public elections. While a majority of states restore voting rights to convicted felons after they complete their prison terms or probation periods, at least ten states, including Virginia, Delaware and New Mexico permanently prohibit former felons from voting.

The legal authority of a state to revoke an inmate's voting rights is based upon the Fourteenth Amendment. While this amendment stipulates that, "no state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States", it allows for the denying of the voting rights of individuals guilty of "participation in rebellion, or other crime". Under current law, the federal government may not infringe upon a state's authority to grant or rescind voting rights to prison inmates and former felons.

The legal disenfranchisement of inmates and former felons has come under increased scrutiny by civil rights and criminal justice groups. According to Human Rights Watch and The Sentencing Project, nearly 3.9 million people are prohibited from voting, a majority of whom are former convicts who completed their sentences. While legislation has been introduced in Congress that would allow former convicts to vote in federal elections if successful, the Supreme Court of New Hampshire ruled in March to strip incarcerated felons of all voting privileges.

On One Hand...

Assertions that the Fourteenth Amendment justifies the disenfranchisement of felons by states are dubious at best, especially when deciding what "other crimes" constitute the serious magnitude of "participation in rebellion." Disenfranchising inmates is counter to the American tradition of laboring for the expansion of voting rights for all citizens. In many states, the prohibiting of former convicts from voting has become a form of government-sanctioned discrimination against felons who have completed their restitution to society. This is especially true for African-American males who constitute a disproportionate percentage of disenfranchised former felons. Congress and state assemblies must support legislation that reverses this unconstitutional practice.

On the Other Hand...

The Fourteenth Amendment clearly demonstrates that the states have the Constitutional authority to disenfranchise both currently incarcerated and former felons for as long as they deem fit. In limiting the freedoms of convicted felons, incarceration is designed to punish inmates and impress upon them the magnitude of their crimes. As a privilege to be enjoyed by law-abiding citizens, prohibiting inmates from voting further drives this point home. Prohibiting former felons from voting for life ensures the integrity of the electoral process, especially in states and jurisdictions where

Surveys

Agree

Despite their convictions, felons are citizens and should be able to exercise their voting rights, especially after they have repaid their debt to society.

Disagree

Under the 14th Amendment, states are well within their powers to deny convicted felons all voting rights during and after their incarcerations.

Documents

Civic Participation and Rehabilitation Act of 1999

Features

A Deafening Silence at the Polls: One in Seven Black Males Cannot Vote

Court Takes Away Inmate Voting Rights

Proposal Would Automatically Restore Ex-Cons' Voting Rights

Organizations

Bureau of Justice Statistics

Human Rights Project

The Sentencing Project

Perspectives

Criminal Voters

The Disenfranchised

the populace directly elects judges, law enforcement officers and district attorneys.

- Alabama, Delaware, Florida, Iowa, Kentucky, Mississippi, Nevada, New Mexico, Virginia and Wyoming permanently prohibit voting rights for felons.
- According to Human Rights Watch and The Sentencing Project, "1.4 million African American men, or 13% of black men, are disenfranchised, a rate seven times the national average."
- At the conclusion of 1998, an estimated 5.9 million people were incarcerated or serving parole throughout the entire U.S. criminal justice system.
- Arizona and Maryland permanently disenfranchise felons after the conviction of a second offense.

Bureau of Justice Statistics, U.S. Department of Justice, Human Rights Watch, The Sentencing Project

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Instate Inmate Count – Alaska Department of Corrections -March-2009

	416	436	104	316	404	58	228	102	318	176	128	557	264	115	131	Max Cap		3753
	400	418	102	309	395	52	222	98	307	176	128	541	258	110	126	Gen Cap		3642
Day	ACCE	ACCW	AMCC	FCC	HMCC	KCC	LCCC	MSPT	PCC Med	PCC Min	PT Mac	SCCC	WCC	WPT	YKCC	Max Cap	Totals	%
1	438	426	114	247	341	61	196	108	318	176	128	538	262	136	124	3753	3613	96%
2	446	420	114	240	340	60	194	109	318	176	127	537	261	135	121	3753	3598	96%
3	441	431	112	246	337	59	195	104	314	173	126	543	262	130	116	3753	3589	96%
4	441	430	108	244	337	58	194	103	317	176	125	541	263	127	117	3753	3581	95%
5	443	430	108	243	341	59	193	103	315	174	126	540	263	120	119	3753	3577	95%
6	453	449	109	243	333	58	195	104	310	176	125	538	260	119	115	3753	3587	96%
7	451	445	109	248	343	58	196	106	308	176	129	537	259	117	116	3753	3598	96%
8	425	456	110	248	349	47	212	107	317	176	128	540	259	121	122	3753	3617	96%
9	425	450	110	252	350	47	215	113	306	176	127	551	259	121	129	3753	3631	97%
10	427	447	110	241	364	46	212	105	306	176	126	551	259	128	128	3753	3626	97%
11	427	435	103	246	361	46	206	104	303	175	124	550	255	134	125	3753	3594	96%
12	420	439	104	238	362	48	201	94	309	175	128	551	250	135	120	3753	3574	95%
13	440	424	104	240	367	48	203	97	305	176	128	551	249	134	118	3753	3584	95%
14	430	434	102	240	364	50	207	96	308	176	124	549	247	137	116	3753	3580	95%
15	418	427	104	250	369	50	206	96	315	175	128	551	246	135	122	3753	3592	96%
16	425	420	103	246	360	48	208	103	314	176	128	550	245	139	117	3753	3592	96%
17	427	415	104	240	364	47	207	106	310	176	127	559	245	138	115	3753	3580	95%
18	420	434	103	242	359	46	207	104	308	176	125	558	254	128	119	3753	3583	95%
19	434	425	101	242	367	48	210	97	310	176	128	555	252	122	113	3753	3580	95%
20	418	443	105	229	364	45	215	98	312	176	128	552	256	117	112	3753	3570	95%
21	438	439	105	241	374	42	223	90	315	176	126	552	254	126	118	3753	3619	96%
22	428	444	109	252	380	44	226	92	315	176	126	553	256	121	122	3753	3644	97%
23	425	443	113	261	378	43	224	93	311	176	126	553	253	119	119	3753	3637	97%
24	411	447	116	254	376	43	222	100	303	176	128	553	250	123	121	3753	3623	97%
25	429	436	116	252	376	41	222	96	302	176	127	557	249	120	117	3753	3616	96%
26	422	437	116	248	374	40	225	99	304	176	127	556	250	119	116	3753	3609	96%
27	438	429	124	246	367	40	226	98	300	176	126	556	249	114	114	3753	3603	96%
28																3753	0	0%
29																3753	0	0%
30																3753	0	0%
31																3753	0	0%
Avg	431.11	435.37	108.74	245.15	359.15	48.963	208.89	100.93	310.11	175.7	126.7	549.33	254.33	126.48	118.93	3753	3600	96%
10 dy	3	0	8	0	0	0	0	0	0	0	0	0	0	0	0			
30/90	74	39	36	0	0	4	0	33	81	0	1	3	0	87	11			

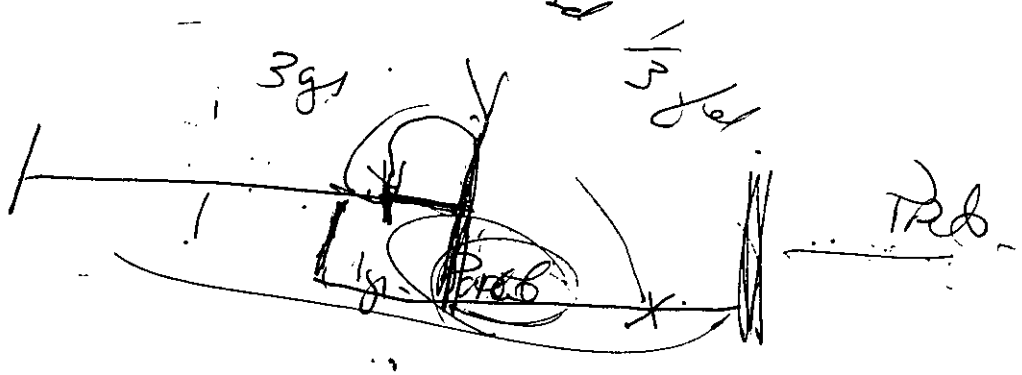
Max Cap=General beds plus half of segregation beds including converted gym beds

General Cap=All hards beds in general population including converted gym beds

4/6
1652 msent 46
1902 sent 5750
not 3850 6226
Instate in Jail 3554 -
1/3 telus-
521

3/31/2009

Institution	MEN Sent.	MEN Unsent	WOMEN Sent.	WOMEN Unsent	TOTAL
ACCE	60	371	0	7	438
ACCW	41	388	0	0	429
Anvil Mt. (Nome)	48	63	7	6	124
Fairbanks CC	34	183	1	28	246
Hiland Mt. CC	0	0	210	157	367
Ketchikan CC	12	24	1	3	40
Lemon Creek CC	137	77	7	5	226
MatSu Pre-Trial	12	72	2	12	98
Palmer Med.CC	228	72	0	0	300
Palmer Min.CC	176	0	0	0	176
Pt. Mac	126	0	0	0	126
Spring Creek CC	548	8	0	0	556
Wildwood CC	221	28	0	0	249
Wildwood PT	22	74	3	15	114
YKCC (Bethel)	18	92	0	4	114
Total	**1683**	**1452**	**231**	**237**	**3,603**
		Unsent		Sent.	
Total		**1689**		**1914**	**3,603**
		47%		**53%**	



Community Residential Program - Treatment Beds							March 27, 2009	
	G.H.S.	Clitheroe	Akeela	RCAOA	YKHC	Manilliq		
Total Contract Beds								
	2	13	5	4	1	1	Allotted:	26
Institutional Beds								
Beds Assigned	0	11	5	3	1	0	Allotted:	20
Furlough	0	4	3	0	3	0	10	
Confined Misd.	0	0	0	0	0	0	0	
Restitution	0	0	0	0	0	0	0	
Unsentenced	0	0	0	0	0	0	0	
3rd Party	0	0	0	0	0	0	0	
Total Filled	0	4	3	0	3	0	Filled:	10
Field Beds								
Beds Assigned	2	2	0	1	0	1	Allotted:	6
Probation	2	5	0	1	5	3	16	
Parole	0	2	0	0	0	0	2	
Total Filled	2	7	0	1	5	3	Filled:	18
JAIL ALTERNATIVE SERVICES								
Jail Alt. Serv.	0	0	0	0	0	0	Filled:	0
TOTAL TREATMENT BEDS								
Total Filled	2	11	3	1	8	3	Total Filled:	28

March 27, 2009

	Cordova	Midtown	Parkview	Glennwd	N.S.	Tundra	Glacier	Seaside		
	170+22*=192	27+5*=32	95+17*=112	78+14*=90	81+16*=107	72+13*=85	72+13*=85	42+8*=50		753
Institutional Beds										
Assigned	182	32	107	70	97	75	75	44	Allotted:	682
Furlough	46	0	44	68	32	4	42	18	254	
Conf Misd/Fel	31	32	20	1	20	32	3	22	161	
Restitution	9	0	8	3	12	0	7	0	39	
Unsent.	62	0	32	2	15	14	0	8	133	
3rd Party	13	0	0	1	0	8	0	0	22	
Filled Beds	161	32	104	75	79	58	52	48	Filled:	609
Field Beds										
Assigned	10	0	5	20	10	10	10	6	Allotted:	71
Probation	5	0	1	2	9	13	22	0	52	
Parole	11	0	6	10	9	2	6	1	45	
Filled Beds	16	0	7	12	18	15	28	1	Filled:	97
TOTAL CRC BEDS										
Total Filled	177	32	111	87	97	73	80	49	Filled:	706
TOTAL CRC SUPERVISION-OSP										
				10+10=20	10		10+5=15			30+15=45
Furlough	0	0	0	5	0	0	1	0	6	
Probation	0	0	0	0	0	0	0	0	0	
Parole	0	0	0	0	0	0	0	0	0	
TTL SUPV	0	0	0	5	0	0	1	0	Total	6
Trk.1,2	0	0	0	1	0	0	8	0	Total	9

						3603	INSTITUTIONAL			
EM	EM					870	Red Rock, AZ			
Anchorage	Fairbanks					17	OTHER: OUT OF STATE			
183	37					706	CRC			
						28	TREATMENT BEDS FILLED			
EM	EM					6	CRC OFF SUP			
Kenai	Ketchikan					231	EM			
9	2				Total	5461				

* PerDiem Slots

		men suit	men naked	women suit	women naked	total
	ACCW	45	391			436
	Anvil Mt.(Nome)	48	57	8	3	116
	Fairbanks CC	35	186	2	29	252
	Hiland Mt. CC			211	165	376
	Ketchikan CC	13	23	1	4	41
	Lemon Creek CC	138	70	7	7	222
	MatSu Pre-Trial	12	73	2	9	96
	Palmer Med.CC	234	68			302
	Palmer Min.CC	176				176
	Pt. Mac	127				127
	Spring Creek CC	549	8			557
	Wildwood CC	220	29			249
	Wilwood PT	28	72	3	17	120
	YKCC (Bethel)	17	95		5	117
3/26/2009	ACCE	58	362		2	422
	ACCW	41	396			437
	Anvil Mt.(Nome)	47	58	7	4	116
	Fairbanks CC	33	185	2	28	248
	Hiland Mt. CC			211	163	374
	Ketchikan CC	13	23	1	3	40
	Lemon Creek CC	138	71	8	8	225
	MatSu Pre-Trial	12	75	1	11	99
	Palmer Med.CC	231	73			304
	Palmer Min.CC	176				176
	Pt. Mac	126	1			127
	Spring Creek CC	548	8			556
	Wildwood CC	222	28			250
	Wilwood PT	24	76	4	15	119
	YKCC (Bethel)	20	92		4	116
3/27/2009	ACCE	60	371		7	438
	ACCW	41	388			429
	Anvil Mt.(Nome)	48	63	7	6	124
	Fairbanks CC	34	183	1	28	246
	Hiland Mt. CC			210	157	367
	Ketchikan CC	12	24	1	3	40
	Lemon Creek CC	137	77	7	5	226
	MatSu Pre-Trial	12	72	2	12	98
	Palmer Med.CC	228	72			300
	Palmer Min.CC	176				176
	Pt. Mac	126				126
	Spring Creek CC	548	8			556
	Wildwood CC	221	28			249
	Wilwood PT	22	74	3	15	114
	YKCC (Bethel)	18	92		4	114
	ACCE					0
	ACCW					0
	Anvil Mt.(Nome)					0
	Fairbanks CC					0
	Hiland Mt. CC					0
	Ketchikan CC					0
	Lemon Creek CC					0
	MatSu Pre-Trial					0

Date	Institution	MEN Sent.	MEN Unsent	WOMEN Sent.	WOMEN Unsent	Total
1/1/2009	Anchorage Jail	44	346	1	5	396
	Anvil Mt.(Nome)	23	57	2	1	83
	Cook Inlet PT	53	389			442
	Fairbanks CC	45	167	5	17	234
	Hiland Mt. CC			194	127	321
	Ketchikan CC	19	21	1	2	43
	Lemon Creek CC	104	71	1	6	182
	MatSu Pre-Trial	8	71	1	6	86
	Palmer Med.CC	199	62			261
	Palmer Min.CC	176				176
	Pt. Mac	117				117
	Spring Creek CC	545	6			551
	Wildwood CC	234	24			258
	Wilwood PT	23	79	5	11	118
	YKCC (Bethel)	16	91		2	109
1/2/2009	Anchorage Jail	44	361	1	6	412
	Anvil Mt.(Nome)	21	60	1	2	84
	Cook Inlet PT	50	387			437
	Fairbanks CC	46	177	4	21	248
	Hiland Mt. CC			200	125	325
	Ketchikan CC	19	21	2	1	43
	Lemon Creek CC	105	74	1	9	189
	MatSu Pre-Trial	7	79	1	9	96
	Palmer Med.CC	200	61			261
	Palmer Min.CC	173				173
	Pt. Mac	116				116
	Spring Creek CC	545	6			551
	Wildwood CC	234	24			258
	Wilwood PT	25	84	4	11	124
	YKCC (Bethel)	15	98	1	2	116
1/3/2009	Anchorage Jail	45	360	1	2	408
	Anvil Mt.(Nome)	21	60	1	2	84
	Cook Inlet PT	51	382			433
	Fairbanks CC	43	173	6	17	239
	Hiland Mt. CC			201	119	320
	Ketchikan CC	22	21	2	1	46
	Lemon Creek CC	108	76	2	8	194
	MatSu Pre-Trial	7	79	1	6	93
	Palmer Med.CC	203	57			260
	Palmer Min.CC	176				176
	Pt. Mac	116				116
	Spring Creek CC	545	6			551
	Wildwood CC	234	24			258
	Wilwood PT	27	84	5	12	128
	YKCC (Bethel)	19	99		2	120
1/4/2009	Anchorage Jail	44	356	1	3	404
	Anvil Mt.(Nome)	21	60	2	1	84
	Cook Inlet PT	50	387			437
	Fairbanks CC	46	173	5	19	243
	Hiland Mt. CC			200	125	325

PATC	Mani	Cordova		Midtown		Parkview		Glenwood		N.S.		Tundra		Glacier		Seaside		G.H.S.		Clithroe		Akeela	
Furlough	**Furlough**	**Con.**	**Misd**	**Con.**	**Misd**	**Con.**	**Misd**	**Con.**	**Misd**	**Con.**	**Misd**	**Con.**	**Misd**	**Con.**	**Misd**	**Con.**	**Misd**	**Con.**	**Misd**	**Con.**	**Misd**	**Con.**	**Misd**
3		30		32		22		1		13		21		5		26							
3		25		32		22		1		13		22		4		25							
3		38		32		22		1		12		21		4		26							
3		35		31		21		1		12		21		3		26							
3		30		30		21		1		11		20		3		24							
3		35		32		23		1		14		24		4		24							
3		38		32		25		1		15		24		7		24							
3		40		32		24		1		14		25		7		24							
3		44		32		26		3		15		24		7		25							
3		64		32		27		3		13		27		7		27							
3		58		32		27		4		13		26		6		27							
3		46		32		27		3		14		26		7		27							
3		49		32		29		3		16		29		6		27							
3		54		32		28		2		20		30		5		26							
3		58		32		28		2		20		30		5		26							
3		59		32		27		2		17		26		6		26							
3		67		32		28		2		19		24		5		26							
3		61		31		28		2		19		23		5		27							
3		52		30		27		2		19		23		5		26							
3		44		32		26		2		19		22		5		25							
3		60		32		26		2		19		24		5		30							
3		57		32		27		2		26		28		5		33							
3		56		32		27		2		25		29		5		31							
3		63		32		27		2		25		29		5		32							
3		60		32		25		2		21		29		6		29							
3		53		32		26		2		20		29		3		28							
3		52		32		26		2		19		27		3		28							
3		49		32		25		3		19		30		2		28							
3		50		32		24		3		17		29		2		28							
3		46		32		24		3		15		27		2		26							

3	49	32	26	5	20	32	1	22
3	50	32	23	5	20	32		21
3	54	32	23	5	19	33		21
3	53	32	26	4	19	34		21
3	49	31	25	4	17	34		20
3	37	32	22	4	17	33		20
3	41	32	21	4	18	32	1	20
3	43	32	21	3	18	33	1	20
3	43	32	21	3	20	33	1	20
3	45	32	24	3	21	32	1	21
3	38	32	23	3	20	31	1	19
3	36	32	22	3	20	26	1	18
3	30	32	23	3	20	26	1	19
3	28	32	22	2	19	31	1	19
3	28	32	22	3	18	31	1	19
3	33	32	20	3	21	30	1	20
3	38	32	21	3	23	29	1	20
3	37	32	21	3	23	26	2	20
3	33	32	20	3	22	26	2	20
3	28	32	20	3	22	26	2	19
3	29	32	19	3	21	25	2	17
3	32	32	19	3	20	30	2	20
3	31	32	20	2	21	29	2	21
3	31	32	20	1	20	32	3	22

3/27/04

Date	Cordova Furlough	Midtown Furlough	Parkview Furlough	Glenwood Furlough	N.S. Furlough	Tundra Furlough	Glacier Furlough	Seaside Furlough	G.H.S. Furlough	Clithroe Furlough	Akeela Furlough	RCAOA Furlough
1/1/2009	33		34	60	50	9	39	11		9	1	
1/2/2009	33		36	60	49	9	39	11		9	1	
1/3/2009	34		36	59	49	9	39	10		9	1	
1/4/2009	34		35	59	49	9	38	10		9	1	
1/5/2009	34		34	59	49	9	38	11		9	1	
1/6/2009	34		32	59	48	9	38	11		8	2	
1/7/2009	34		33	57	49	8	39	12		8	3	
1/8/2009	35		32	59	48	7	39	12		8	3	
1/9/2009	39		31	57	48	7	39	12		8	3	
1/10/2009	41		31	57	44	7	39	12		8	3	
1/11/2009	41		32	56	44	7	40	12		8	3	
1/12/2009	41		31	57	48	7	39	12		8	3	
1/13/2009	40		31	57	45	7	41	12		10	3	
1/14/2009	40		31	59	46	7	42	12		10	3	
1/15/2009	40		31	58	43	7	42	12		8	3	
1/16/2009	40		31	58	46	8	42	12		8	3	
1/17/2009	42		31	55	46	8	41	12		8	3	
1/18/2009	42		31	55	46	8	42	11		8	3	
1/19/2009	42		31	55	46	8	42	11		8	3	
1/20/2009	41		31	55	46	8	42	11		8	3	
1/21/2009	39		30	56	46	8	42	11		8	3	
1/22/2009	44		30	58	46	8	44	10		8	3	
1/23/2009	47		30	57	46	8	43	10		8	3	
1/24/2009	49		30	58	46	8	43	10		8	3	
1/25/2009	49		30	59	45	8	43	12		8	3	
1/26/2009	49		30	59	45	8	41	11		8	3	
1/27/2009	49		30	61	45	8	40	12		8	3	
1/28/2009	47		31	63	46	8	42	11		8	3	
1/29/2009	49		31	61	46	8	43	12		8	3	
1/30/2009	50		31	60	47	7	45	12		8	3	

3/4/2009	44	39	69	44	7	46	16	5	3
3/5/2009	46	40	71	44	7	46	16	5	3
3/6/2009	46	40	70	43	7	46	16	5	3
3/7/2009	46	40	73	43	6	46	16	5	3
3/8/2009	44	40	73	43	6	46	16	4	3
3/9/2009	43	40	73	42	6	46	16	4	3
3/10/2009	43	40	71	42	6	46	16	4	3
3/11/2009	43	40	71	44	6	46	17	4	3
3/12/2009	45	43	72	42	6	46	17	4	3
3/13/2009	45	43	72	44	6	46	17	4	3
3/14/2009	44	44	74	44	6	48	18	4	3
3/15/2009	44	44	73	44	6	46	18	4	3
3/16/2009	44	44	75	44	6	45	20	4	3
3/17/2009	45	43	72	42	6	45	20	4	3
3/18/2009	45	43	71	37	6	45	20	4	3
3/19/2009	46	46	72	37	6	45	20	4	3
3/20/2009	44	46	72	37	6	45	20	4	3
3/21/2009	45	47	71	37	6	44	20	4	3
3/22/2009	47	48	70	36	6	44	20	4	3
3/23/2009	47	48	70	36	6	43	19	4	3
3/24/2009	48	47	71	35	5	44	19	4	3
3/25/2009	46	47	72	33	5	44	18	4	3
3/26/2009	46	45	68	33	4	42	18	4	3
3/27/2009	46	44	68	32	4	42	18	4	3
3/28/2009									
3/29/2009									
3/30/2009									
3/31/2009									
4/1/2009									
4/2/2009									
4/3/2009									
4/4/2009									

Incount Data

	ACE	ACCW														
2/28/2009	429	437	106	226	349	58	197	105	316	175	127	531	259	131	122	3568
3/1/2009	438	426	114	247	341	61	196	108	318	176	128	538	262	136	124	3613
3/2/2009	446	420	114	240	340	60	194	109	318	176	127	537	261	135	121	3598
3/3/2009	441	431	112	246	337	59	195	104	314	173	126	543	262	130	116	3589
3/4/2009	441	430	108	244	337	58	194	103	317	176	125	541	263	127	117	3581
3/5/2009	443	430	108	243	341	59	193	103	315	174	126	540	263	120	119	3577
3/6/2009	453	449	109	243	333	58	195	104	310	176	125	538	260	119	115	3587
3/7/2009	451	445	109	248	343	58	196	106	308	176	129	537	259	117	116	3598
3/8/2009	425	456	110	248	349	47	212	107	317	176	128	540	259	121	122	3617
3/9/2009	425	450	110	252	350	47	215	113	306	176	127	551	259	121	129	3631
3/10/2009	427	447	110	241	364	46	212	105	306	176	126	551	259	128	128	3626
3/11/2009	427	435	103	246	361	46	206	104	303	175	124	550	255	134	125	3594
3/12/2009	420	439	104	238	362	48	201	94	309	175	128	551	250	135	120	3574
3/13/2009	440	424	104	240	367	48	203	97	305	176	128	551	249	134	118	3584
3/14/2009	430	434	102	240	364	50	207	96	308	176	124	549	247	137	116	3580
3/15/2009	418	427	104	250	369	50	206	96	315	175	128	551	246	135	122	3592
3/16/2009	425	420	103	246	360	48	208	103	314	176	128	560	245	139	117	3592
3/17/2009	427	415	104	240	364	47	207	106	310	176	127	559	245	138	115	3580
3/18/2009	420	434	103	242	359	46	207	104	308	176	125	558	254	128	119	3583
3/19/2009	434	425	101	242	367	48	210	97	310	176	128	555	252	122	113	3580
3/20/2009	418	443	105	229	364	45	215	98	312	176	128	552	256	117	112	3570
3/21/2009	438	439	105	241	374	42	223	90	315	176	126	552	254	126	118	3619
3/22/2009	428	444	109	252	380	44	226	92	315	176	126	553	256	121	122	3644
3/23/2009	425	443	113	261	378	43	224	93	311	176	126	553	253	119	119	3637
3/24/2009	411	447	116	254	376	43	222	100	303	176	128	553	250	123	121	3623
3/25/2009	429	436	116	252	376	41	222	96	302	176	127	557	249	120	117	3616
3/26/2009	422	437	116	248	374	40	225	99	304	176	127	556	250	119	116	3609
3/27/2009	438	429	124	246	367	40	226	98	300	176	126	556	249	114	114	3603

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921 P.2d 636
Alaska App.,1996.
Jul 05, 1996

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921 P.2d 636, 75 A.L.R.5th 701
Court of Appeals of Alaska.
Brenda J. ◆**SINGLETON,**◆ Appellant,
v.
◆**STATE**◆ of Alaska, Appellee.
No. A-5578.
July 5, 1996.

Ethan A. Berkowitz, Anchorage, for Appellant.
Cynthia L. Herren, Assistant Attorney General, Office of Special Prosecutions and Appeals, Anchorage, and Bruce M. Botelho, Attorney General, Juneau, for Appellee.

Before BRYNER, C.J., and COATS and MANNHEIMER, JJ.

OPINION

BRYNER, Chief Judge.

Brenda J. Singleton was convicted by a jury of robbery in the second degree, AS 11.41.510(a)(1). On appeal, she argues that the trial court erred in allowing an unqualified person to serve as a juror and that the state failed to preserve exculpatory evidence. We affirm.

Singleton and two codefendants, Dudley Fuqua, Jr., and Tyree McCray, were jointly indicted and tried for robbing Elaine G. Copeland. The robbery occurred outside Copeland's Anchorage apartment building. Singleton, Fuqua, and McCray--possibly accompanied by two other people--had driven to the building in a white van, ostensibly to enable Singleton to get money that she claimed Copeland owed her. An altercation between Singleton and Copeland ensued, culminating in Singleton forcibly taking a jacket, which had $201 cash in its pocket, from Copeland's person. After Singleton took the jacket, she, Fuqua and McCray left the area in the van.

The incident was immediately reported to the police by the manager of Copeland's apartment building. A short time later, the police found the van stopped on a nearby street, with Singleton, Fuqua, McCray, and two or three other people present. Copeland and a friend of her's who had witnessed the robbery were brought to the scene and identified Singleton, Fuqua, and McCray. They were arrested. Copeland and her friend evidently told the police that the other individuals present at the arrest scene had not been involved in the incident.

The state brought Singleton, Fuqua and McCray to trial on robbery charges. During the jury selection process, prospective juror Richard Porter disclosed that he had been convicted ten years previously of "felony retail theft" for stealing 52 cartons of cigarettes from a store in Chicago. Porter stated that he had served seventeen days in jail for the offense and had received three years' probation, which he had successfully completed. Because he never received any formal notice that his civil rights had been restored, Porter had not hunted or voted since his conviction. Porter did not believe the conviction would affect his ability to be fair and impartial.

All parties had the opportunity to question Porter about his prior

conviction and his fitness for jury service. All passed him for cause, and none exercised a peremptory challenge.

For the first time on appeal, Singleton questions Porter's qualifications to serve as a juror. Singleton cites AS 09.20.020(2), which provides that "[a] person is disqualified from serving as a juror if the person ... (2) has been convicted of a felony for which the person has not been unconditionally discharged[.]" Singleton argues that, since Porter's civil rights had apparently never been restored, he had not been "unconditionally discharged" and therefore did not qualify for jury duty. Singleton insists that, for this reason, the trial court was obligated to strike Porter from the panel *sua sponte*. Singleton maintains that Porter's inclusion on the panel violated her right to an impartial jury; she further maintains that she was deprived of due process because she was never personally informed of her right to challenge Porter for cause and did not knowingly waive that right.

Strong authority supports the conclusion that Singleton waived her argument on appeal by failing to exercise a challenge--either for cause or peremptory--after learning of Porter's potential disability. *See United States v. Boney*, 977 F.2d 624, 632-34 (D.C.Cir.1992); *Sirotiak v. H.C. Price Co.*, 758 P.2d 1271, 1275 n. 2 (Alaska 1988); *Sharp v. State*, 837 P.2d 718, 723 (Alaska App.1992). However, we need not decide the issue of waiver, for here the record fails to substantiate Singleton's claim that Porter was disqualified.

Singleton builds her argument for Porter's disqualification on the premise that formal restoration of Porter's civil rights--such as the right to vote or to carry a firearm--was a prerequisite to Porter's being "unconditionally discharged" from his prior felony conviction, as required under AS 09.20.020(2). However, the juror disqualification statute itself specifies that the term "unconditional discharge has the meaning given in AS 12.55.185." AS 09.20.020(2). Alaska Statutes 12.55.185 defines the term "unconditional discharge" to mean "that a defendant is released from all disability arising under a sentence, including probation and parole[.]" This definition conditions renewed eligibility for jury service upon release from all restrictions directly imposed "under a sentence," but not from collateral disabilities--such as loss of firearms or voting privileges--that flow from sources outside the judgment of conviction or sentencing order. Singleton cites no authority to support a departure from the apparent plain meaning of the statutory definition.

Moreover, adopting Singleton's argument would yield anomalous results. Alaska's voting laws illustrate the point. Under AS 15.05.030(a), any person convicted of a felony involving moral turpitude loses the right to vote "from the date of the conviction through the date of the unconditional discharge of the person." For purposes of this provision, the term "unconditional discharge" is defined in AS 15.60.010(33) to mean "that a person is released from all disability arising under a conviction and sentence, including probation and parole[.]" This definition is functionally identical to the definition of the same term set out in AS 12.55.185(12), which AS 09.20.020(2) adopts for purposes of determining juror qualification.

When viewed through the prism of the voting statutes, the flaw in Singleton's argument becomes apparent. For if, as Singleton argues, the right to vote must be restored as a prerequisite of unconditional discharge, then a person's right to vote could never be restored: under AS 15.05.030(a) a person who lost the right to vote upon conviction of a felony would be entitled to have that right restored only upon unconditional discharge, but unconditional discharge could occur only upon restoration of the right to vote. Singleton's definition of unconditional discharge would thus be wholly circular and entirely self-defeating.

[1] We conclude that the definition of "unconditional discharge" set forth in AS 12.55.185 must be interpreted in accordance with the statute's plain meaning. So interpreted, unconditional discharge

requires completion of any sentence of imprisonment, discharge from parole or probation, and release from any other restriction directly imposed as part of the judgment of conviction. Restoration of collaterally affected rights or privileges is not required.[[FN1]]

FN1. In this connection, it is worth noting that the Attorney General has interpreted "unconditional discharge" in the context of the voting rights statutes to require completion of probation or parole, but not formal restoration of collaterally affected civil rights. *See* 1985 Op. Att'y Gen. No. 103 (Alaska, Jan. 29, 1985).

[2] Applying this interpretation to Singleton's case, we conclude that the record fails to support Singleton's claim that juror Porter was disqualified from jury service under AS 09.20.020(2). Porter's testimony on *voir dire* indicated a prior conviction for a felony involving moral turpitude. But according to Porter, he had long ago been discharged after serving his sentence and successfully completing his probation. The record provides no reason to suspect that Porter had not been "released from all disability arising under [the] sentence" in his case, and so, no reason to conclude that he had not been "unconditionally discharged." AS 09.20.020(2). Under these circumstances, the status of Porter's voting or hunting rights was irrelevant to his qualification as a juror in Singleton's case.

Singleton next claims that the state violated her right to due process and her discovery rights under Criminal Rule 16 by failing to preserve the names of the witnesses who were at the scene when Singleton, Fuqua, and McCray were arrested. The argument is meritless. At a pretrial discovery hearing on June 16, 1994, Singleton's counsel mentioned that Singleton had not yet received copies of notes made by the officers who arrested her. Counsel went on to say: "The officers interviewed some people or at least spoke to some people at the scene of the--at the incident scene, and we don't have the names of those people. We're hoping they would appear in the officer notes." Superior Court Judge Elaine M. Andrews ordered the notes produced by June 23. Following this deadline, on July 1, 1994, Fuqua's attorney moved to compel discovery of the names and addresses of the interviewed witnesses. In an affidavit accompanying the motion, Fuqua's attorney indicated that police notes disclosed by the District Attorney's Office did not name the witnesses; the affidavit also indicated that all existing police notes had apparently already been transmitted by the police to the District Attorney's office. Fuqua thus requested a hearing to determine "the reason for the disappearance of the names and the appropriate sanction." The record provides no indication that Singleton joined in Fuqua's motion to compel.

Several days after Fuqua filed his motion to compel, Judge Andrews denied it, concluding that all police notes had been disclosed and that a failure to memorialize the names of bystanders at the scene of the arrest would not amount to a discovery violation or an impermissible failure to preserve evidence. In reaching this conclusion, the judge emphasized that, in the absence of notes, defense counsel's remedy was to interview the arresting officers:

Defense counsel is free to call the officers and ask them to name the witnesses that they claim to have been able to identify.... There is no basis to claim a "disappearance" of real evidence on the defense version of the facts.

At trial, one of Singleton's arresting officers mentioned that he had not taken notes of the names of bystanders at the arrest scene but that he "knew one of the individuals." The other arresting officer testified that he did not know of any previously undisclosed witnesses to the alleged robbery; when asked about an unidentified person at the arrest scene; the officer responded that the police did not know if that person had

been an eyewitness.
No further mention of the discovery issue was made by Fuqua or Singleton. The record is silent as to whether Singleton made any attempt to conduct pretrial interviews with the arresting officers. Neither Singleton nor Fuqua claimed any prejudice at trial.
Singleton fails to demonstrate any error by the trial court. As we have recently held:
While officers have a duty to preserve potentially exculpatory evidence actually gathered during a criminal investigation, the due process clause has never required officers to undertake a state-of-the-art investigation of all reported crimes. Officers investigating a crime need not "track down every conceivable investigative lead and seize every scintilla of evidence regardless of its apparent importance or lack of importance at the time, or run the risk of denying a defendant due process or his discovery rights." *Nicholson v. State*, 570 P.2d 1058, 1064 (Alaska 1977).
March v. State, 859 P.2d 714, 716 (Alaska App.1993).
[3] Here, officers at the scene of Singleton's arrest were evidently informed that no one other than Singleton, Fuqua, and McCray had been involved in the alleged robbery. The officers had no obvious basis to believe that other individuals at the arrest scene had "potentially exculpatory evidence." *Id.* If the other individuals were merely bystanders at the scene of the arrest, there is little reason to suppose that they had any material information to offer--exculpatory or inculpatory. If, on the other hand, the individuals at the arrest scene had been companions of Singleton in the van and had indeed witnessed the alleged robbery, their identities would presumably have been known by, or readily available to, Singleton without police assistance. Moreover, Singleton has failed to establish any effort on her part to determine the identities of potential witnesses through direct interview of her arresting officers, as suggested by Judge Andrews. And finally, it appears that Singleton failed even to join in Fuqua's motion to compel disclosure of the bystanders' names.
Under the circumstances, we find no discovery or due process violation. The conviction is AFFIRMED.
Alaska App.,1996.
Singleton v. **State**
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FELON DISENFRANCHISEMENT IN ALASKA AND THE VOTING RIGHTS ACT OF 1965

CHRISTOPHER R. MURRAY*

Alaska and forty-seven other states have provisions that limit the voting rights of felons. In many of these states, including Alaska, minority groups are disproprtionately affected by these felon disenfranchisement laws. This Note examines the validity of these laws generally, and Alaska's laws in particular, under the the Voting Rights Act of 1965.

I. INTRODUCTION

Alaska limits the voting rights of felons.[1] Forty-seven other states have similar policies.[2] And, as in many of these other states, racial minorities in Alaska are disproportionately affected.[3] Indeed, the state's largest minority group, Alaska Natives, is overrepresented in the state's prison population, indicating a greater likelihood of disenfranchisement.[4] Because the right to vote is central to democratic government, any law that tends more frequently to disenfranchise racial minorities should be cause for

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1. ALASKA CONST. art. V, § 2 ("No person may vote who has been convicted of a felony involving moral turpitude unless his civil rights have been restored.").

2. JAMIE FELLNER & MARC MAUER, LOSING THE VOTE: THE IMPACT OF FELONY DISENFRANCHISEMENT LAWS IN THE UNITED STATES pt. IV (1998), *available at* http://www.hrw.org/reports98/vote.

3. *Id.* pt. III.

4. Alaska Natives constituted approximately sixteen percent of Alaska's general population as of 2000, United States Census, *available at* http://factfinder.census.gov (under "get a Fact Sheet for your community" enter "Alaska" into "state" field; then follow "2000" link) [hereinafter U.S. Census], but represent over thirty-seven percent of the state's prison population, ALASKA DEPT. OF CORRECTIONS, 2003 OFFENDER PROFILE 11 (2004), *available at* http://www.correct.state.ak.us/corrections/admin/docs/profile2003.pdf [hereinafter ALASKA OFFENDER PROFILE].

alarm. Nevertheless, because Alaska's felon disenfranchisement laws appear not to have been enacted with a discriminatory purpose, they likely do not violate the Federal Constitution.[5]

The laws may, however, run afoul of the Voting Rights Act of 1965 ("VRA"), which was amended in 1982 to invalidate state voting qualifications that have a racially disproportionate impact.[6] Recent litigation has challenged state felon disenfranchisement laws on this basis.[7] Though none of these challenges have succeeded—and two circuits have held that the VRA simply does not apply to felon disenfranchisement[8]—the Ninth Circuit recently allowed a VRA challenge to the State of Washington's felon disenfranchisement provision.[9]

To date, no case has been brought challenging felon disenfranchisement in Alaska. This Note is directed to that possibility. Part II puts Alaska's felon disenfranchisement laws into national context and explains why, even if they produce a racially discriminatory impact, they are likely not unconstitutional. Next, Part III assesses the circuit split over whether the VRA applies to felon disenfranchisement laws and the Ninth Circuit's decision that it does. Lastly, Part IV outlines the Ninth Circuit law that would govern a VRA challenge to Alaska's felon disenfranchisement laws in light of a recent similar challenge in Washington.

II. ALASKA'S FELON DISENFRANCHISEMENT LAWS

A. National Context

Disenfranchisement of criminals is neither a unique nor a recent phenomenon. The United Kingdom, Canada, and Australia all, to some degree, have voting qualifications based on criminal status.[10] The ancient Greeks and Romans disenfranchised those guilty of infamous crimes, and voting was among a range of civil

5. *See* discussion *infra* Part II.C.

6. *See* Thornburg v. Gingles, 478 U.S. 30, 43–44 (1986).

7. *See, e.g.*, Hayden v. Pataki, 449 F.3d 305 (2d Cir. 2006); Johnson v. Governor of Fla., 405 F.3d 1214 (11th Cir. 2005).

8. *Hayden*, 449 F.3d at 310; *Johnson*, 405 F.3d at 1234.

9. Farrakhan v. Washington (*Farrakhan I*), 338 F.3d 1009, 1016 (9th Cir. 2003).

10. Debra Parkes, *Ballot Boxes Behind Bars: Toward the Repeal of Prisoner Disenfranchisement Laws*, 13 TEMP. POL. & CIV. RTS. L. REV. 71, 73 (2003). Restrictions abroad, however, tend to be more mild than those found in the United States. *Id.*

rights denied in post-Renaissance Europe on the theory that criminals suffer a "civil death."[11]

Today in the United States, disenfranchisement is among many collateral consequences of felony conviction such as exclusion from certain professions and restrictions on carrying a concealed weapon.[12] In a frequently quoted opinion, Judge Henry Friendly justified the practice on a Lockean social-contract theory by arguing that criminals, in breaking societal rules, waive their rights to participate in the rule-making.[13] Other courts have expressed an interest in preserving the "purity of the ballot box" from infection by those who by their acts have proven themselves morally unfit.[14]

Nevertheless, the practice is not without critics.[15] With respect to traditional justifications for criminal sanction—rehabilitation, retribution, and deterrence—felon disenfranchisement seems to fall short given the counter-productivity of keeping criminals from participating in civil society, the disproportionate application of, in some cases, lifetime disenfranchisement to a broad range of crimes, and the limited deterrent effect of the threat of disenfranchisement.[16] Abroad, felon disenfranchisement laws have been judicially rejected on political and human-rights grounds.[17]

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11. *Id.* at 73–74; Alec C. Ewald, *"Civil Death": The Ideological Paradox of Criminal Disenfranchisement Law in the United States*, 2002 WIS. L. REV. 1045, 1059–60 (2002).

12. *See* Scott M. Bennett, Note, *Giving Ex-Felons the Right to Vote*, 6 CAL. CRIM. L. REV. 1 (2004) (outlining the most common normative arguments for and against felon disenfranchisement).

13. Green v. Bd. of Elections, 380 F.2d 445, 451–52 (2d Cir. 1967) (Friendly, J.) ("A contention that the equal protection clause requires New York to allow convicted mafiosi to vote for district attorneys or judges would not only be without merit but as obviously so as anything can be.").

14. Dunn v. Blumstein, 405 U.S. 330, 345 (1972) (quoting TENN. CONST. art. IV, § 1).

15. *See, e.g.*, Alec. C. Ewald, *An "Agenda for Demolition": The Fallacy and the Danger of the "Subversive Voting" Argument for Felony Disenfranchisement*, 36 COLUM. HUM. RTS. L. REV. 109 (2004).

16. *See* Bennett, *supra* note 12, ¶¶ 29–45.

17. The Canadian Supreme Court recently struck down a law preventing prisoners from voting. Suavé v. Canada, [2002] S.C.R. 519. The European Court of Human Rights held that a United Kingdom felon disenfranchisement law violated the human rights of convicts. Hirst v. United Kingdom (No 2), 38 Eur. Ct. H.R. 40 (2005). For a detailed analysis of the Canadian decision, see Parkes, *supra* note 10, at 79–85. For an analysis of the ECHR decision as well as an assessment of a "growing international consensus," see Robin L. Nunn, Comment, *Lock Them Up and Throw Away the Vote*, 5 CHI. J. INT'L L. 763, 778–79 (2005).

The modern practice of felon disenfranchisement in the United States is primarily a function of state law.[18] Forty-eight states and the District of Columbia have some form of felon disenfranchisement, generally consisting of constitutional provisions buttressed by statute.[19] Felon disenfranchisement expanded after the nation's founding, with most such laws enacted during the mid- to late-nineteenth century.[20] At the time the Reconstruction Amendments were enacted, twenty-nine of the thirty-six states had some form of felon disenfranchisement.[21]

Modern practice varies by state. At the extreme, at least three states impose lifetime voting bans on felons.[22] These jurisdictions go beyond the historical scope of felon disenfranchisement laws in the United States and the contemporary practice in other states and internationally.[23] The reach of these laws is striking—lifetime disenfranchisement may even be predicated upon crimes such as jaywalking, vagrancy, or breaking a water pipe.[24]

Alaska's felon disenfranchisement law is not as severe. The state constitution provides that "[n]o person may vote who has

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18. Although the United States Constitution generally grants states the authority to establish voter qualifications, *see* U.S. CONST. art. I, § 2, cl. 1, that authority is constrained, not only by other express constitutional provisions, *e.g.*, U.S. CONST. amend. XV (right to vote cannot be denied on account of race); U.S. CONST. amend. XIX (gender); U.S. CONST. amend. XXIV (poll taxes), but also by strict scrutiny under the Equal Protection Clause as interfering with the fundamental right of voting, *see* Kramer v. Union Free Sch. Dist., 395 U.S. 621 (1969); Reynolds v. Sims, 377 U.S. 533 (1964).

19. *See* FELLNER & MAUER, *supra* note 2, pt. II (surveying severity of felon disenfranchisement laws by state). For a state-by-state summary of state felon disenfranchisement laws, see SUSAN M. KUZMA, U.S DEP'T OF JUSTICE, OFFICE OF THE PARDON ATTORNEY (DOJ/OPA), CIVIL DISABILITIES OF CONVICTED FELONS: A STATE-BY-STATE SURVEY (1996), http://www.usdoj.gov/pardon/forms/state_survey.pdf (last visited Oct. 2, 2006).

20. Angela Behrens, Christopher Uggens & Jeff Manza, *Ballot Manipulation and the "Menace of Negro Domination": Racial Threat and Felon Disenfranchisement in the United States, 1850-2002*, 109 AM. J. SOC. 559, 563–67 (2003).

21. Johnson v. Governor of Fla., 405 F.3d 1214, 1218 n.5 (11th Cir. 2005).

22. *See* FELLNER & MAUER, *supra* note 2, pt. II. Restoration of civil rights, including the franchise, is possible in some states upon pardon of the offense. *See id.*

23. For example, the United Kingdom, Canada, and Australia generally restore voting rights upon the completion of sentence. *See* Parkes, *supra* note 10, at 73.

24. Richardson v. Ramirez, 418 U.S. 24, 75–76 n.24 (1964) (Marshall, J., dissenting).

been convicted of a felony involving moral turpitude unless his civil rights have been restored."[25] The provision was adopted at Alaska's constitutional convention in 1956 and became law upon Alaska's admission to the union in 1959.[26] Congress approved Alaska's constitution, including the felon disenfranchisement provision, when it granted statehood.[27] The language mirrored that of contemporary provisions in other states' constitutions.[28]

The contours of the constitutional provision are set by statute. The term "felony involving moral turpitude" is defined to include nearly all felonies.[29] Voting registration is automatically cancelled upon conviction.[30] Voting rights are restored, and felons may re-register to vote upon completion of their sentences including any terms of parole or probation.[31] Felon disenfranchisement in Alaska, which is more lenient than the lifetime ban imposed in

25. ALASKA CONST. art. V, § 2.

26. GORDON HARRISON, ALASKA'S CONSTITUTION: A CITIZEN'S GUIDE, 3 (4th ed. 2003), *available at* http://w3.legis.state.ak.us/infodocs/constitution/citizens_guide.pdf [hereinafter CITIZEN'S GUIDE].

27. *See id.* at 3–4.

28. GERALD A. MCBEATH, THE ALASKA STATE CONSTITUTION: A REFERENCE GUIDE 125 (1997). The voting qualifications in Alaska's original constitution included a literacy test. CITIZEN'S GUIDE, *supra* note 26, at 105.

29. ALASKA STAT. § 15.60.010(8)–(2006). At present, crimes meriting disenfranchisement ("felon[ies] involving moral turpitude") include:

> those crimes that are immoral or wrong in themselves such as murder, manslaughter, assault, sexual assault, sexual abuse of a minor, unlawful exploitation of a minor, robbery, extortion, coercion, kidnapping, incest, arson, burglary, theft, forgery, criminal possession of a forgery device, offering a false instrument for recording, scheme to defraud, falsifying business records, commercial bribe receiving, commercial bribery, bribery, receiving a bribe, perjury, perjury by inconsistent statements, endangering the welfare of a minor, escape, promoting contraband, interference with official proceedings, receiving a bribe by a witness or a juror, jury tampering, misconduct by a juror, tampering with physical evidence, hindering prosecution, terroristic threatening, riot, criminal possession of explosives, unlawful furnishing of explosives, promoting prostitution, criminal mischief, misconduct involving a controlled substance or an imitation controlled substance, permitting an escape, promoting gambling, possession of gambling records, distribution of child pornography, and possession of child pornography.

Id.

30. ALASKA STAT. § 15.07.135.

31. ALASKA STAT. § 15.05.030 ("Upon the unconditional discharge, the person may register under AS 15.07."). "Unconditional discharge" occurs when "a person is released from all disability arising under a conviction and sentence, including probation and parole." ALASKA STAT. § 15.60.010(38).

some states, is in line with the policies of a majority of other states.[32]

B. Felon Disenfranchisement and Race

Though facially race-neutral, felon disenfranchisement laws were, historically, enacted with a discriminatory purpose. Authors have noted that many states enacted such laws in the aftermath of the Civil War as part of a larger defensive response to the Reconstruction Amendments' extension of the franchise to African-Americans.[33] This response included poll taxes, literacy tests, and other Jim Crow measures to suppress the voting power of African-Americans.[34] For example, a 1901 felon disenfranchisement provision to Alabama's state constitution was expressly intended to single out only those felonies believed to be more frequently committed by African-Americans.[35] In 1985, the Supreme Court struck down that provision in the case of *Hunter v. Underwood*.[36]

To the extent felon disenfranchisement laws were tailored to maximize a racially disparate impact, they have enjoyed considerable success.[37] Nationally, an estimated thirteen percent of African-American men are disenfranchised, with as many as thirty-one percent of African-American men in two states—Alabama and Florida—permanently disenfranchised.[38] Following a review of voting in the United States, the National Commission on Federal Election Reform, chaired by former presidents Jimmy Carter and Gerald Ford, urged states to scale back felon disenfranchisement laws, citing that as many as one in six African-Americans were disenfranchised in many states.[39] Even where discriminatory intent

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32. *See* FELLNER & MAUER, *supra* note 2, pt. III.

33. Behrens et al., *supra* note 20, at 563 (analyzing post-Civil War responses to extending the franchise to African-Americans and drawing on social science theories of race competition and criminal justice).

34. *Id.*

35. Hunter v. Underwood, 471 U.S. 222, 228–29 (1985). The Alabama statute at issue was not discriminatory on its face, but the Court nevertheless struck it down on the basis of discriminatory intent evidenced in the legislative history. *See id.* at 227–32; Underwood v. Hunter, 730 F.2d 614, 618–20 (11th Cir. 1984).

36. Hunter v. Underwood, 471 U.S. at 232–33.

37. *See* FELLNER & MAUER, *supra* note 2, pt. II (setting out the racially disproportionate impact of felon disenfranchisement laws).

38. *Id.* pt III.

39. THE NATIONAL COMMISSION ON FEDERAL ELECTION REFORM, TO ASSURE PRIDE AND CONFIDENCE IN THE ELECTORAL PROCESS 51 (August 2001), *available at* http://millercenter.virginia.edu/programs/natl_commissions/final_report.html.

has not been proven, discriminatory effect continues to be the reality.[40]

Alaska's experience is comparable. Although comprehensive studies of racial disparity in felon disenfranchisement in Alaska are unavailable, incarceration statistics provide a useful proxy.[41] Alaska's largest minority group, Alaska Natives, comprise approximately sixteen percent of the state's general population,[42] but they account for thirty-seven percent of its prison population.[43] Similar disparity exists in the cases of other minorities, including African-Americans, who account for over ten percent of the prison population[44] while representing less than four percent of the general population.[45] It has been suggested that cultural factors may make Alaska Natives more susceptible to felon disenfranchisement.[46] The precise mechanism by which racial bias in the criminal justice system may result in disproportionate disenfranchisement, and indeed whether racial bias is the cause of the disparity, is unclear and would require further study.

C. Constitutionality of Alaska's Felon Disenfranchisement Law

Felon disenfranchisement laws come under constitutional scrutiny in two ways. First, as a restriction on voting, the laws interfere with a fundamental right and implicate the Equal

40. In Florida, the Eleventh Circuit denied an equal protection challenge to the state's felon disenfranchisement laws for lack of demonstrated racially discriminatory intent, Johnson v. Governor of Fla., 405 F.3d 1214, 1223 (11th Cir. 2005), even though nearly one in three African-American men in Florida is permanently disenfranchised, *see* FELLNER & MAUER, *supra* note 2, pt. III.

41. Incarceration rates are, at best, an imprecise proxy for felon disenfranchisement. They are over-inclusive in that they include those inmates who are ineligible to vote, as well as those incarcerated for misdemeanors, and they are under-inclusive in that they do not include parolees or Alaska felons incarcerated outside of the state who are also unable to vote.

42. U.S. Census, *supra* note 4.

43. ALASKA OFFENDER PROFILE, *supra* note 4.

44. *Id.*

45. U.S. Census, *supra* note 4.

46. *See, e.g.*, Dave Stephenson, *For Alaska Natives: Extermination by Incarceration?*, INDIAN COUNTRY TODAY, June 26, 2003, *available at* http://www.indiancountry.com/content.cfm?id=1056628610 (advancing the argument that Alaska Natives may be more likely to confess to a crime upon arrest than are white arrestees, thereby reducing the likelihood of a plea agreement for a lesser charge or sentence). If true, such factors might make felony—as opposed to misdemeanor—conviction more likely, leading to longer incarceration periods and thereby exacerbating the impact of felon disenfranchisement.

Protection Clause of the Fourteenth Amendment. Second, because the laws affect the voting rights of racial minorities, they also implicate the Fifteenth Amendment's prohibition on disenfranchisement "on account of race."[47] Supreme Court decisions addressing both theories have concluded that felon disenfranchisement laws are constitutional unless it can be proved they were enacted with racially discriminatory intent.[48]

Ordinarily, a state law affecting a fundamental right, such as voting, would be subject to strict scrutiny.[49] However, in the 1974 case of *Richardson v. Ramirez*, the Supreme Court held that felon disenfranchisement laws are not subject to heightened scrutiny under Section 1 of the Fourteenth Amendment because Section 2 of that Amendment includes an "affirmative sanction" of such laws.[50] Section 2 of the Fourteenth Amendment, which reduces a state's representation in Congress in proportion to its disenfranchisement of otherwise qualified voters, provides an exception for disenfranchisement based on "participation in rebellion, or other crime."[51] Chief Justice Rehnquist, writing for a divided court, reasoned that "those who framed and adopted the Fourteenth Amendment could not have intended to prohibit outright in § 1 of that Amendment that which was expressly exempted from the lesser sanction of reduced representation imposed by § 2 of the Amendment."[52] Put another way, the voting

47. *See* U.S. CONST. amend. XV.

48. The Court has also heard and rejected Eighth Amendment challenges to felon disenfranchisement. *See* Trop v. Dulles, 356 U.S. 86, 96–97 (1958) (felon disenfranchisement is not punitive and merely designates a grounds for voting eligibility). For an in-depth treatment of felon disenfranchisement as punishment in the context of the Eighth Amendment, see Pamela A. Wilkins, *The Mark of Cain: Disenfranchised Felons and the Constitutional No Man's Land*, 56 SYRACUSE L. REV. 85 (2005).

49. *See, e.g.*, Kramer v. Union Free Sch. Dist., 395 U.S. 621, 627–28 (1969) (applying strict scrutiny to voting restrictions); Reynolds v. Sims, 377 U.S. 533, 561–62 (1964) ("Undoubtedly, the right of suffrage is a fundamental matter. . . ."); Yick Wo v. Hopkins, 118 U.S. 356, 370 (1886) ("[T]he political franchise . . . is regarded as a fundamental political right . . . .").

50. Richardson v. Ramirez, 418 U.S. 24, 54 (1974).

51. U.S. CONST. amend. XIV, § 2. The Amendment provides in pertinent part that "when the right to vote at any election . . . is denied . . . or in any way abridged, *except for participation in rebellion, or other crime*, the basis of representation [in Congress] shall be reduced . . . ." *Id.* (emphasis added).

52. *Richardson*, 418 U.S. at 43.

rights of *felons* are not protected as "fundamental" under the Equal Protection Clause.[53]

Nevertheless, even if *Richardson* shields felon disenfranchisement laws from strict scrutiny under the Equal Protection Clause,[54] Section 1 of the Fourteenth Amendment still operates independently to prevent purposeful racial discrimination. In *Hunter v. Underwood*,[55] the Supreme Court struck down a provision in Alabama's constitution disenfranchising those convicted of certain enumerated felonies.[56] The provision was enacted in 1901 with the purpose of disenfranchising on the basis of race and applied only to felonies believed committed more frequently by African-Americans.[57] Chief Justice Rehnquist, writing for the Court as he did in *Richardson*, explained that "[w]ithout again considering the implicit authorization of [felon disenfranchisement under § 2 of the Fourteenth Amendment], we are confident that § 2 was not designed to permit the purposeful

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53. At least one circuit has framed the law in this way. *See* Owens v. Barnes, 711 F.2d 25, 27 (3d Cir. 1983).

54. *Richardson*'s reading of Section 2 of the Fourteenth Amendment has been widely criticized. *See, e.g.*, Carlos M. Portugal, *Democracy Frozen in Devonian Amber: The Racial Impact of Permanent Felon Disenfranchisement in Florida*, 57 U. MIAMI L. REV. 1317, 1325–26 (2003); John Hart Ely, *Interclausal Immunity*, 87 VA. L. REV. 1185, 1195 (2001). Dissenting, Justice Marshall argued in *Richardson* that Section 2 merely established a system of punitive reduction in representation for disenfranchisement as a compromise because wholesale enfranchisement of African-Americans would have been unpalatable and, therefore, that the scope of the language of Section 2 is limited to the operation of its punitive sanction and not to the entirety of the Fourteenth Amendment. *Richardson*, 418 U.S. at 73–74 (Marshall, J., dissenting).

For an argument that the Fifteenth Amendment effectively repealed Section 2 of the Fourteenth Amendment and, therefore, that the latter cannot shield felon disenfranchisement laws from equal protection scrutiny, see Gabriel J. Chin, *Reconstruction, Felon Disenfranchisement, and the Right to Vote: Did the Fifteenth Amendment Repeal Section 2 of the Fourteenth Amendment?*, 92 GEO. L.J. 259 (2004).

Richardson preempts the question of whether, without a Section 2 shield, felon disenfranchisement would survive strict scrutiny. For an argument that felon disenfranchisement fails strict scrutiny because it is over-inclusive and only tenuously related to the most commonly cited state interests, see Angela Behrens, Note, *Voting—Not Quite a Fundamental Right? A Look at Legal and Legislative Challenges to Felon Disenfranchisement Laws*, 98 MINN. L. REV. 231, 259–72 (2004).

55. 471 U.S. 222, 232 (1985).

56. *Id.* at 232.

57. *Id.* at 227–28; *see* discussion *supra* note 35.

racial discrimination attending the enactment and operation of [a law] which otherwise violates § 1 of the Fourteenth Amendment."[58]

Independently of the Fourteenth Amendment, the Fifteenth Amendment prohibits the denial of the right to vote "on account of race."[59] The Supreme Court has construed this prohibition to apply only to intentional discrimination.[60] In *City of Mobile v. Bolden*, the Supreme Court held that "action by a State that is racially neutral on its face violates the Fifteenth Amendment only if motivated by a discriminatory purpose."[61]

Alaska's felon disenfranchisement laws are facially neutral and would, therefore, be unconstitutional only if enacted with a discriminatory purpose. Because the laws do not appear to have been adopted with racially discriminatory intent,[62] they are subject to legal challenge, if at all, only under federal legislation.[63]

III. THE VOTING RIGHTS ACT OF 1965

A. The Voting Rights Act of 1965 and the 1982 Amendments

Though the Fifteenth Amendment was ratified in 1870, it took nearly one hundred years before Congress systematically addressed disenfranchisement of racial minorities.[64] The Voting Rights Act of 1965[65] was enacted by Congress to "banish the blight of racial discrimination in voting, which has infected the electoral process in parts of our country for nearly a century."[66] Congress was prompted to act after case-by-case litigation under previous legislation, including the Civil Rights Act of 1957, failed to

58. *Id.* at 233.

59. U.S. CONST. amend. XV.

60. City of Mobile v. Bolden, 446 U.S. 55, 62 (1980).

61. *Id.*

62. This Note assumes, for the purpose of analysis, that discriminatory intent did not drive enactment of Alaska's felon disenfranchisement laws—or, at the very least, that discriminatory purpose likely could not be proven in the context of a constitutional challenge.

63. Of course, less countermajoritarian methods of legal reform remain available to Alaskans, such as constitutional amendment and the state legislative process.

64. Portugal, *supra* note 54, at 1328.

65. 42 U.S.C. §§ 1971–1973 (2000), as amended in 1970, Pub. L. 91-285, 84 Stat. 314 (1970), and in 1982, Pub. L. 97-205, 96 Stat. 131 (1982). The VRA has been reauthorized and amended by Congress on several occasions, including in 1970, 1975, and 1982, and was reauthorized by the President in July 2006. *Bush Signs Extension of Voting Rights Act*, N.Y. TIMES, July 28, 2006, at A22.

66. South Carolina v. Katzenbach, 383 U.S. 301, 308 (1966).

adequately prevent disenfranchisement on account of race.[67] The VRA imposed bold measures, including section 5, which prohibited the use of discriminatory tests or devices, such as literacy tests, and required that any state making use of such devices would thereafter have to apply for pre-clearance from the U.S. Attorney General or a federal circuit judge in Washington, D.C. for any future changes to voting laws.[68] At the time of the VRA's enactment, Alaska employed a literacy test and was, therefore, designated a "covered jurisdiction" for these purposes.[69] Federal supervision of the voting laws of "covered jurisdictions," most of which are in the South, continues today.[70]

In 1966, the Supreme Court upheld the VRA as a valid exercise of Congress's enforcement powers under Section 2 of the Fifteenth Amendment.[71] In 1980, however, the Court narrowed the effect of the VRA in *City of Mobile v. Bolden*.[72] There, the Court held that section 2 of the VRA[73] had "an effect no different from that of the Fifteenth Amendment itself" and that a voting qualification law would only be struck down under the Act if it were proved that the law was enacted with a racially discriminatory purpose.[74] In so doing, the Court overruled the then-applicable "effects test" for voting qualifications.[75]

In 1982, Congress responded to *City of Mobile* by adding a "totality of the circumstances" test to section 2 of the VRA.[76]

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67. *Id.* at 313.

68. *See* Voting Rights Act of 1965, 89 Pub. L. 110, 79 Stat. 437 (1965).

69. *See* Laughlin McDonald, *The Voting Rights Act in Indian Country: South Dakota, A Case Study*, 29 AM. INDIAN L. REV. 43, 45–46 (2004); CITIZEN'S GUIDE, *supra* note 26, at 107.

70. Congressional representatives from southern states covered by the VRA's section 5 pre-clearance provisions sought to remove those provisions during the reauthorization of the VRA in 2006. *See* Raymond Hernandez, *After Challenges, House Approves Renewal of Voting Act*, N.Y. TIMES, July 14, 2006, at A13.

71. *Katzenbach*, 383 U.S. at 337.

72. 446 U.S. 55 (1980) (plurality opinion).

73. The original text of the section read, "No voting qualification or prerequisites to voting, or standard, practice, or procedure shall be imposed or applied by any State or political subdivision to deny or abridge the right of any citizen of the United States to vote on account of race or color." Voting Rights Act of 1965, 89 Pub. L. 11, 79 Stat. 437 (1965).

74. *City of Mobile*, 446 U.S. at 61–62.

75. *See, e.g.*, White v. Regester, 412 U.S. 755, 769 (1973) (totality of the circumstances test applied to vote dilution case brought under section 2 of the VRA).

76. Thornburg v. Gingles, 478 U.S. 30, 43 (1986). The amended section 2 provides, in pertinent part:

Under the amended VRA, "plaintiffs [can] prevail by showing that, under the totality of the circumstances, a challenged election law or procedure [has] the effect of denying a protected minority an equal chance to participate in the electoral process."[77] As the Court later explained, "[t]he essence of a § 2 claim is that a certain electoral law, practice, or structure interacts with social and historical conditions" to cause unequal voting power.[78]

B. Applicability of the VRA to Felon Disenfranchisement Laws

Since the 1982 amendments to the VRA, several plaintiffs have sought to use it to invalidate felon disenfranchisement laws on the basis of their racially disproportionate effects.[79] Circuits have split over whether the VRA does, in fact, apply to felon disenfranchisement laws. The Second Circuit in *Hayden v. Pataki* and the Tenth Circuit in *Johnson v. Governor of Florida* both held the VRA inapplicable to felon disenfranchisement laws.[80] In contrast, in *Farrakhan v. Washington*,[81] the Ninth Circuit held that "[f]elon disenfranchisement is a voting qualification, and Section 2 is clear that *any* voting qualification that denies citizens the right to vote in a discriminatory manner violates the VRA."[82] Therefore, a claim against Alaska's felon disenfranchisement laws would be

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> (a) No voting qualification or prerequisite to voting or standard, practice, or procedure shall be imposed or applied by any State or political subdivision *in a manner which results* in a denial or abridgement of the right of any citizen of the United States to vote on account of race or color . . . .
>
> (b) A violation of subsection (a) of this section is established if, based on the *totality of the circumstances*, it is shown that . . . members of [protected racial minorities] have less opportunity than other members of the electorate to participate in the political process and to elect representatives of their choice.

42 U.S.C. § 1973 (2000) (emphasis added).

77. *Gingles*, 478 U.S. at 44 n.8.

78. *Id.* at 47.

79. *Id.*; *see, e.g.*, Hayden v. Pataki, 449 F.3d 305 (2d Cir. 2006); Johnson v. Governor of Fla., 405 F.3d 1214 (11th Cir. 2005).

80. *Hayden*, 449 F.3d at 310; *see Johnson*, 405 F.3d at 1234.

81. Farrakhan v. Washington (*Farrakhan I*), 338 F.3d 1009, 1016 (9th Cir. 2003).

82. *Id.* The Sixth Circuit also considered a VRA challenge to Tennessee's felon disenfranchisement law in *Wesley v. Collins*, 791 F.2d 1255 (2d Cir. 1986). The court did not directly consider whether the VRA applies to felon disenfranchisement but appears to have assumed that it did. *See id.* at 1262 (affirming dismissal of the VRA claim on summary judgment).

"cognizable under Section 2 of the VRA" under Ninth Circuit precedent.[83]

The Second and Tenth Circuit opinions concluding that the VRA does not apply to felon disenfranchisement laws rely on three arguments: (1) that the Fourteenth Amendment authorizes felon disenfranchisement laws (the "affirmative sanction" argument); (2) that application of the VRA to felon disenfranchisement would be an unconstitutional exercise of Congress's enforcement power; and (3) that canons of statutory construction support construing the VRA not to apply to felon disenfranchisement laws. The relative merits of each argument are assessed in turn.

1. The "Affirmative Sanction" Argument. As discussed previously, the *Richardson* case established that felon disenfranchisement laws enacted without racially discriminatory intent do not violate the Equal Protection Clause.[84] This is because Section 2 of the Fourteenth Amendment's enforcement mechanism—that a state's representation in Congress will be reduced in proportion to the disenfranchisement of otherwise qualified voters—carries an express exception for disenfranchisement based on "participation in rebellion, or other crime."[85]

The Eleventh Circuit, in *Johnson*, seized on language in *Richardson* describing Section 2 of the Fourteenth Amendment as an "affirmative sanction" of felon disenfranchisement and cited it for the proposition that states have discretion to deny the vote to convicted felons.[86] The court argued that applying the VRA to Florida's felon disenfranchisement law would allow "a congressional statute to override the text of the Constitution."[87] More recently, the Second Circuit, in *Hayden*, cited Section 2 of the Fourteenth Amendment as the "starting point" in the analysis of the VRA's applicability to New York's felon disenfranchisement law.[88] The Second Circuit, while noting that felon

83. *Farrakhan I*, 338 F.3d at 1016.

84. *See* Richardson v. Ramirez, 418 U.S. 24, 54–55 (1974); *supra* notes 50–58 and accompanying text.

85. U.S. CONST. amend. XIV, § 2.

86. Johnson v. Governor of Fla., 405 F.3d 1214, 1228–29 (11th Cir. 2005) (quoting *Richardson*, 418 U.S. at 54).

87. *Id.* at 1229.

88. Hayden v. Pataki, 449 F.3d 305, 316 (2d Cir. 2006); *accord* Muntaqim v. Coombe, 366 F.3d 102, 122 (2d Cir. 2004). *Hayden* is the *en banc* rehearing of the *Muntaqim* decision, which is incorporated by reference. *Hayden*, 449 F.3d at 313–14.

disenfranchisement provisions are not entirely immune from constitutional or congressional scrutiny, found that the Fourteenth Amendment provided "explicit approval" of those types of laws.[89] Dissenting from the Ninth Circuit's denial of an *en banc* rehearing of the *Farrakhan* case, Judge Alex Kozinski argued that felon disenfranchisement laws were presumptively valid due to the Fourteenth Amendment's textual endorsement of such laws.[90]

Interestingly, neither the Second Circuit nor Judge Kozinski addressed the fact that the VRA was enacted to enforce the Fifteenth Amendment, not the Fourteenth. The Eleventh Circuit brushed off the distinction in a footnote.[91] The distinction is, however, the key weakness to the "affirmative sanction" argument because the Fifteenth Amendment grants its own protections that are not hindered by purported limitations to the scope of the Fourteenth Amendment.

Judge Barrington Daniels Parker, Jr. of the Second Circuit made this point in his dissent in *Hayden*. Pointing out that *Richardson's* "affirmative sanction" came in the context of a claim that felon disenfranchisement was a *per se* violation of the Fourteenth Amendment, Judge Parker noted that "*Richardson* did not grant felon disenfranchisement immunity against any other ground of invalidity. . . ."[92] As a textual matter, Section 2 of the Fourteenth Amendment at most "*declines to prohibit*" felon disenfranchisement and does not affirmatively immunize the practice relative to other constitutional protections.[93] As Judge Parker reasoned:

> The Constitution does not endorse felon disenfranchisement when it declines to prohibit the practice, any more than the Constitution endorses felon enslavement when the Thirteenth Amendment states: "Neither slavery nor involuntary servitude, *except as punishment for crime whereof the party shall have been duly convicted*, shall exist within the United States . . . ." Declining to prohibit something is not the same as protecting it.[94]

Nor does Section 2 of the Fourteenth Amendment *require* states to disenfranchise felons. If states can choose not to disenfranchise felons without running afoul of the Fourteenth Amendment, then Congress, acting pursuant to its power to

89. *Hayden*, 449 F.3d at 316.

90. Farrakhan v. Washington (*Farrakhan II*), 359 F.3d 1116, 1121 (9th Cir. 2004) (Kozinski, J., dissenting).

91. *Johnson*, 405 F.3d at 1228–29 n.29.

92. *Hayden*, 449 F.3d at 349 (Parker, J., dissenting).

93. *Id.* (citation omitted) (emphasis added).

94. *Id.* (citation omitted).

enforce the Fifteenth Amendment, can compel the same result. Indeed, the "affirmative sanction" argument is more of a rhetorical device than an independent constitutional limitation on the VRA.

2. Arguments on the Constitutionality of the VRA as Enforcement Legislation. Enforcement legislation under the Fourteenth and Fifteenth Amendments is valid only to the extent that it remedies or prevents actual constitutional violations.[95] The Eleventh Circuit, Chief Judge John M. Walker, Jr.'s concurrence to the Second Circuit's *Hayden* opinion, and Judge Kozinski's dissent in the Ninth Circuit have all argued that the VRA would be unconstitutional as applied to felon disenfranchisement laws.[96]

The enforcement power is limited by two independent requirements. The first is that enforcement legislation must be supported by a history of constitutional violations.[97] The second is that the measures must be narrowly tailored to the constitutional ill sought to be avoided.[98] In his *Hayden* concurrence, Chief Judge Walker found no congressional record establishing that felon disenfranchisement laws have been used to discriminate against minority voters.[99] In *Johnson*, the petitioners had argued that specific examples of violations should not be required because Congress could not envision every possible means of racial discrimination.[100] The Eleventh Circuit rejected this argument, citing the widespread use of felon disenfranchisement laws at the time that the VRA was enacted.[101] Lastly, Judge Kozinski emphasized in his dissent from the Ninth Circuit's denial of a rehearing in *Farrakhan* that "[t]he theoretical, undocumented threat of unconstitutional felon disenfranchisement laws simply doesn't justify" application of section 2 to those state laws.[102]

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95. *See* City of Boerne v. Flores, 521 U.S. 507, 519 (1997).

96. *See Hayden*, 449 F.3d at 330 (Walker, C.J., concurring); *Johnson*, 405 F.3d at 1231–32; Farrakhan v. Washington (*Farrakhan II*), 359 F.3d 1116, 1121 (9th Cir. 2004) (Kozinski, J., dissenting).

97. Bd. of Trs. of the Univ. of Ala. v. Garrett, 531 U.S. 356, 374 (2001); Kimel v. Fla. Bd. of Regents, 528 U.S. 62, 91 (2000); Oregon v. Mitchell, 400 U.S. 112, 130 (1970) (holding the amendment to VRA lowering the voting age to eighteen invalid because Congress made no findings that an age limit of twenty-one was used to discriminate on race).

98. *See City of Boerne*, 521 U.S. at 520.

99. *Hayden*, 449 F.3d at 330–31 (Walker, C.J., concurring).

100. *Johnson*, 405 F.3d at 1231 n.33.

101. *Id.*

102. Farrakhan v. Washington (*Farrakhan II*), 359 F.3d 1116, 1123 (9th Cir. 2004) (Kozinski, J., dissenting).

Lack of congressional findings of a pattern of historical discrimination through felon disenfranchisement laws[103] informs the analysis of the proportionality and congruence of the purported remedial measure at issue. Although the Supreme Court has repeatedly emphasized the importance that enforcement legislation be geographically targeted,[104] the VRA applies to all states regardless of their individual histories.[105] To the extent the VRA is either inadequately supported by findings of a pattern of discrimination or not narrowly tailored, application of the VRA to felon disenfranchisement would be unconstitutional.

The Ninth Circuit did not consider this issue in *Farrakhan* when it allowed a VRA challenge to Washington's felon disenfranchisement law to proceed.[106] On remand, the *Farrakhan* case was dismissed on summary judgment, mooting for now the question of constitutionality of the VRA as applied to felon disenfranchisement laws.[107] Indeed, the narrow issue of as-applied constitutionality of the VRA as enforcement legislation relative to felon disenfranchisement laws would not be ripe until such a law is actually invalidated. Rather, the constitutional doubt associated with application of the VRA to felon disenfranchisement serves primarily as a predicate for the statutory construction arguments discussed next.

3. Statutory Interpretation Arguments. The Ninth Circuit's interpretation of the VRA was the same as that pointedly expressed in a dissent by Judge Sonia Sotomayor of the Second Circuit: "[i]t is plain to anyone reading the Voting Rights Act that it applies to all 'voting qualification[s].'"[108] The majority in the

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103. This is not to say that there is not an actual record of state use of felon disenfranchisement laws to discriminate on race. That states used felon disenfranchisement laws in order to discriminate is well documented. *See supra* notes 33-37 and accompanying text. Rather, that history is not part of the congressional findings made at the time of the enactment of the VRA and its relevant amendments. *See Hayden*, 449 F.3d at 330–31 (Walker, C.J., concurring).

104. *Farrakhan II*, 359 F.3d at 1124 (Kozinski, J., dissenting) (noting that a purported enforcement legislation was not geographically targeted and was therefore struck down in United States v. Morrison, 529 U.S. 598 (2000)).

105. Geographic targetedness is particularly relevant to the present analysis of Alaska and is addressed in Part IV.

106. *See* Farrakhan v. Washington (*Farrakhan I*), 338 F.3d 1009, 1016 (9th Cir. 2003).

107. *See* Farrakhan v. Gregoire (*Farrakhan III*), No. CV-96-076-RHW, 2006 U.S. Dist. LEXIS 45987, at *2 (E.D. Wash. July 7, 2006).

108. *Hayden*, 449 F.3d at 367–68 (Sotomayor, J., dissenting) (second alteration in original); *Farrakhan I*, 338 F.3d at 1016.

Second Circuit, though admitting that "[t]here is no question that the language of [section 2] is extremely broad . . . and could be read to include felon disenfranchisement provisions," nevertheless stressed the importance of interpretation in light of congressional intent, cryptically citing dated authority for the proposition that "[t]he circumstances of the enactment of particular legislation may persuade a court that Congress did not intend the words of common meaning to have their literal effect."[109]

Two canons of construction have been deployed to interpret the VRA away from felon disenfranchisement provisions: the avoidance canon and the clear statement rule. The Eleventh Circuit relied upon the avoidance canon, which counsels that, in the case of an ambiguous statute, "where an otherwise acceptable construction of a statue would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress."[110]

The Second Circuit—both sitting *en banc* in *Hayden* and through the three-judge panel that decided *Muntaqim v. Coombe*, the predecessor to *Hayden*—distanced itself from the Eleventh Circuit's reliance on the avoidance canon.[111] The reason expressed in *Muntaqim* is that the clarity of the text of section 2 of the VRA is impossible to reconcile with the avoidance canon's ambiguity requirement.[112] Indeed, a concurring judge on the Eleventh Circuit conceded that the majority "overstates the case for constitutional avoidance" because "[a]s a purely textual matter, a voting

109. *Hayden*, 449 F.3d at 315 (quoting Watt v. Alaska, 451 U.S. 259, 266 (1981)).

110. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council, 485 U.S. 568, 575 (1988).

111. *See* 366 F.3d 102, 128 n.22 (2d Cir. 2004) ("[Section 2], while vague, does not seem ambiguous."), *aff'd en banc*, *Hayden*, 449 F.3d 305. The *Hayden* court barely mentioned the avoidance canon and made only passing reference to the Eleventh Circuit's reliance on it. 449 F.3d at 313, 328 n.24.

112. *See Muntaqim*, 366 F.3d at 128 n.22. The *Johnson* court, ironically, turned to the *Muntaqim* decision for the proposition that section 2 is ambiguous, citing that court's assessment that the meaning of section 2 is "exceedingly difficult to discern." Johnson v. Governor of Fla., 405 F.3d 1214, 1229 n.30 (11th Cir. 2005) (quoting *Muntaqim*, 366 F.3d at 116). In the quoted passage, however, the *Muntaqim* court referred to ambiguity in the degree of intent required to establish a violation of section 2, not the scope of the Act's coverage relative to felon disenfranchisement laws. *Johnson*, 405 F.3d at 1229 n.30; *Muntaqim*, 366 F.3d at 116–18.

qualification based on felony status . . . falls within the scope of the VRA."[113]

A stronger statutory construction argument, and the one adopted by the majority in *Hayden*, is premised on the so-called clear statement rule. The rule provides that "if Congress intends to alter the 'usual constitutional balance between the States and the Federal Government,' it must make its intention to do so 'unmistakably clear in the language of the statute.'"[114] The *Hayden* court held that the clear statement rule does not require ambiguity but only a lack of a clear statement, explaining that "we will apply the clear statement rule when a statute admits of an interpretation that would alter the federal balance but there is reason to believe . . . that Congress may not have intended such an alteration of the federal balance."[115] The rule is intended to prevent a statute from inadvertently affecting the federal-state balance of power. The Supreme Court has held, in another context, that "clear statement rules ensure Congress does not, by broad or general language, legislate on a sensitive topic inadvertently or without due deliberation."[116] Given that sweeping language alone may not satisfy the clear statement rule, the question becomes one of congressional intent.

Considerable evidence suggests that Congress did not intend the VRA to apply to felon disenfranchisement laws.[117] For example, though Congress expressly identified common forms of discriminatory voter qualifications, including literacy, educational, and moral character tests, it never mentioned felon disenfranchisement in the text of the VRA.[118] In fact, as noted by the *Hayden* court, the only reference to felon disenfranchisement in the legislative history of the VRA was to clarify that the VRA's character test provisions "would not result in the proscription of the frequent requirement of States and political subdivisions that an applicant for voting or registration for voting be free of conviction of a felony or mental disability."[119] Indeed, the *Hayden*

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113. *Johnson*, 405 F.3d at 1239–40 (Wilson, J., concurring in part).

114. Gregory v. Ashcroft, 501 U.S. 452, 460–61 (1991) (quoting Will v. Mich., 491 U.S. 58, 65 (1989) (internal citation omitted)).

115. *Hayden*, 449 F.3d at 325.

116. Spector v. Norwegian Cruise Line, Ltd., 545 U.S. 119, 139 (2005) (addressing a presumption against applying statutes to the internal affairs of foreign vessels).

117. *See, e.g.*, *Hayden*, 449 F.3d at 315.

118. *See* 42 U.S.C. § 1973b(c) (2000).

119. *Hayden*, 449 F.3d at 318 (quoting S. Rep. No. 89-162, at 24 (1965), *reprinted in* 1965 U.S.C.C.A.N. 2508, 2562); *see also* H.R. Rep. No. 89-439, at 19

court reasoned that, given the prevalence of felon disenfranchisement statutes, "it seems unfathomable that Congress would silently amend the Voting Rights Act in a way that would affect them."[120]

Whether application of the VRA to felon disenfranchisement laws would upset the federal-state balance is in dispute. In *Muntaqim*, the Second Circuit held that the federal-state balance would be upset because applying the VRA to felon disenfranchisement laws would exceed Congress's enforcement power and contradict Section 2 of the Fourteenth Amendment.[121] The Eleventh Circuit in *Johnson* concurred generally with that conclusion but did not rely on it.[122] On a rehearing of *Muntaqim* in *Hayden*, the Second Circuit hewed its analysis more directly to "three important state interests" that would be affected by applying the VRA to New York's felon disenfranchisement law: "(1) the regulation of the franchise; (2) the State's authority to craft its criminal law; and (3) the regulation of correctional institutions."[123]

Rejecting the federalism concerns similarly raised by the Tenth Circuit in *Johnson*, Judge Rosemary Barkett in dissent reasoned that federalism is not implicated by the VRA because the "Fourteenth and Fifteenth Amendments altered the constitutional balance between the two sovereigns—*not* the Voting Rights Act, which merely enforces the guarantees of those amendments."[124] This argument was repeated in Judge Parker's *Hayden* dissent.[125]

(1965), *reprinted in* 1965 U.S.C.C.A.N. 2437, 2457. Nor did the 1982 amendments expand the scope of the VRA. Chisom v. Roemer, 501 U.S. 380, 383–84 (1991) ("[T]he coverage provided by the 1982 amendment is coextensive with the coverage provided by the Act prior to 1982."). The 1982 amendments merely lowered the evidentiary burden to establish a violation by replacing an "intent" test with an "effects" test. *Id.* at 403–04.

120. *Hayden*, 449 F.3d at 317 (quoting Johnson v. Governor of Fla., 405 F.3d 1214, 1234 (11th Cir. 2005)).

121. *See* Muntaqim v. Coombe, 366 F.3d 102, 126 (2d Cir. 2004). Both arguments against applying the VRA to felon disenfranchisement discussed serve as predicates for application of the clear statement rule because they implicate federalism.

122. The court makes passing reference to the clear statement rule in a footnote. *See Johnson*, 405 F.3d at 1232 n.35.

123. *Hayden*, 449 F.3d at 326.

124. *Johnson*, 405 F.3d at 1250 (Barkett, J., dissenting) (citing a dissent from an equally divided court in the Second Circuit's first consideration of the question in *Baker v. Pataki*, 85 F.3d 919, 938 (2d Cir. 1996) (Feinberg, J., dissenting)).

125. *Hayden*, 449 F.3d at 358.

Whatever the uncertainties of the basis for these divergent circuit decisions, Ninth Circuit law is, for now, clear that a challenge to Alaska's felon disenfranchisement law is possible under section 2 of the VRA.

IV. ALASKA'S FELON DISENFRANCHISEMENT LAW AND THE VOTING RIGHTS ACT OF 1965

A. Ninth Circuit's Framework for Challenges Under Section 2 of the VRA

Nearly a decade before *Farrakhan*, the Ninth Circuit set a framework for challenges under section 2 of the VRA in *Smith v. Salt River*.[126] *Salt River* involved an Arizona agricultural district power board election rule that limited voting to landowners within the district.[127] African-American plaintiffs claimed that the voting qualification combined with racial disparities in land ownership rates had a racially disproportionate effect on voting rights in violation of section 2 of the VRA.[128]

The *Salt River* court affirmed that section 2 of the VRA "prohibits voting qualifications which *result in* discrimination on account of race or color . . . [and] requires proof only of a discriminatory result, not of discriminatory intent."[129] Further, the intent is judged under the "totality of the circumstances" test with reference to several non-exclusive, so-called Senate Factors identified in the legislative history of the VRA.[130]

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126. Smith v. Salt River Project Agric. Improvement & Power Dist., 109 F.3d 586 (9th Cir. 1997).

127. *Id.* at 589.

128. *Id.* at 588.

129. *Id.* at 594 (citing Chisom v. Roemer, 501 U.S. 380, 394 (1991)).

130. *Id.* at 594 n.6. The Senate Factors are:

> (1) the extent of any history of official discrimination in the state or political subdivision that touched the right of the members of the minority group to register, to vote, or otherwise to participate in the democratic process[;]
> (2) the extent to which voting in the elections of the state or political subdivision is racially polarized;
> (3) the extent to which the state or political subdivision has used unusually large election districts, majority vote requirements, anti-single shot provisions, or other voting practices or procedures that may enhance the opportunity for discrimination against the minority group;
> (4) if there is a candidate slating process, whether the members of the minority group have been denied access to that process;
> (5) the extent to which members of the minority group in the state or political subdivision bear the effects of discrimination in such areas as

Significantly, in interpreting the "totality of the circumstances" test under the VRA, the *Salt River* court held that "a bare statistical showing of disproportionate *impact* on a racial minority does not satisfy the § 2 'results' inquiry. Instead, 'section 2 plaintiffs must show a causal connection between the challenged voting practice and [a] prohibited discriminatory result.'"[131]

As the Ninth Circuit explained, "[t]he real question this case presents is whether the land ownership requirement denies African-Americans the right and opportunity to vote . . . ."[132] Affirming the district court's dismissal for lack of a "causal connection," the Ninth Circuit, relying heavily on a stipulated lack of historical racial discrimination, concluded that "the statistical disparity in African-American and white home ownership does not prove the District has violated § 2."[133]

B. Applying the VRA in *Farrakhan*

In late 2000, the Eastern District of Washington dismissed for the first time a claim by Muhammad Shabazz Farrakhan and others that Washington's felon disenfranchisement law violated section 2 of the VRA.[134] The court held that "although the disenfranchisement provision clearly has a disproportionate impact on racial minorities, there is no evidence that the provision's enactment was motivated by racial animus, or that its operation *by*

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education, employment and health, which hinder their ability to participate effectively in the political process;

(6) whether political campaigns have been characterized by overt or subtle racial appeals;

(7) the extent to which members of the minority group have been elected to public office in the jurisdiction;

Additional factors . . . are:

whether there is a significant lack of responsiveness on the part of elected officials to the particularized need of the members of the minority group; [and] whether the policy underlying the state or political subdivision's use of such voting qualification, prerequisite to voting, or standard, practice, or procedure is tenuous.

Id. (citing S. Rep. No. 97-417, at 28–29 (1982), *reprinted in* 1982 U.S.C.C.A.N. 177, 206–07).

131. *Id.* at 595 (alteration in original) (quoting Ortiz v. City of Philadelphia Office of the City Comm'rs Voter Registration Div., 28 F.3d 306, 312 (9th Cir. 1997)).

132. *Id.* at 596.

133. *Id.*

134. Farrakhan v. Locke, No. CS-96-76-RHW, 2000 U.S. Dist. LEXIS 22212, at *18 (E.D. Wash. Dec. 1, 2000), *rev'd in part sub nom.*, Farrakhan v. Washington (*Farrakhan I*), 338 F.3d 1009 (9th Cir. 2003).

itself has a discriminatory effect."[135] The court referenced the Senate Factors but declined to apply them directly.[136] Instead, the court reasoned that, factoring out racial discrimination in the criminal justice system, it was impossible to show a discriminatory effect from the disenfranchisement provision.[137]

The Ninth Circuit rejected the district court's reasoning and held that section 2 of the VRA required more than an isolated inquiry into the challenged voting qualification without reference to external factors.[138] Instead, the court emphasized that section 2's "totality of the circumstances" test "requires courts to consider how a challenged voting practice *interacts with* external factors such as 'social and historical conditions' to result in denial of the right to vote on account of race or color."[139] Holding that an inquiry into a "causal connection" between racial discrimination and denial of voting rights involves reference to the relevant Senate Factors, the court specifically noted that "racial bias in the criminal justice system" is relevant and encompassed in the factors.[140]

Having rejected the "by itself" causation standard applied by the district court, the Ninth Circuit remanded the case for an evaluation of the external factors that may establish a causal relationship between discrimination in the criminal justice system and the voting mechanism based on felony status.[141] The court explained that "a causal connection may be shown where the discriminatory impact of a challenged voting practice is attributable to racial discrimination in the surrounding social and historical circumstances."[142] The court illustrated the test with reference to the *Salt River* case.[143] There, the challenge failed because the external factor—a difference in land ownership rates—was not "*substantially explained by race.*"[144]

Captioned *Farrakhan v. Gregoire* on remand, the case was heard a second time by Judge Robert Whaley of the Eastern

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135. *Locke*, 2000 U.S. Dist. LEXIS 22212, at *9–*10.
136. *Id.* at *9 n.4.
137. *Id.* at *10.
138. *Farrakhan I*, 338 F.3d at 1011–12.
139. *Id.* (quoting Thornburg v. Gingles, 478 U.S. 30, 47 (1986)).
140. *Id.* at 1020.
141. *Id.* at 1019–20 ("[C]ourts must be able to consider whether voting practices 'accommodate or amplify the effect that . . . discrimination has on the voting process.'" (alteration in original) (quoting Smith v. Salt River Project Agric. Improvement and Power Dist., 109 F.3d 595 n.7 (9th Cir. 1997))).
142. *Id.* at 1019.
143. *Id.* (citing *Salt River*, 109 F.3d at 595).
144. *Id.* at 1017 (quoting *Salt River*, 109 F.3d at 591).

District of Washington.[145] Reviewing statistical evidence of racial discrimination in Washington's criminal justice system, Judge Whaley wrote that "the Court is compelled to find that there is discrimination in Washington's criminal justice system on account of race . . . [and] this discrimination 'clearly hinder[s] the ability of racial minorities to participate effectively in the political process . . . .'"[146]

In spite of this finding, the court in *Farrakhan III* took the "totality of the circumstances" test as an opportunity to balance away intentional discrimination in the criminal justice system with reference to historical and social factors indicating a lack of discriminatory intent in Washington. Addressing the Senate Factors, the court cited a range of historical and social conditions such as: Washington's support for racial minorities; a lack of discriminatory intent in the enactment of the felon disenfranchisement law; the long tradition of felon disenfranchisement in the United States; and even the implicit endorsement of felon disenfranchisement in Section 2 of the Fourteenth Amendment.[147] Weighing the factors, the court concluded that "the totality of the circumstances does not support a finding that Washington's felon disenfranchisement law results in discrimination in its electoral process on account of race."[148]

C. Alaska's Felon Disenfranchisement Law in Light of *Farrakhan III*

The court in *Farrakhan III* found that Washington's felon disenfranchisement law did not violate section 2 of the VRA in spite of "compelling" evidence of racial discrimination in the criminal justice system.[149] Despite the Ninth Circuit's holding that a violation depends on the interaction between a voting mechanism and external factors, the court in *Farrakhan III* weighed "Washington's history, or lack thereof, of racial bias in its electoral process" to find that the totality of the circumstances test does not support a finding that Washington's felon disenfranchisement law violates the VRA.[150]

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145. Farrakhan v. Gregoire (*Farrakhan III*), No. CV-96-076-RHW, 2006 U.S. Dist. LEXIS 45987 (E.D. Wash. July 7, 2006).

146. *Id.* at *18 (quoting *Farrakhan I*, 338 F.3d at 1020) (evaluating evidence under the summary judgment standard).

147. *Id.* at *23–*28.

148. *Id.* at *29.

149. *Id.* at *28.

150. *Id.* at *28–*29.

Significantly, the court in *Farrakhan III* allowed historical evidence to stand in for an analysis of the required causal connection between discrimination and racially disproportionate effects of a voting qualification. In *Salt River*, the disproportionate land ownership rates were not the result of discrimination—they were simply a statistical anomaly.[151] In *Farrakhan III*, disproportionate felony conviction was more than a statistical anomaly—it was evidence of racial discrimination.[152] Nevertheless, this causal nexus was deemed outweighed by other Senate Factors. Indeed, applying a balancing test to the Senate Factors may provide a back door for other arguments, such as the "affirmative sanction argument," which the Ninth Circuit has rejected.[153]

In Alaska, the statistics demonstrate that felon disenfranchisement has a racially disproportionate impact.[154] Compared with Washington, however, Alaska may not be able to rely so heavily on evidence of a historical lack of racial bias to defeat a challenge to its felon disenfranchisement law. One factor sure to be considered by any court hearing a VRA challenge to Alaska's felon disenfranchisement law will be that Alaska was designated a "covered jurisdiction" because of its use of a literacy test at the time of the VRA's enactment.[155] Although Alaska was able to demonstrate in 1966 that it had not made racially discriminatory use of that test for the preceding five years,[156] the stigma of having been singled out under section 5 of the VRA weighs in favor, perhaps, of additional scrutiny under section 2. Nevertheless, the outcome of a challenge to Alaska's felon disenfranchisement law is certain to be, as it was in *Salt River* and *Farrakhan III*, a fact-specific inquiry shaded by the trial court's view of the proper application of the totality of the circumstances test.

V. CONCLUSION

Felon disenfranchisement in Alaska will continue to be cause for concern as long as it works a racially disproportionate effect. Though recent decisions in the Tenth and Second Circuits have

151. Smith v. Salt River Project Agric. Improvement & Power Dist., 109 F.3d 586, 596 (9th Cir. 1997).

152. *Farrakhan III*, 2006 U.S. Dist. LEXIS 45987 at *28.

153. *See* Wesley v. Collins, 791 F.2d 1255, 1261 (6th Cir. 1986) (considering the Fourteenth Amendment as a factor in the totality of the circumstances test).

154. *See* discussion *supra* Part II.B.

155. *See supra* note 68 and accompanying text.

156. CITIZEN'S GUIDE, *supra* note 26, at 107 (noting that literacy tests in Alaska "lingered under a cloud of suspicion").

rejected claims against state felon disenfranchisement laws brought under section 2 of the Voting Rights Act of 1965, the Ninth Circuit has expressly held that such challenges can proceed. One such claim, in the State of Washington, was ultimately unsuccessful. Nevertheless, a case brought in Alaska, on different facts and before a different court, may well invalidate the state's practice of disenfranchising felons on the basis of its racially disproportionate impact.

Alaska Department of Corrections

Division of Administrative Services

2008 Offender Profile

www.correct.state.ak.us/corrections/admin

Vision Statement

The Alaska Department of Corrections enhances the safety of our communities. We provide secure confinement, reformative programs, and a process of supervised community reintegration.

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Commissioner's Letter

The Mission of the Department of Corrections is to enhance the safety of our communities while providing secure confinement, reformative programs, and a process of supervised community reintegration.

I am pleased to make this profile available on line. This report is based on our best information and serves as a snapshot of a typical day. Data comes from our Offender Tracking Information System (OTIS), and is meant to give a general summary of Alaska's offender population.

The 2008 Offender Profile – which encompasses many hours of research and calculation on the part of department staff – serves as a valuable tool for our department in the successful accomplishment of our mission.

Joe Schmidt
Commissioner

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Questions regarding data in this report may be e-mailed to: Bonnie.Walters@alaska.gov

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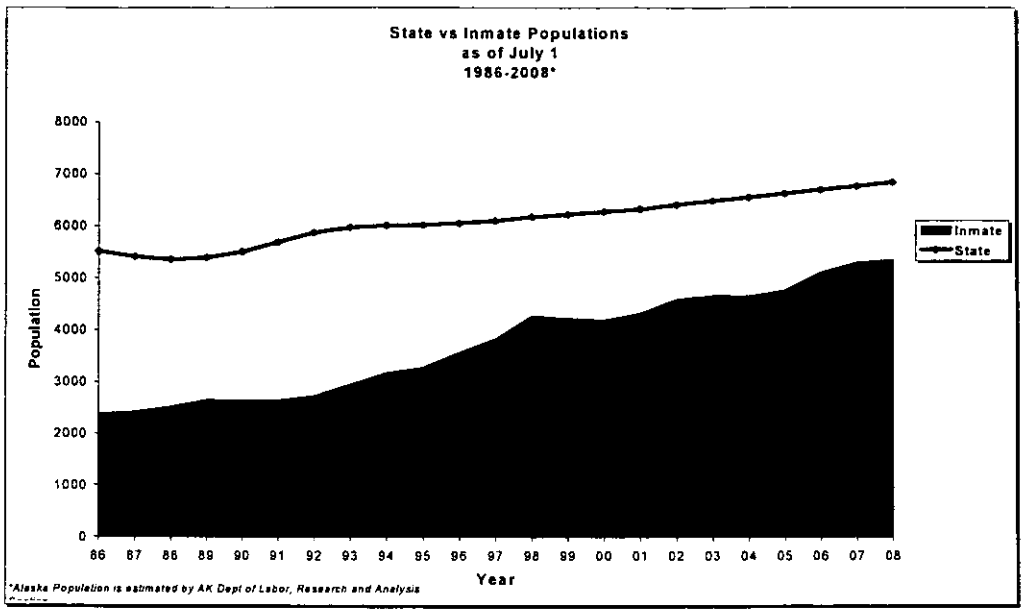
Trends

Notes:
Count and admissions data include information about all offenders under the jurisdiction of the state of Alaska who are entered into the OTIS database.
Count information consists of monthly averages of daily counts; incarcerated offenders not entered into the OTIS database when a count was tallied were not included.
Admissions data includes all criminal admits (except transfers) for all offenders.

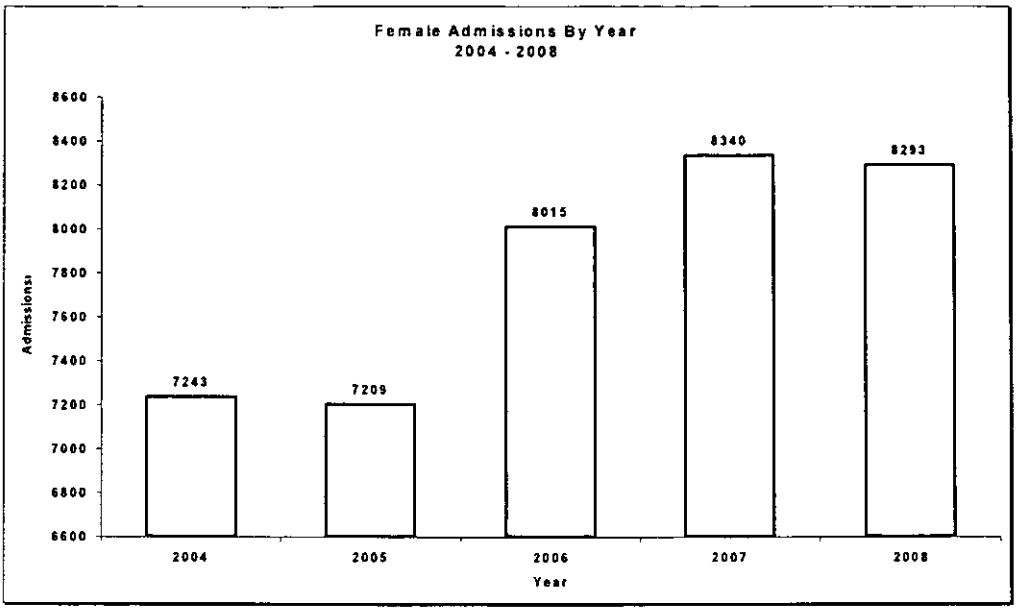


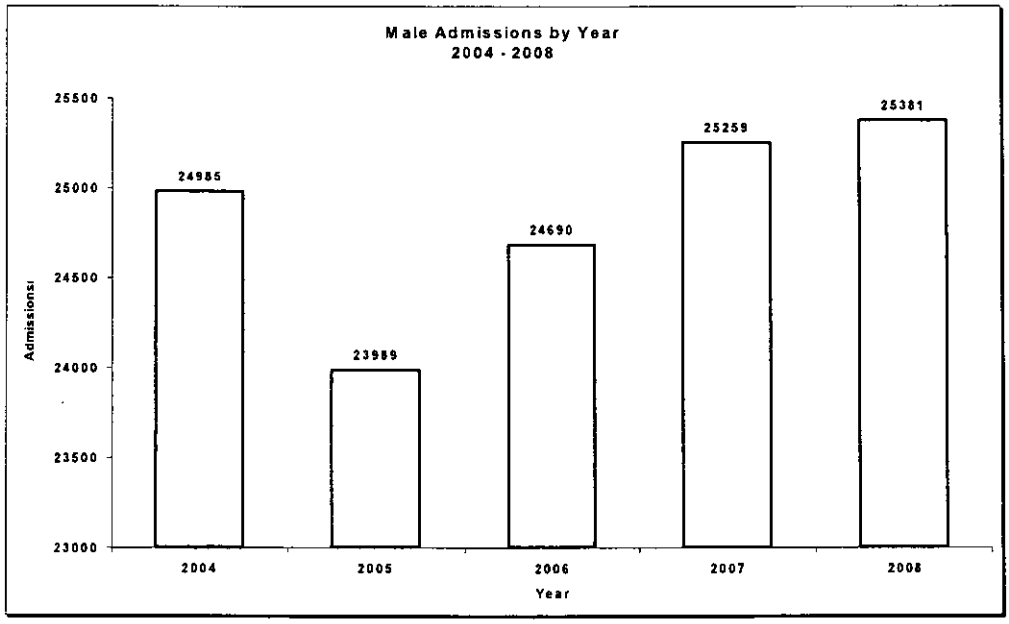
Total Offender Population Based on Monthly Averages - January 2006 to December 2008
Includes all Offenders in all Facilities (CCs and CRCs)

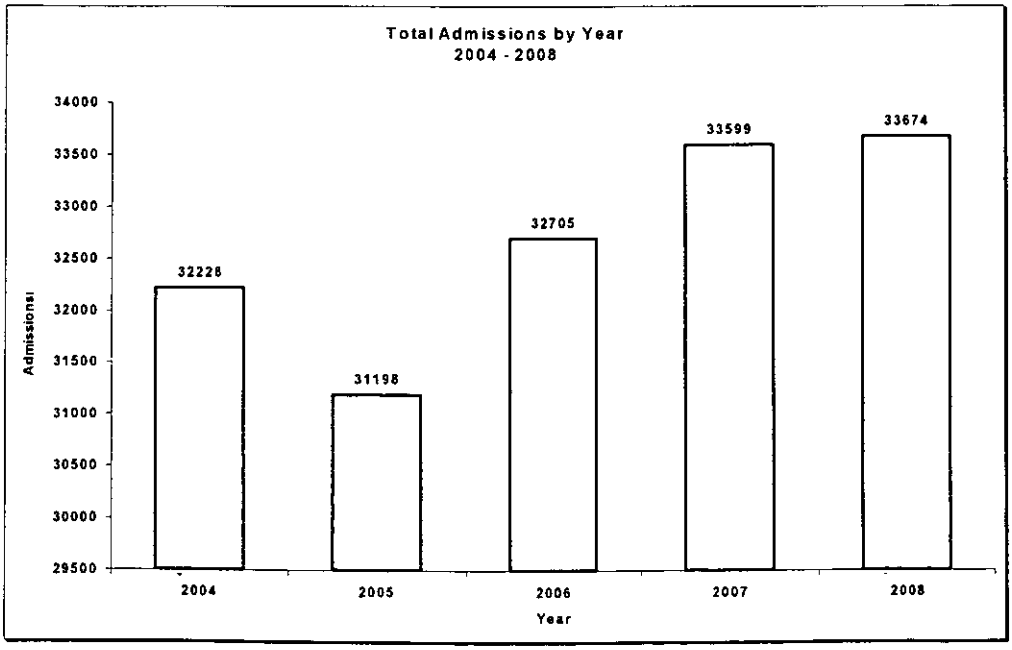
YEAR	2006			2007			2008		
Month	Female	Male	Total	Female	Male	Total	Female	Male	Total
January	493	4507	5000	526	4682	5208	619	4802	5421
February	512	4489	5001	556	4670	5226	607	4798	5405
March	486	4538	5024	550	4657	5207	610	4791	5401
April	484	4589	5073	579	4721	5300	619	4790	5409
May	523	4594	5117	610	4822	5432	622	4777	5399
June	530	4543	5073	607	4679	5286	617	4715	5332
July	512	4596	5108	603	4678	5281	585	4716	5301
August	545	4584	5129	624	4703	5327	589	4734	5323
September	554	4597	5151	646	4754	5400	588	4754	5342
October	520	4689	5209	640	4742	5382	591	4729	5320
November	528	4618	5146	639	4835	5474	564	4718	5282
December	510	4559	5069	638	4759	5397	522	4674	5196
Daily Avg	**516**	**4575**	**5092**	**602**	**4725**	**5327**	**594**	**4750**	**5344**

Total Admissions - January 2006 to December 2008
Includes all Offenders in all Facilities (CCs and CRCs)

YEAR	2006			2007			2008		
Month	Female	Male	Total	Female	Male	Total	Female	Male	Total
January	630	2007	2639	681	2007	2688	704	2031	2735
February	608	1867	2475	611	1910	2521	617	1942	2559
March	635	2135	2770	672	2062	2734	731	2179	2910
April	638	2126	2764	710	2137	2847	671	2078	2749
May	737	2141	2878	729	2246	2975	738	2287	3025
June	654	2078	2732	729	2187	2916	741	2177	2918
July	744	2227	2971	735	2096	2831	673	2090	2763
August	771	2114	2885	713	2324	3037	746	2212	2958
September	695	2009	2704	651	2099	2750	671	2105	2776
October	669	2109	2778	720	2085	2805	749	2183	2932
November	586	1857	2443	717	2103	2820	628	2048	2676
December	648	2018	2666	672	2003	2675	624	2049	2673
Total	**8015**	**24690**	**32705**	**8340**	**25259**	**33599**	**8293**	**25381**	**33674**


Female Admissions By Year
2004 - 2008
Admissions
8600
8400
8200
8000
7800
7600
7400
7200
7000
6800
6600
7243
7209
8015
8340
8293
2004
2005
2006
2007
2008
Year


Male Admissions by Year
2004 - 2008
Admissions
25500
25000
24500
24000
23500
23000
24985
23989
24690
25259
25381
2004
2005
2006
2007
2008
Year


Total Admissions by Year
2004 - 2008
Admissions
34000
33500
33000
32500
32000
31500
31000
30500
30000
29500
32228
31198
32705
33599
33674
2004
2005
2006
2007
2008
Year

Institutions

Institution Address List

Institution	Address	City	Zip	Superintendent	Phone
Anchorage Correctional Complex	1400 E 4th Avenue	Anchorage	99501	Debbie Miller	907-269-4100
Anvil Mtn Correctional Center	PO Box 730	Nome	99762	Marc Okuley	907-443-2241
Fairbanks Correctional Center	1931 Eagan Avenue	Fairbanks	99701	Charles Stevenson	907-458-6700
Hiland Mtn Correctional Center	9101 Hesterberg Road	Eagle River	99577	Dean Marshall	907-694-9511
Ketchikan Correctional Center	1201 Schoenbar Road	Ketchikan	99901	Alan Bailey	907-228-7350
Lemon Creek Correctional Center	2000 Lemon Ck. Road	Juneau	99801	Scott Wellard	907-465-6200
Matsu Pretrial Facility	339 E Dogwood Road	Palmer	99645	Steve Brunger	907-745-0943
Palmer Correctional Center	PO Box 919	Palmer	99645	Cindy Betts	907-745-5054
Pt. MacKenzie Correctional Farm	PO Box 877730	Wasilla	99687	Amy Rabeau	907-376-2976
Spring Creek Correctional Center	PO Box 2109	Seward	99664	Craig Turnbull	907-224-8200
Wildwood Correctional Complex	10 Chugach Avenue	Kenai	99611	Robert Hibpshman	907-260-7200
Yukon-Kuskowim Correctional Ctr	Box 400	Bethel	99559	Chris Liu	907-543-5245
Red Rock Correctional Center	1750 E Arica Road	Eloy, AZ	85231	Bruno Stoll	520-464-3899

Notes:
Includes information about all offenders incarcerated in in-state and out-of-state institutions who are entered into the OTIS database.
Consists of a snapshot of offenders incarcerated and entered into the OTIS database on or before December 31, 2008.
Alaska Native race category includes a small number of Native Americans not indigenous to Alaska.
Information about offenses is the most serious charge only.
Offense classes are semi-arbitrary.

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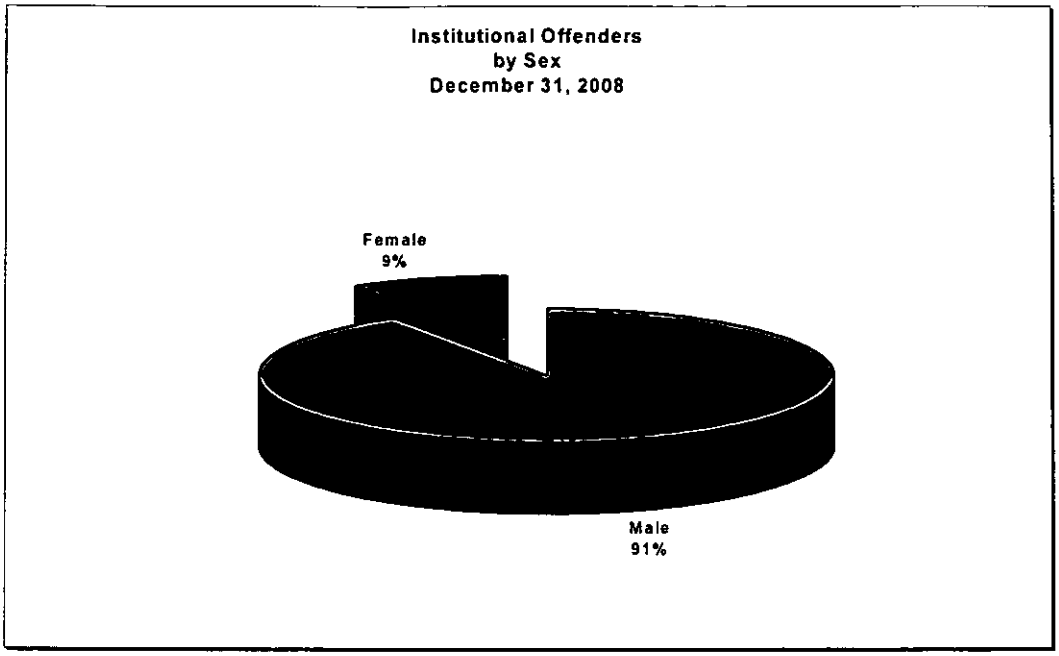


Number of Offenders in Institutions
December 31, 2004 - 2008

	Females					Males					All Offenders				
Institutions	**2008**	**2007**	**2006**	**2005**	**2004**	**2008**	**2007**	**2006**	**2005**	**2004**	**2008**	**2007**	**2006**	**2005**	**2004**
In-State															
Anchorage CCE	6	1	1	34	18	390	456	473	421	361	396	457	474	455	379
Anchorage CCW	-	-	-	-	-	442	484	486	420	397	442	484	486	420	397
Anvil Mountain CC	3	12	10	8	10	80	101	97	116	91	83	113	107	124	101
Fairbanks CC	22	28	28	35	20	212	250	231	229	187	234	278	259	264	207
Hiland Mountain CC	321	362	311	240	204	-	-	-	73	70	321	362	311	313	274
Ketchikan CC	3	7	8	4	4	40	47	44	59	60	43	54	52	63	64
Lemon Creek CC	7	13	8	16	20	175	182	183	183	152	182	195	191	199	172
Mat-Su Pretrial	7	13	7	15	6	79	107	86	97	80	86	120	93	112	86
Palmer Medium CC	-	-	-	-	-	261	254	231	245	209	261	254	231	245	209
Palmer Minimum CC	-	-	-	-	-	176	176	133	175	172	176	176	133	175	172
Point Mackenzie CF	-	-	-	-	-	117	112	100	85	97	117	112	100	85	97
Spring Creek CC	-	-	-	-	-	551	537	465	495	491	551	537	465	495	491
Wildwood CC	-	-	-	-	-	258	254	227	254	230	258	254	227	254	230
Wildwood Pretrial	16	22	21	24	16	102	103	106	103	97	118	125	127	127	113
Yukon-Kuskokwim CC	2	7	5	4	5	107	105	98	112	112	109	112	103	116	117
Total	*387*	*465*	*399*	*380*	*303*	*2990*	*3168*	*2960*	*3067*	*2806*	*3377*	*3633*	*3359*	*3447*	*3109*
Out-of-State															
Arizona Detention Ctr	-	-	-	-	-	-	-	-	765	755	-	-	-	765	755
Red Rock CC, AZ	-	-	-	-	-	879	853	993	-	-	879	853	993	-	-
Colorado State Prison	1	1	1	1	-	2	2	2	1	2	3	3	3	2	2
Federal Bureau of Prisons	1	1	1	1	3	12	9	10	13	20	13	10	11	14	23
Minnesota State Prison	1	1	1	1	-	-	-	-	-	-	1	1	1	1	0
Oregon State Prison	-	-	-	-	-	1	-	-	-	-	1	0	0	0	0
Washington State Prison	-	-	-	-	-	-	2	2	2	-	0	2	2	2	0
Total	*3*	*3*	*3*	*3*	*3*	*894*	*866*	*1007*	*779*	*777*	*897*	*869*	*1010*	*784*	*780*
Total All	**390**	**468**	**402**	**383**	**306**	**3884**	**4034**	**3967**	**3846**	**3583**	**4274**	**4502**	**4369**	**4231**	**3889**

Demographic Information for Offenders in Institutions
December 31, 2004-2008

	Females					Males					All Offenders				
Ethnicity	**2008**	**2007**	**2006**	**2005**	**2004**	**2008**	**2007**	**2006**	**2005**	**2004**	**2008**	**2007**	**2006**	**2005**	**2004**
Asian/Pacific Islan	11	7	9	8	6	117	113	104	91	81	128	120	113	99	87
Black	30	42	26	27	22	416	443	420	415	405	446	485	446	442	427
Hispanic	9	11	6	9	8	102	94	93	89	111	111	105	99	98	119
Alaska Native*	124	159	136	132	112	1404	1381	1413	1378	1319	1528	1540	1549	1510	1431
Caucasian	213	246	223	205	156	1832	1989	1922	1867	1656	2045	2235	2145	2072	1812
Unknown	3	3	2	2	2	13	14	15	8	11	16	17	17	10	13
Total	**390**	**468**	**402**	**383**	**306**	**3884**	**4034**	**3967**	**3848**	**3583**	**4274**	**4502**	**4369**	**4231**	**3889**

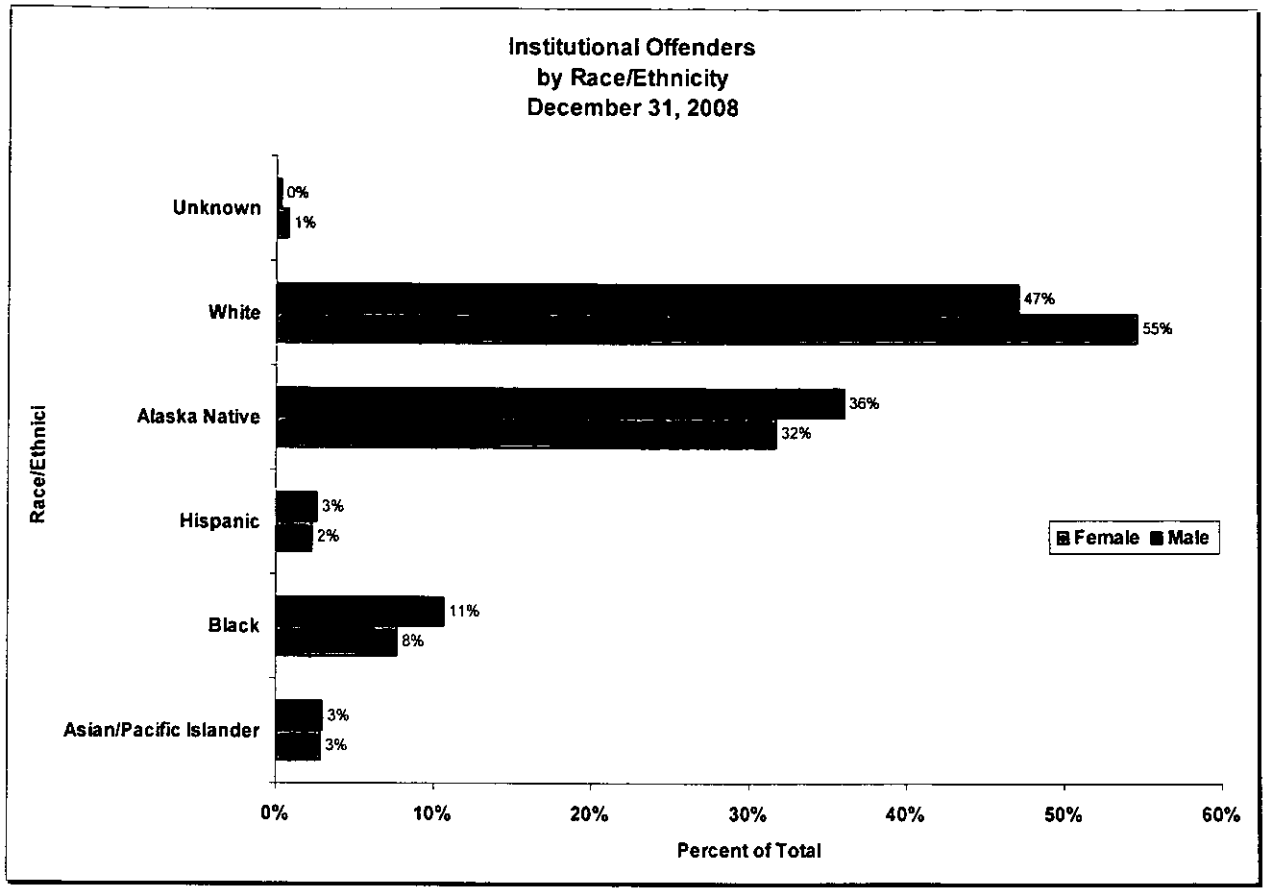
	Females					Males					All Offenders				
Age Group (Years	**2008**	**2007**	**2006**	**2005**	**2004**	**2008**	**2007**	**2006**	**2005**	**2004**	**2008**	**2007**	**2006**	**2005**	**2004**
19 and Under	10	15	13	12	14	109	114	98	105	116	119	129	111	117	130
20-24	67	74	62	53	47	613	637	672	672	632	680	711	734	725	679
25-29	78	65	65	57	48	754	724	660	574	522	832	789	725	631	570
30-34	58	67	62	61	47	475	495	510	503	494	533	562	572	564	541
35-39	52	74	50	48	51	481	514	513	533	505	533	588	563	581	556
40-44	47	74	58	77	51	460	552	567	566	501	507	626	625	643	552
45-49	48	54	64	46	33	423	470	454	439	392	471	524	518	485	425
50-54	15	26	17	17	7	278	262	245	229	209	293	288	262	246	216
55-59	9	13	5	8	4	155	142	136	133	111	164	155	141	141	115
60-64	4	3	3	1	1	72	74	60	61	63	76	77	63	62	64
65 and over	2	3	3	3	3	64	50	52	33	38	66	53	55	36	41
Total	**390**	**468**	**402**	**383**	**306**	**3884**	**4034**	**3967**	**3848**	**3583**	**4274**	**4502**	**4369**	**4231**	**3889**
Mean Age	***35.02***					***36.55***					***36.41***				
Median Age	***33.64***					***34.91***					***34.71***				

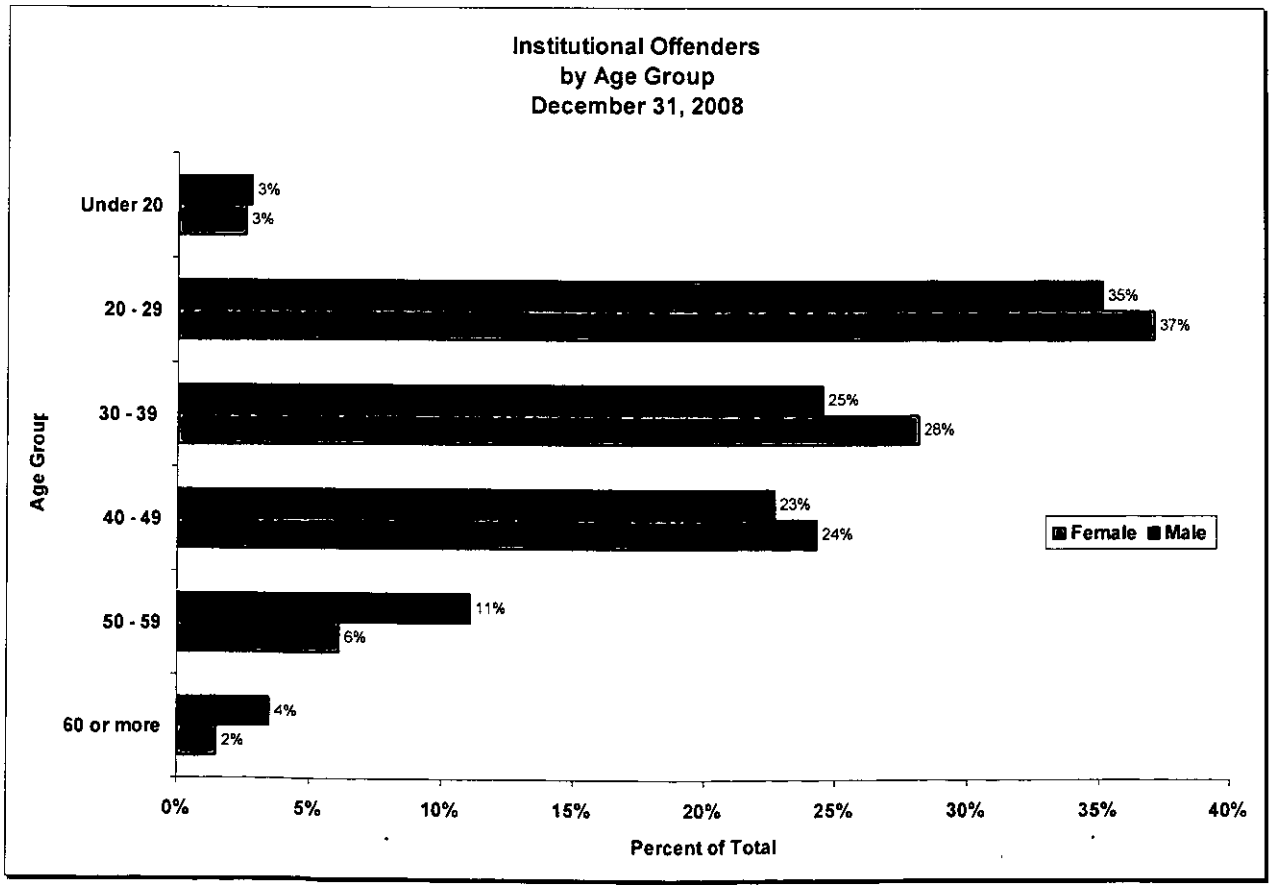
*includes a small number of Native Americans not indigenous to Alaska

Length of Time from Admissions for Offenders in Institutions
December 31, 2008

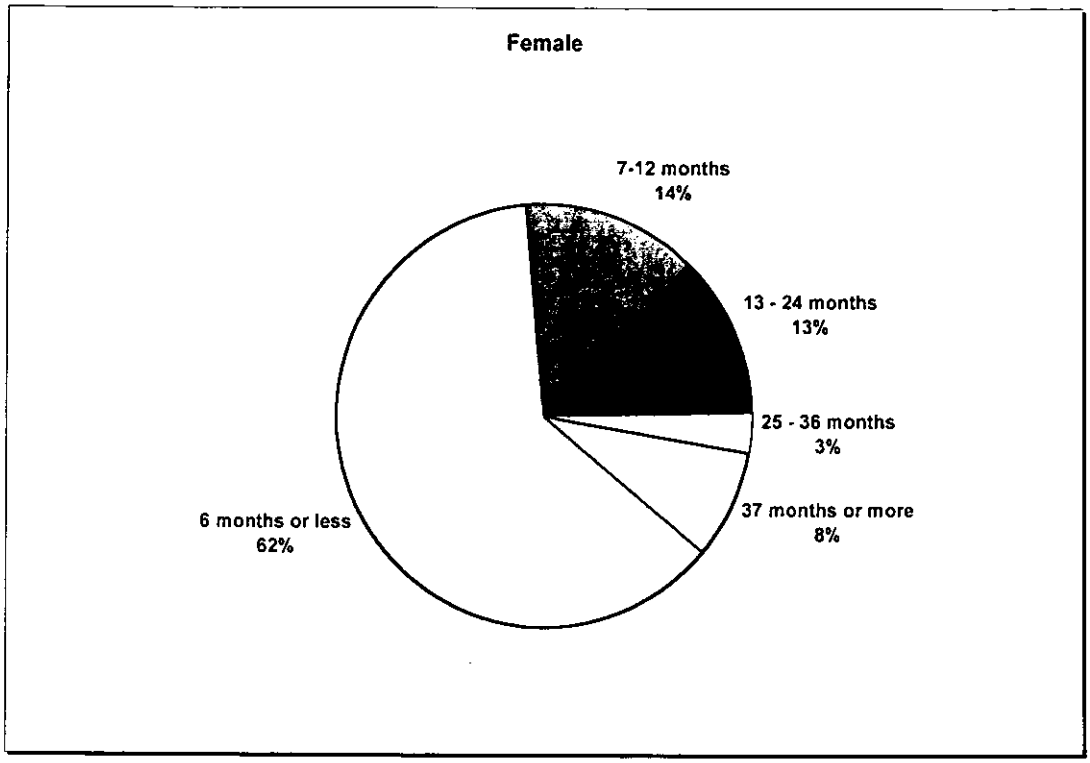
Months In	**Females**	**Males**	**Total**
6months or less	244	1767	2011
7 months - 12 months	53	524	577
13 months - 24 mon	49	539	588
25 months 36 months	11	269	280
37 months or more	33	785	818
Total	**390**	**3884**	**4274**
Mean Length (months)	***13.07***	***25.57***	***24.43***
Median Length (months)	***3.00***	***8.00***	***8.00***

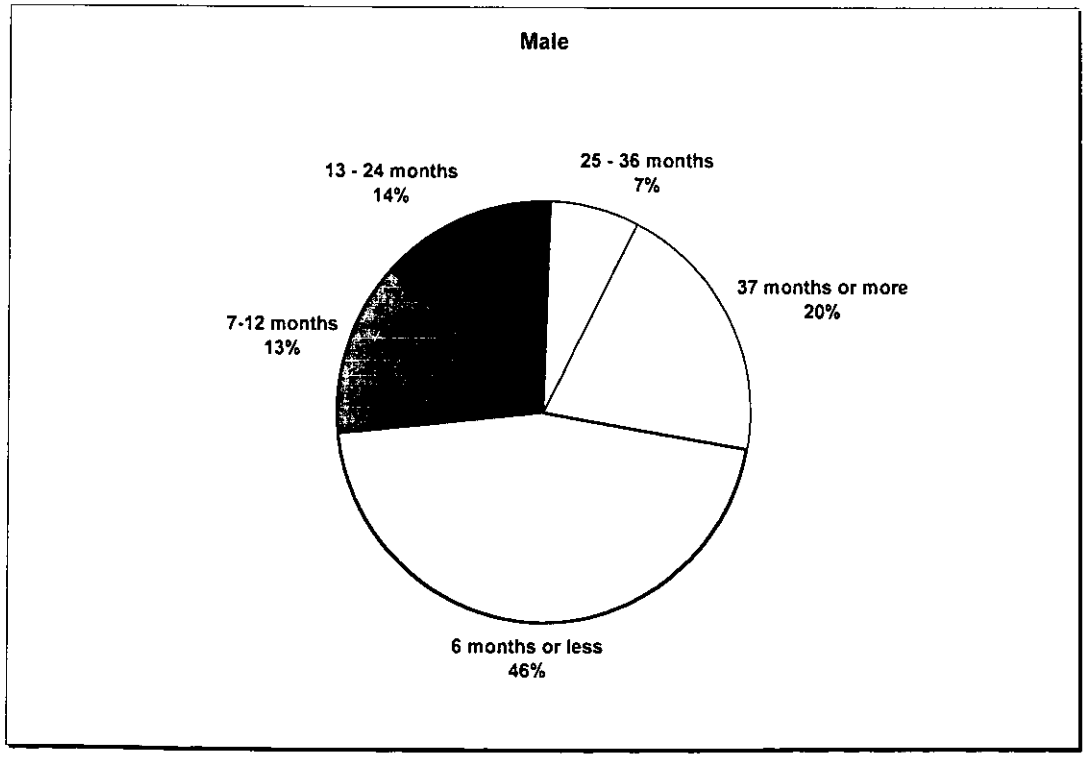
3926


Institutional Offenders
by Race/Ethnicity
December 31, 2008
Race/Ethnicity
Unknown
White
Alaska Native
Hispanic
Black
Asian/Pacific Islander
0%
1%
47%
55%
36%
32%
3%
2%
11%
8%
3%
3%
Female
Male
0%
10%
20%
30%
40%
50%
60%
Percent of Total


Institutional Offenders
by Age Group
December 31, 2008
Age Group
Under 20
20 - 29
30 - 39
40 - 49
50 - 59
60 or more
3%
3%
35%
37%
25%
28%
23%
24%
11%
6%
4%
2%
Female
Male
0%
5%
10%
15%
20%
25%
30%
35%
40%
Percent of Total

Length of Time from Admission
Institutional Offenders by Sex
December 31, 2008





3928

Offense Classifications of Offenders in Institutions
December 31, 2008

Offense Level	Female	Male	Total	Pct
Felony	308	3398	3,706	86.7%
Misdemeanor	81	486	567	13.3%
Violation	1	-	1	0.0%
Total	**390**	**3,884**	**4,274**	**100.0%**
Alcohol				
Attempt to Furnish Liquor to a Minor	-	1	1	
Drinking in Public	-	1	1	
Driving While Intoxicated	9	54	63	
Drunk Person on Licensed Premises	-	2	2	
Felony DWI - 2+ Priors w/in 5 Yrs	23	184	207	
Felony Refusal of Chem Test- 2+ Priors	-	9	9	
Furnish Alcohol to a Minor	-	5	5	
Illegal Liquor - Make, Possess, Sell	-	2	2	
License or Permit Required	-	1	1	
Minor Consuming/Possessing Alcohol	1	2	3	
Persons Under 21 on Alcohol Premises	-	1	1	
Prohibition of Importation after Election	1	1	2	
Refuse to Submit to Chem Test	-	1	1	
Total	**34**	**264**	**298**	**7.0%**
Drugs				
Attempted Drugs 2	3	15	18	
Attempted Drugs 3	-	3	3	
Misconduct - Controlled Substance 1	1	5	6	
Misconduct - Controlled Substance 2	9	59	68	
Misconduct - Controlled Substance 3	11	57	68	
Misconduct - Controlled Substance 4	35	107	142	
Misconduct - Controlled Substance 5	1	1	2	
Total	**60**	**247**	**307**	**7.2%**
Person				
Assault 1	7	92	99	
Assault 2	5	117	122	
Assault 3	16	176	192	
Assault 4	10	122	132	
Assault	7	33	40	
Attempted Assault 1	-	1	1	
Attempted Murder 1	1	46	47	
Attempted Murder 2	-	2	2	
Attempted Robbery 1	-	2	2	
Child Abuse	1	-	1	
Coercion	-	6	6	
Conspiracy Murder 1	-	3	3	
Conspiracy Robbery 1	2	1	3	
Contributing to Delinquency of Minor	-	1	1	
Criminally Negligent Homicide	-	4	4	
Custodial Interference 1	-	1	1	
DV Assault	3	16	19	

3929

Person	Female	Male	Total	Pct
Endanger Vulnerable Adult 1	-	1	1	
Endanger Welfare Minor 1	2	-	2	
Kidnapping	1	51	52	
Manslaughter	12	47	59	
Murder 1	12	233	245	
Murder 2	15	184	199	
Reckless Endangerment	1	5	6	
Robbery 1	9	112	121	
Robbery 2	-	42	42	
Robbery	-	2	2	
Stalking 1	-	1	1	
Total	**104**	**1,301**	**1,405**	**32.9%**
Property				
Arson 1	1	9	10	
Arson 2	-	3	3	
Attempted Arson 1	-	2	2	
Attempted Burglary 1	-	4	4	
Attempted Forgery 1	1	-	1	
Attempted Forgery 2	-	1	1	
Attempted Fraud	-	1	1	
Attempted Issue Bad Checks	-	1	1	
Attempted Theft 2	1	-	1	
Attempted Theft 3	-	1	1	
Attempted Vehicle Theft 1	-	2	2	
Burglary 1	6	94	100	
Burglary 2	2	36	38	
Conceal Merch - <$50	-	1	1	
Conceal Merch - Value $500+	-	2	2	
Criminal Impersonation 1	-	3	3	
Criminal Mischief 1	-	1	1	
Criminal Mischief 2	-	2	2	
Criminal Mischief 3	1	22	23	
Criminal Mischief 4	1	5	6	
Criminal Trespass 1	1	4	5	
Criminal Trespass 2	1	2	3	
Criminal Trespass	-	5	5	
Criminally Negligent Burning	1	-	1	
Forgery 1	-	2	2	
Forgery 2	4	12	16	
Fraud Use of Access Device Value $500 - $2,500	1	2	3	
Issuing Bad Check - Value $50-$499	-	1	1	
Issuing Bad Check - Value $500-$24,999	-	1	1	
Issuing Bad Check - Value >$25,000	-	1	1	
Malicious Destruction of Property	-	1	1	
Obtain Credit Card by Fraud	-	1	1	
Scheme to Defraud	2	8	10	
Theft 1	6	4	10	
Theft 2	28	138	166	
Theft 3	3	8	11	
Theft 4	-	2	2	

3930

Property	Female	Male	Total	Pct
Theft	-	1	1	
Theft by Shoplifting	4	5	9	
Unauthorized Entry	-	1	1	
Vehicle Tampering	-	2	2	
Vehicle Theft 1	4	65	69	
Vehicle Theft 2	-	3	3	
Total	**68**	**459**	**527**	**12.3%**

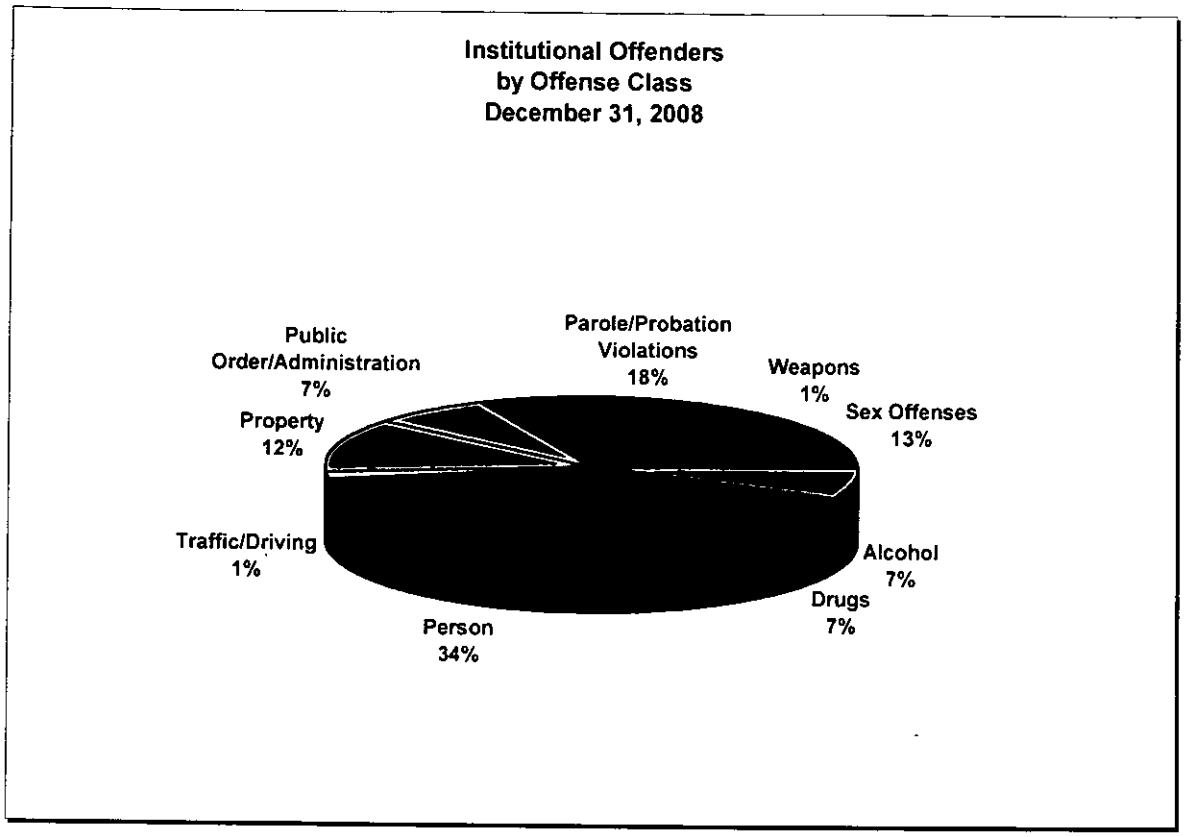
Public Order/Administration	Female	Male	Total	Pct
Bribery	-	1	1	
Contempt of Court	3	8	11	
Disorderly Conduct	2	8	10	
Eluding	-	2	2	
Escape 1	-	2	2	
Escape 2	-	25	25	
Escape 3	-	5	5	
Escape 4	-	5	5	
Failure to Satisfy Judgement	2	8	10	
Failure to Appear	8	43	51	
Failure to Comply	-	5	5	
Failure to Reg as Sex Offender 1	1	11	12	
Failure to Reg as Sex Offender 2	-	2	2	
Failure to Remand	-	1	1	
False Information	1	3	4	
Federal Offense	4	31	35	
Fugitive from Justice	-	15	15	
Harassment	-	1	1	
Hindering Prosecution 1	2	-	2	
Interfere w/ Report of DV Crime	-	1	1	
Interstate Custody Compact	-	1	1	
Leaving Scene of Accident	1	3	4	
Making a False Report	3	6	9	
Perjury	-	3	3	
Promoting Contraband 1	-	4	4	
Promoting Contraband 2	-	1	1	
Resist/Interfere Arrest	-	3	3	
Resist/Interfere Officer	1	4	5	
Tampering w/ Physical Evidence	-	11	11	
Tampering w/ Witness 1	-	1	1	
Unlawful Contact 1	-	1	1	
Unlawful Evasion 1	3	3	6	
Urinating in Public	-	1	1	
Violate Conditions of Release	5	45	50	
Violate DV Restraining Order	3	13	16	
Violate Order to Submit to DNA Testing	1	-	1	
Total	**40**	**277**	**317**	**7.4%**

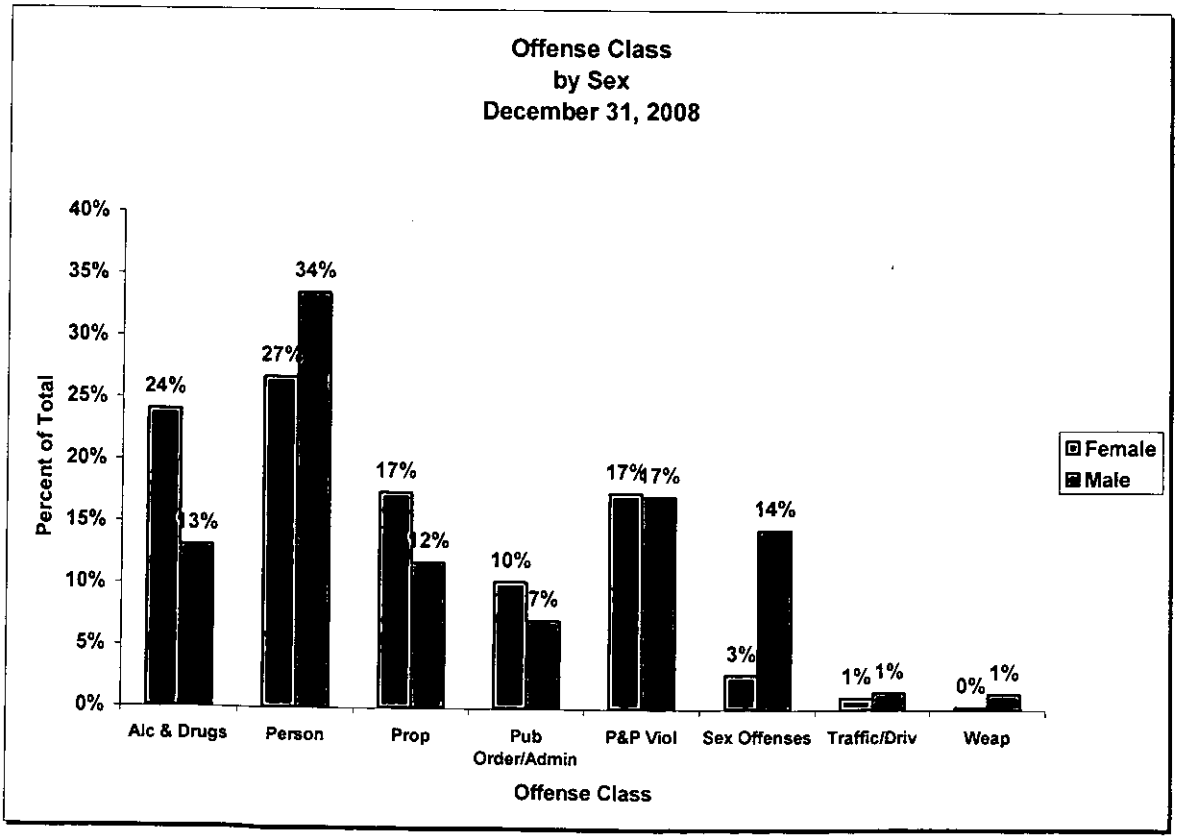
Parole/Probation Violations				
Parole Violation	8	157	165	
Probation Violation	60	509	569	
Total	**68**	**666**	**734**	**17.2%**

3931

Non-Registerable Sex Offenses	Female	Male	Total	Pct
Indecent Exposure 2	-	1	1	
Practicing Prostitution	4	-	4	
Total	**4**	**1**	**5**	**0.1%**
Registerable Sex Offenses				
Attempted Sex Abuse 1	-	14	14	
Attempted Sex Abuse Minor 2	-	14	14	
Attempted Sex Abuse Minor 3	-	2	2	
Attempted Sex Assault 1	-	10	10	
Attempted Sex Assault 2	-	6	6	
Attempted Sex Assault 3	-	3	3	
Distribute Child Pornography	-	5	5	
Incest	-	1	1	
Indecent Exposure 1	-	2	2	
Indecent Exposure 2	-	2	2	
Online Enticement of a Minor	-	1	1	
Possess Child Pornography	-	16	16	
Promote Prostitution 1	1	-	1	
Sex Abuse Minor 1	2	143	145	
Sex Abuse Minor 2	1	114	115	
Sex Abuse Minor 3	1	10	11	
Sex Assault 1	-	151	151	
Sex Assault 2	2	49	51	
Sex Assault 3	-	18	18	
Solicitation Sex Abuse 1	-	1	1	
Total	**7**	**562**	**569**	**13.3%**
Traffic/Driving				
Drive w/ License Canc/Susp/Revoked/Lim	4	24	28	
Drive without Valid Operator's License	-	3	3	
Fail to Stop at Direction of Officer 1	-	20	20	
Fail to Stop at Direction of Officer 2	-	3	3	
Improper Use of Regis/Title/Plates	-	1	1	
No MV Liability Insurance	-	2	2	
Reckless Driving	-	3	3	
Total	**4**	**56**	**60**	**1.4%**
Weapons				
Attempted Misconduct - Weapons 3	-	1	1	
Concealed Weapon	-	1	1	
Misconduct - Weapons 1	-	6	6	
Misconduct - Weapons 2	1	15	16	
Misconduct - Weapons 3	-	25	25	
Misconduct - Weapons 4	-	1	1	
Misconduct - Weapons 5	-	1	1	
Unlawful Discharge of Firearm	-	1	1	
Total	**1**	**51**	**52**	**1.2%**
Total All	**390**	**3,884**	**4,274**	**100.0%**

3932


Institutional Offenders
by Offense Class
December 31, 2008
Public Order/Administration 7%
Parole/Probation Violations 18%
Weapons 1%
Sex Offenses 13%
Property 12%
Traffic/Driving 1%
Alcohol 7%
Drugs 7%
Person 34%


Offense Class
by Sex
December 31, 2008
Percent of Total
40%
35%
30%
25%
20%
15%
10%
5%
0%
24%
13%
27%
34%
17%
12%
10%
7%
17%
17%
3%
14%
1%
1%
0%
1%
Female
Male
Alc & Drugs
Person
Prop
Pub Order/Admin
P&P Viol
Sex Offenses
Traffic/Driv
Weap
Offense Class

Crime Classifications by Class/Sex/Ethnicity for Offenders in Institutions December 31, 2008

Class/Sex	Ethnicity	Count	Percent
Alcohol			
Females	Asian	1	0.3%
	Black	1	0.3%
	Caucasian	17	5.7%
	Hispanic	1	0.3%
	Ak Native	12	4.0%
	Unknown	2	0.7%
Males	Asian	7	2.3%
	Black	14	4.7%
	Caucasian	157	52.7%
	Hispanic	8	2.7%
	Ak Native	78	26.2%
	Total	**298**	**100.0%**
Drugs			
Females	Asian	1	0.3%
	Black	6	2.0%
	Caucasian	44	14.3%
	Hispanic	0	0.0%
	Ak Native	9	2.9%
Males	Asian	7	2.3%
	Black	50	16.3%
	Caucasian	157	51.1%
	Hispanic	4	1.3%
	Ak Native	28	9.1%
	Unknown	1	0.3%
	Total	**307**	**100.0%**
Person			
Females	Asian	2	0.1%
	Black	7	0.5%
	Caucasian	46	3.3%
	Hispanic	2	0.1%
	Ak Native	47	3.3%
Males	Asian	53	3.8%
	Black	155	11.0%
	Caucasian	580	41.3%
	Hispanic	36	2.6%
	Ak Native	475	33.8%
	Unknown	2	0.1%
	Total	**1,405**	**100.0%**

3934

Class/Sex	Ethnicity	Count	Percent
Property			
Females	Asian	1	0.2%
	Black	7	1.3%
	Caucasian	45	8.5%
	Hispanic	3	0.6%
	Ak Native	11	2.1%
	Unknown	1	0.2%
Males	Asian	9	1.7%
	Black	39	7.4%
	Caucasian	261	49.5%
	Hispanic	10	1.9%
	Ak Native	138	26.2%
	Unknown	2	0.4%
	Total	**527**	**100.0%**
Public Order/Administration			
Females	Asian	3	0.9%
	Black	5	1.6%
	Caucasian	14	4.4%
	Hispanic	1	0.3%
	Ak Native	17	5.4%
Males	Asian	14	4.4%
	Black	38	12.0%
	Caucasian	116	36.6%
	Hispanic	15	4.7%
	Ak Native	94	29.7%
	Total	**317**	**100.0%**
Parole/Probation Violations			
Females	Asian	2	0.3%
	Black	3	0.4%
	Caucasian	38	5.2%
	Hispanic	2	0.3%
	Ak Native	23	3.1%
Males	Asian	12	1.6%
	Black	76	10.4%
	Caucasian	283	38.6%
	Hispanic	9	1.2%
	Ak Native	284	38.7%
	Unknown	2	0.3%
	Total	**734**	**100.0%**
Non-Registerable Sex Offenses			
Females	Caucasian	1	20.0%
	Ak Native	3	60.0%
Males	Ak Native	1	20.0%
	Total	**5**	**100.0%**

Class/Sex	Ethnicity	Count	Percent
Registerable Sex Offenses			
Females	Asian	1	0.2%
	Black	1	0.2%
	Caucasian	4	0.7%
	Ak Native	1	0.2%
Males	Asian	11	1.9%
	Black	25	4.4%
	Caucasian	223	39.2%
	Hispanic	9	1.6%
	Ak Native	288	50.6%
	Unknown	6	1.1%
	Total	**569**	**100.0%**
Traffic/Driving			
Females	Caucasian	3	5.0%
	Ak Native	1	1.7%
Males	Black	5	8.3%
	Caucasian	35	58.3%
	Hispanic	6	10.0%
	Ak Native	10	16.7%
	Total	**60**	**100.0%**
Weapons			
Females	Caucasian	1	1.9%
Males	Asian	4	7.7%
	Black	14	26.9%
	Caucasian	20	38.5%
	Hispanic	5	9.6%
	Ak Native	8	15.4%
	Total	**52**	**100.0%**
	Total All	**4,274**	**100.0%**

3936

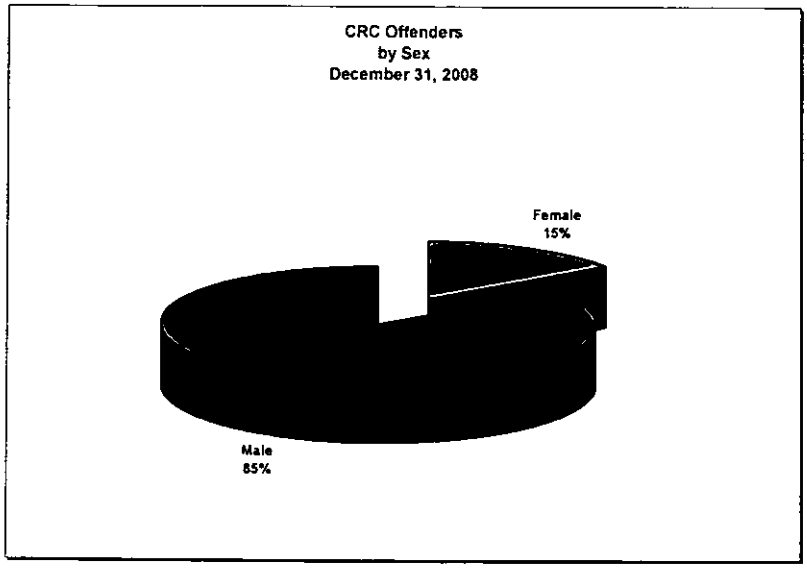
Community Residential Centers (CRC's)

CRC Facility Address List

CRC	Address	City	Zip	Phone
Akeela House	2804 Bering St.	Anchorage	99503	561-1200
Clitheroe Center	P.O. Box 190567	Anchorage	99519	276-2898
Cordova Center	130 Cordova St.	Anchorage	99501	274-1022
Glacier Manor	5597 Aisek	Juneau	99801	780-3020
Glennwood Center	835 D St.	Anchorage	99501	277-4501
Maniilaq	PO Box 256	Kotzebue	99752	442-7640
Midtown Center	2507 Eide St.	Anchorage	99503	222-6502
Northstar Center	PO Box 80670	Fairbanks	99708	474-4955
Parkview Center	831 B St.	Anchorage	99501	272-1641
Phillips Ayagnirvik Treattment Center	PO Box 528	Bethel	99559	543-6735
Ralph Perdue Center	3100 S Cushman St.	Fairbanks	99701	456-7819
Seaside Center	PO Box 2129	Nome	99762	443-6390
Tundra Center	PO Box 485	Bethel	99559	543-3414

Notes:
Includes information about all offenders incarcerated in CRC's and treatment centers as well as those under electronic monitoring and those who are monitored by CRC's offsite who are entered into the OTIS database.
Consists of a snapshot of offenders incarcerated and entered into the OTIS database on or before December 31, 2008.
Alaska Native race category includes a small number of Native Americans not indigenous to Alaska.
Information about offenses is the most serious charge only.
Offense classes are semi-arbitrary.

3937



Number of Offenders in Community Residential Centers
December 31, 2004 - 2008

	Females					Males					All Offenders				
CRCs	**08**	**07**	**06**	**05**	**04**	**08**	**07**	**06**	**05**	**04**	**08**	**07**	**06**	**05**	**04**
Akeela House	1	-	1	1	1	1	1	-	3	3	2	1	1	4	4
Aullaqisaatqigvik*	-	-	-	-	-	-	-	-	-	4	-	-	-	-	4
Clitheroe Center	3	1	2	-	2	6	2	2	10	9	9	3	4	10	11
Cordova Center	28	23	23	19	23	93	83	41	123	138	121	106	64	142	161
Glacier Manor	11	7	3	11	8	44	50	35	39	49	55	57	38	50	57
Glennwood Center	9	7	8	8	12	59	57	43	33	43	68	64	51	41	55
Safe Harbor/Hope House*	-	-	1	1	1	-	-	1	2	1	-	-	2	3	2
Kar House*	-	-	-	-	1	-	-	-	-	2	-	-	-	-	3
Maniilaq	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-
Midtown Center	-	-	-	-	-	35	29	-	12	28	35	29	-	12	28
Northstar Center	6	9	9	13	10	74	67	41	64	47	80	76	50	77	57
Parkview Center	-	-	-	-	-	98	113	95	71	69	98	113	95	71	69
PhilipsTreatment Center	-	-	-	-	-	-	-	-	1	1	-	-	-	1	1
Ralph Perdue Center	-	-	-	1		-	-	2	3	3	-	-	2	4	3
Seaside Center	13	6	9	6	7	37	29	28	42	40	50	35	37	48	47
Tundra Center	1	3	2	5	8	52	40	36	47	43	53	43	38	52	51
Total	*72*	*56*	*58*	*65*	*73*	*499*	*471*	*324*	*451*	*480*	*571*	*527*	*382*	*516*	*553*
Special Offsite Programs															
Anchorage Elect Monitor	32	25	29	15	20	95	73	127	68	70	127	98	156	83	90
Anchorage CRC Monitor	-	1	-	-	2	1	1	1	2	8	1	2	1	2	10
Fairbanks Elect Monitor	8	9	6	5	1	26	25	12	2	12	34	34	18	7	13
Fairbanks CRC Monitor	-	-	-	-	-	-	1	-	1	4	-	1	-	1	4
Kenai Elect Monitor	1	2	-	-	-	6	2	-	-	-	7	4	-	-	-
Ketchikan Elect Monitor	-	2	-	-	-	-	2	1	-	3	-	4	1	-	3
Total	*41*	*39*	*35*	*20*	*23*	*128*	*104*	*141*	*73*	*97*	*169*	*143*	*176*	*93*	*120*
Total All	**113**	**95**	**93**	**85**	**96**	**627**	**575**	**465**	**524**	**577**	**740**	**670**	**558**	**609**	**673**

3938 * Not currently operational

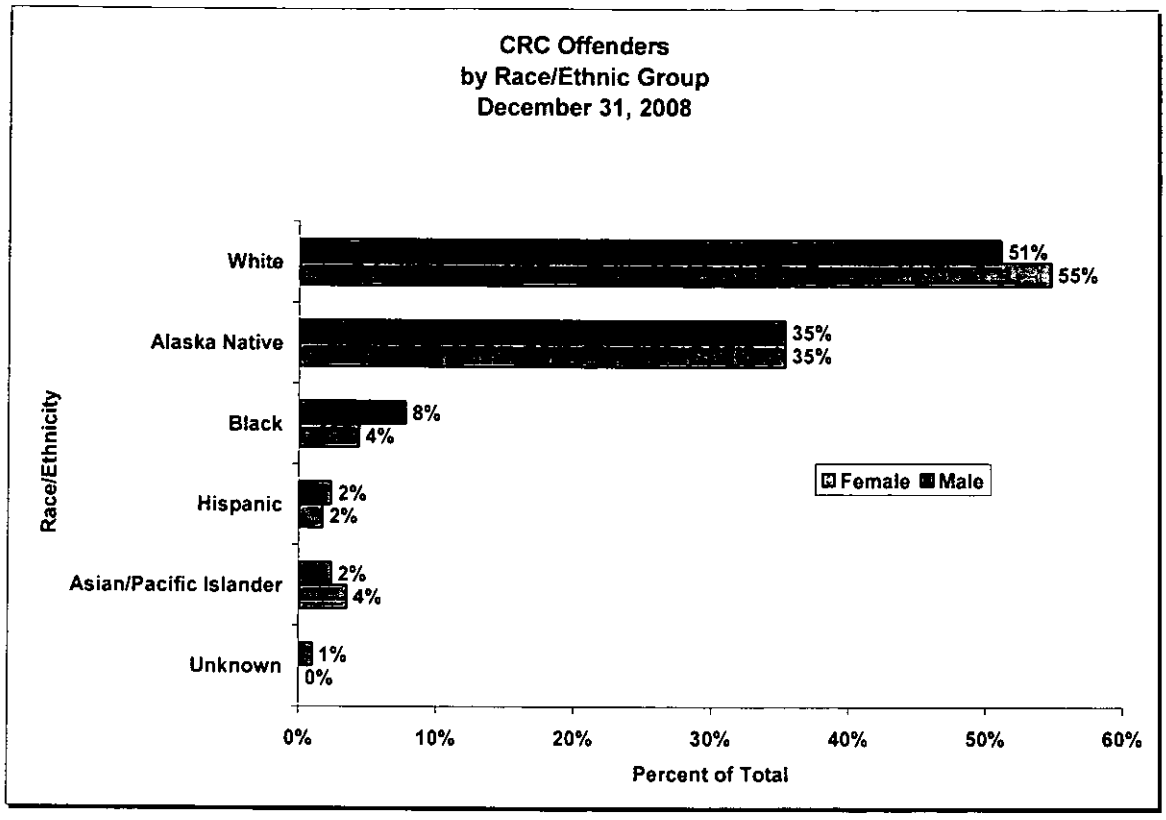
Demographic Information for Offenders in Community Residential Centers December 31, 2004-2008

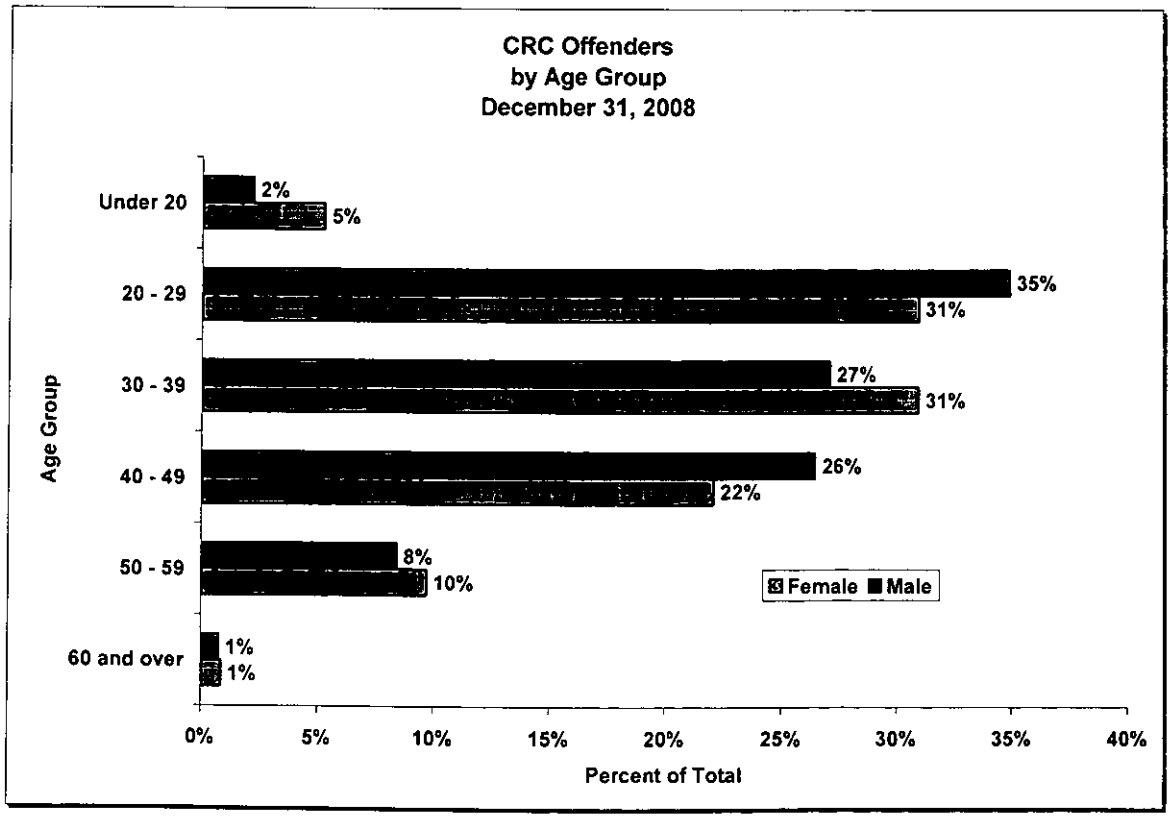
	Females					Males					All Offenders				
Ethnicity	**08**	**07**	**06**	**05**	**04**	**08**	**07**	**06**	**05**	**04**	**08**	**07**	**06**	**05**	**04**
Asian/Pac Island	4	2	1	0	1	17	14	12	17	14	21	16	13	17	15
Black	5	7	9	7	7	49	39	45	46	50	54	46	54	53	57
Hispanic	2	1	1	3	0	15	7	9	22	17	17	8	10	25	17
AK Native	40	34	34	34	47	222	223	204	200	224	262	257	238	234	271
Caucasian	62	50	46	40	40	321	289	193	237	272	383	339	239	277	312
Unknown	0	1	2	1	1	3	3	2	2	1	3	4	4	3	2
Total	**113**	**95**	**93**	**85**	**95**	**627**	**575**	**465**	**524**	**577**	**740**	**670**	**558**	**609**	**672**
19 and Under	6	3	3	3	4	14	8	14	11	19	20	11	17	14	23
20-24	18	10	13	12	11	103	107	57	87	87	121	117	70	99	98
25-29	17	20	15	17	11	116	116	82	85	87	133	136	97	102	98
30-34	17	11	8	11	15	94	77	73	83	89	111	88	81	94	104
35-39	18	11	16	11	15	76	82	60	75	99	94	93	76	86	114
40-44	13	14	20	15	19	86	70	76	75	82	99	84	96	90	101
45-49	12	16	11	12	16	80	60	63	65	68	92	76	74	77	84
50-54	7	5	5	1	3	36	34	22	29	34	43	39	27	30	37
55-59	4	2	2	2	0	17	16	10	8	6	21	18	12	10	6
60-64	1	2	0	0	1	5	5	6	3	3	6	7	6	3	4
65 and over	0	1	0	1	1	0	0	2	3	4	0	1	2	4	5
Total	**113**	**95**	**93**	**85**	**96**	**627**	**575**	**465**	**524**	**578**	**740**	**670**	**558**	**609**	**674**
Mean Age (yrs)	***35.34***					***35.67***					***35.62***				
Median Age (yrs)	***34.48***					***34.27***					***34.30***				

Length of time from admission for Offenders in CommunityResidential Centers December 31, 2008

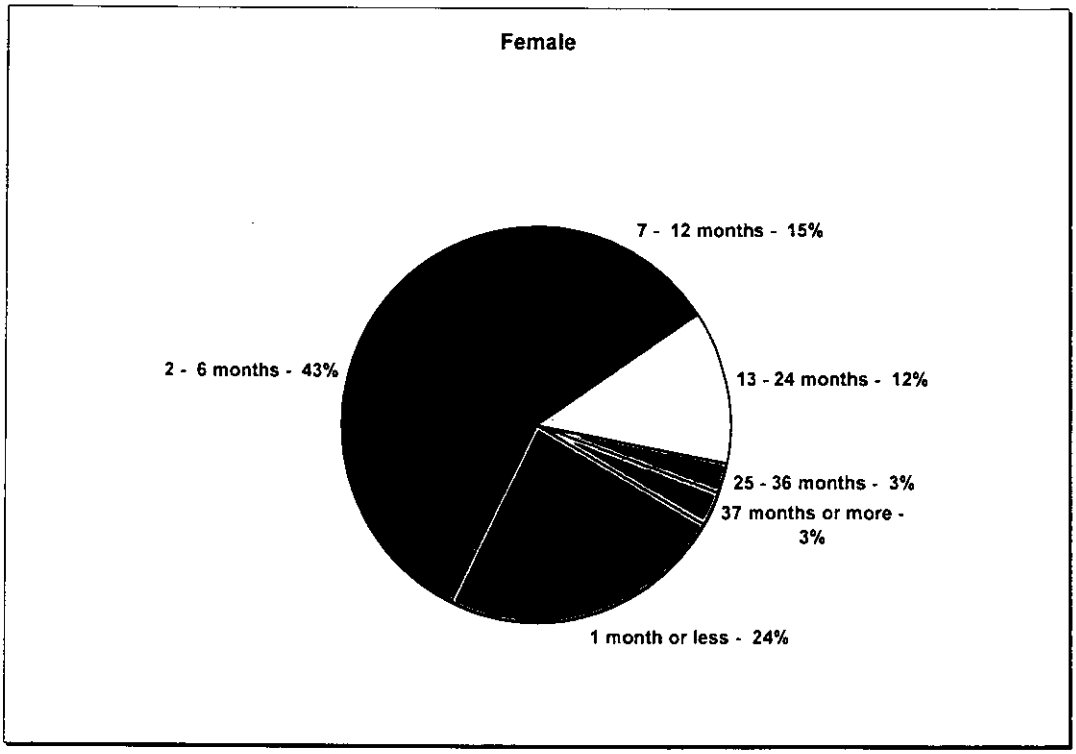
Months In	**Females**	**Males**	**All Offenders**
1 month or less	27	175	**202**
2 months - 6 months	49	283	**332**
7 months - 12 months	17	91	**108**
13 months - 24 months	14	51	**65**
25 months - 36 months	3	18	**21**
37 months or more	3	9	**12**
Total	**113**	**627**	**740**
Mean Length (months)	***6.66***	***8.13***	***7.90***
Median Length (months)	***3.00***	***3.00***	***3.00***

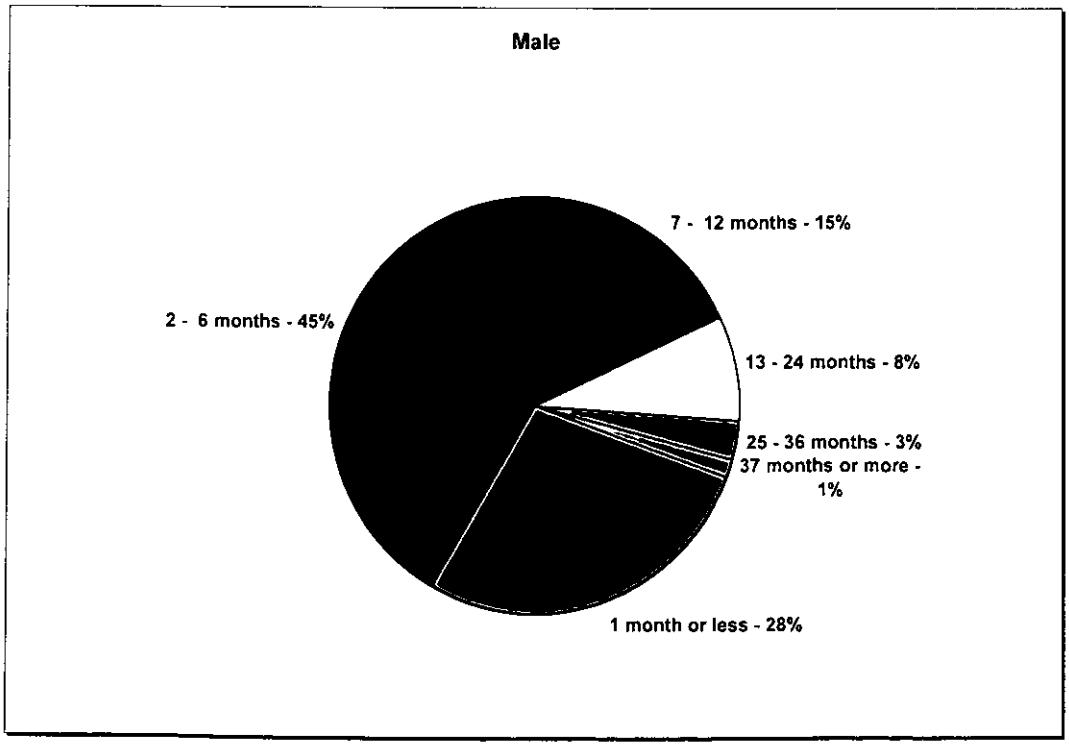
3939


CRC Offenders
by Race/Ethnic Group
December 31, 2008
Race/Ethnicity
White
Alaska Native
Black
Hispanic
Asian/Pacific Islander
Unknown
51%
55%
35%
35%
8%
4%
2%
2%
2%
4%
1%
0%
Female
Male
0%
10%
20%
30%
40%
50%
60%
Percent of Total


CRC Offenders
by Age Group
December 31, 2008
Age Group
Under 20
20 - 29
30 - 39
40 - 49
50 - 59
60 and over
2%
5%
35%
31%
27%
31%
26%
22%
8%
10%
1%
1%
Female
Male
0%
5%
10%
15%
20%
25%
30%
35%
40%
Percent of Total

Length of Time from Admission
CRC Offenders by Sex
December 31,2008





Offense Classifications of Offenders in Community Residential Centers December 31, 2008

Offense Level	Female	Male	Total	Pct
Felony	74	364	438	59.2%
Misdemeanor	35	259	294	39.7%
Violation	4	4	8	1.1%
Total	**113**	**627**	**740**	**100.0%**
Alcohol				
Drinking in Public	-	1	1	
Driving While Intoxicated	14	54	68	
Felony DWI - 2+ Priors w/in 5 Yrs	14	80	94	
Felony Refusal of Chem Test- 2+ Priors	-	5	5	
Furnish Alcohol to a Minor	-	2	2	
License or Permit Required	-	1	1	
Manufacture, Sell, Offer for Sale	-	2	2	
Minor Consuming/Possessing Alcohol	4	6	10	
Prohibition of Importation after Election	1	1	2	
Refuse Chemical Test	-	2	2	
Send/Bring Alcohol to Dry Area	1	-	1	
Total	**34**	**154**	**188**	**25.4%**
Drugs				
Attempted MICS2	-	3	3	
Attempted MICS4	1	-	1	
Misconduct - Controlled Substance 2	3	10	13	
Misconduct - Controlled Substance 3	6	7	13	
Misconduct - Controlled Substance 4	9	25	34	
Misconduct - Controlled Substance 5	-	2	2	
Misconduct - Controlled Substance 6	-	1	1	
Total	**19**	**48**	**67**	**9.1%**
Person				
Assault 1	-	3	3	
Assault 2	-	9	9	
Assault 3	2	17	19	
Assault 4	6	67	73	
Assault	1	19	20	
Attempted Murder 1	-	1	1	
Child Abuse	-	1	1	
Contributing to the Delinquency Minor	-	3	3	
Criminal Nonsupport	-	1	1	
Criminally Negligent Homicide	2	-	2	
DV Assault	-	11	11	
Endanger Welfare Minor 1	-	1	1	
Kidnapping	-	1	1	
Manslaughter	-	2	2	
Murder 1	-	3	3	
Murder 2	-	1	1	
Reckless Endangerment	-	3	3	

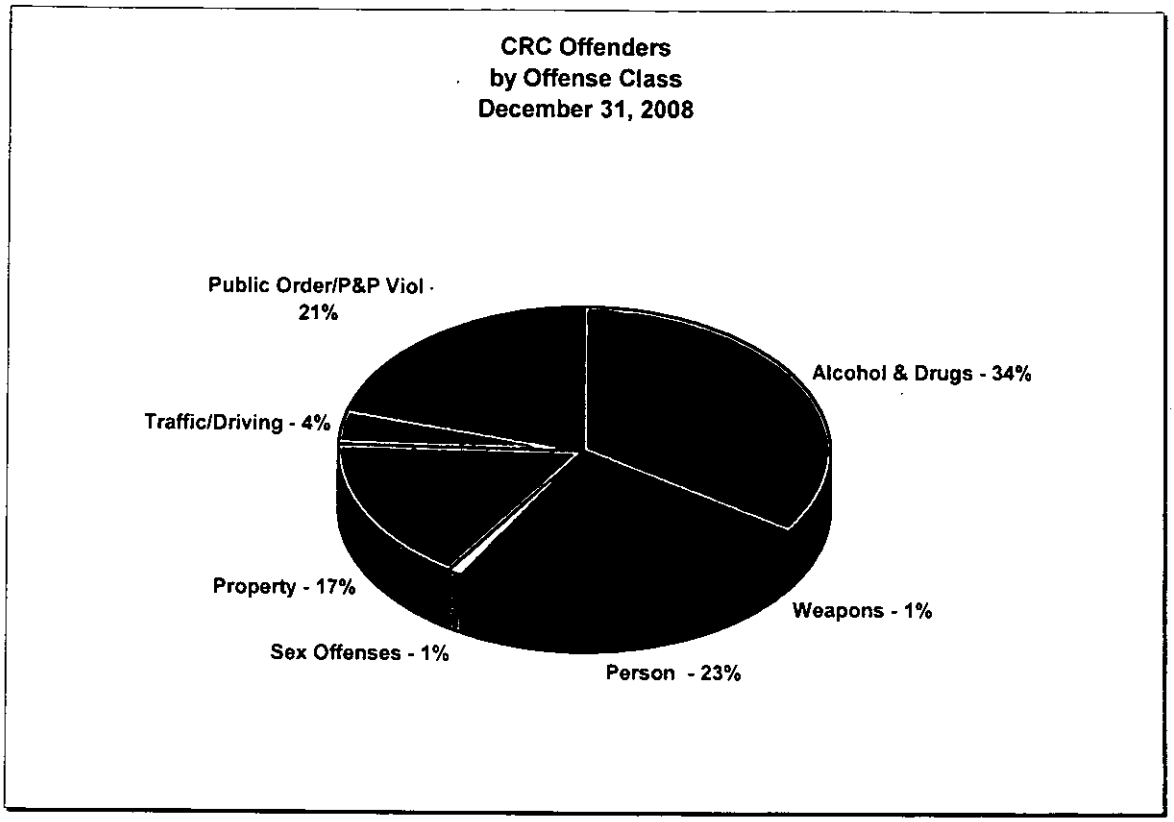
3942

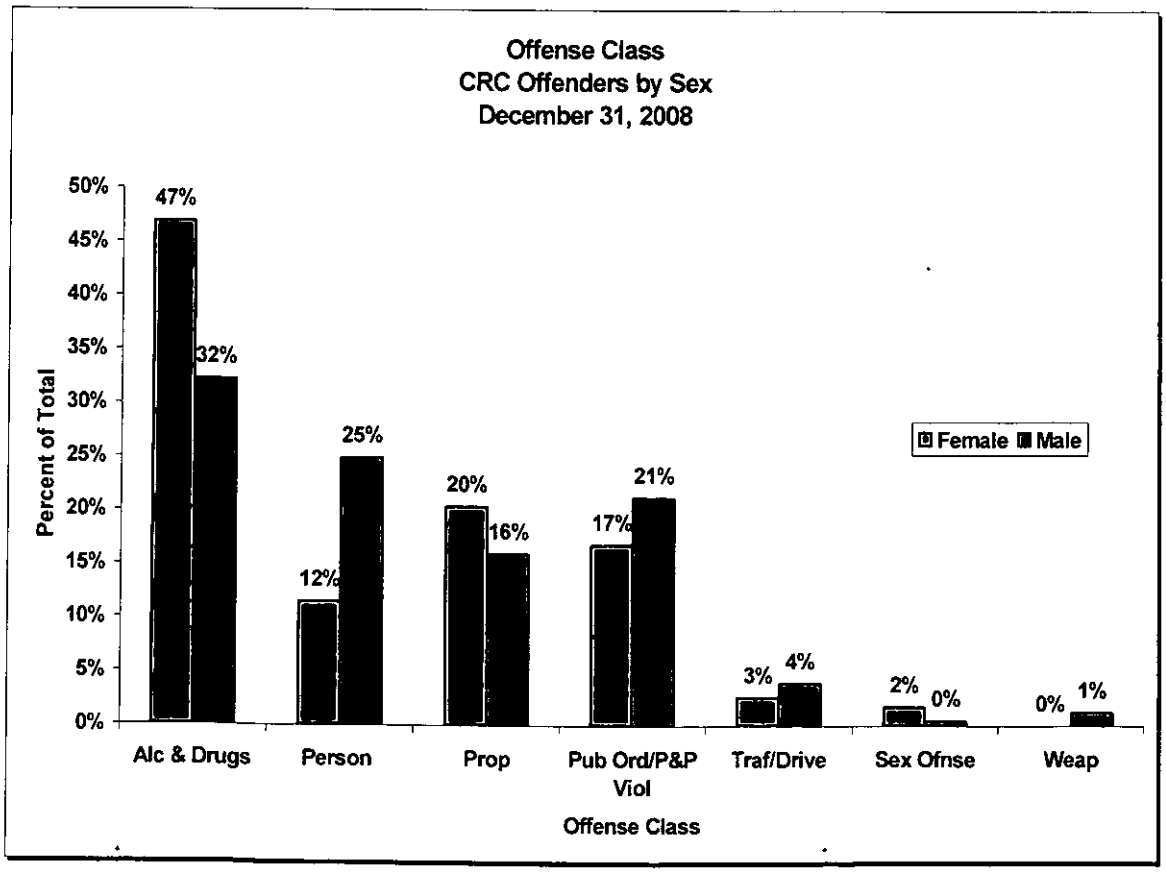
Person	Female	Male	Total	Pct
Robbery 1	1	10	11	
Robbery 2	1	3	4	
Total	**13**	**156**	**169**	**22.8%**
Property				
Attempted Theft 1	-	1	1	
Attempted Vehicle Theft 1	-	2	2	
Burglary 1	1	14	15	
Burglary 2	-	3	3	
Criminal Impersonation	-	1	1	
Criminal Mischief 3	-	3	3	
Criminal Mischief 4	1	3	4	
Criminal Mischief 5	-	1	1	
Criminal Trespass 1	-	2	2	
Criminal Trespass 2	1	2	3	
Criminal Trespass	-	1	1	
Forgery 1	-	1	1	
Forgery 2	4	5	9	
Fraud Use of Access Device	-	2	2	
Issuing Bad Check - $500-$24,999	1	-	1	
Scheme to Defraud	-	2	2	
Theft 1	1	1	2	
Theft 2	11	26	37	
Theft 3	1	9	10	
Theft by Shoplifting	1	5	6	
Vehicle Theft 1	1	16	17	
Total	**23**	**100**	**123**	**16.6%**
Public Order/Administration				
Contempt of Court	1	1	2	
Disorderly Conduct	-	3	3	
Failure to Satisfy Judgement	-	2	2	
Failure to Appear	-	1	1	
Failure to Comply	-	3	3	
False Information	-	1	1	
Federal Offense - INS	-	1	1	
Fugitive from Justice	1	-	1	
Harassment	-	1	1	
Hinder Prosecution 1	1	-	1	
Leaving Scene of Accident	3	3	6	
Making a False Report	2	2	4	
Medical Assistance Fraud	1	1	2	
Promote Contraband 2	-	1	1	
Resist/Interfere with Arrest	-	3	3	
Resist/Interfere with Officer	-	2	2	
Tampering with Physical Evidence	-	2	2	
Violate Conditions of Release	-	12	12	
Violate DV Restraining Order	-	2	2	
Total	**9**	**41**	**50**	**6.8%**

3943

Parole/Probation Violations				
Parole Violation	10	13	23	
Probation Violation	-	79	79	
Total	**10**	**92**	**102**	**13.8%**
Non-Registerable Sex Offenses				
Family Violence	-	1	1	
Practicing Prostitution	2	-	2	
Total	**2**	**1**	**3**	**0.4%**
Registerable Sex Offenses	**Female**	**Male**	**Total**	**Pct**
Sex Assault 2	-	2	2	
Total	**-**	**2**	**2**	**0.3%**
Traffic/Driving				
Drive w/ License Canc/Susp/Rev/Lim	1	14	15	
Driving w/o Valid Operators License	-	6	6	
Fail to Stop at Direction of Officer 1	2	4	6	
Reckless Driving	-	1	1	
Total	**3**	**25**	**28**	**3.8%**
Weapons				
Misconduct - Weapons 2	-	3	3	
Misconduct - Weapons 3	-	4	4	
Misconduct - Weapons 4	-	1	1	
Total	**-**	**8**	**8**	**1.1%**
Total All	**113**	**627**	**740**	**100.0%**

3944


CRC Offenders
by Offense Class
December 31, 2008
Public Order/P&P Viol - 21%
Alcohol & Drugs - 34%
Traffic/Driving - 4%
Property - 17%
Weapons - 1%
Sex Offenses - 1%
Person - 23%


Offense Class
CRC Offenders by Sex
December 31, 2008
Percent of Total
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
47%
32%
12%
25%
20%
16%
17%
21%
3%
4%
2%
0%
0%
1%
Female
Male
Alc & Drugs
Person
Prop
Pub Ord/P&P Viol
Traf/Drive
Sex Ofnse
Weap
Offense Class

3945

Crime Classifications by Class/Sex/Ethnicity for Offenders in CRC's December 31, 2008

Class/Sex	Ethnicity	Count	Percent
Alcohol			
Females	Asian	0	0.0%
	Black	1	0.5%
	White	18	9.6%
	Hispanic	1	0.5%
	AK Native	14	7.4%
Males	Asian	3	1.6%
	Black	6	3.2%
	White	97	51.6%
	Hispanic	3	1.6%
	AK Native	45	23.9%
	Total	**188**	**100.0%**
Drugs			
Females	Asian	1	1.5%
	Black	0	0.0%
	White	15	22.4%
	Hispanic	0	0.0%
	AK Native	3	4.5%
Males	Asian	1	1.5%
	Black	6	9.0%
	White	32	47.8%
	Hispanic	2	3.0%
	AK Native	6	9.0%
	Unknown	1	1.5%
	Total	**67**	**100.0%**
Person			
Females	Asian	1	0.6%
	Black	0	0.0%
	White	4	2.4%
	Hispanic	1	0.6%
	AK Native	7	4.1%
Males	Asian	6	3.6%
	Black	17	10.1%
	White	46	27.2%
	Hispanic	5	3.0%
	AK Native	82	48.5%
	Total	**169**	**100.0%**

3946

Class/Sex	Ethnicity	Count	Percent
Property			
Females	Asian	0	0.0%
	Black	2	1.6%
	White	15	12.2%
	Hispanic	0	0.0%
	AK Native	6	4.9%
Males	Asian	5	4.1%
	Black	11	8.9%
	White	59	48.0%
	AK Native	24	19.5%
	Unknown	1	0.8%
	Total	**123**	**100.0%**
Pub Order/Administration			
Females	Asian	2	4.0%
	Black	1	2.0%
	White	5	10.0%
	Hispanic	0	0.0%
	AK Native	1	2.0%
Males	Asian	0	0.0%
	Black	1	2.0%
	White	22	44.0%
	Hispanic	2	4.0%
	AK Native	16	32.0%
	Total	**50**	**100.0%**
Parole/Probation Violations			
Females	Asian	0	0.0%
	Black	1	1.0%
	White	3	2.9%
	Hispanic	0	0.0%
	AK Native	6	5.9%
Males	Asian	0	0.0%
	Black	7	6.9%
	White	42	41.2%
	Hispanic	2	2.0%
	AK Native	41	40.2%
	Total	**102**	**100.0%**
Non-Registerable Sex Offenses			
Females	Asian	0	0.0%
	Black	0	0.0%
	White	1	33.3%
	Hispanic	0	0.0%
	AK Native	1	33.3%

3947

Class/Sex	Ethnicity	Count	Percent
Non-Registerable Sex Offenses			
Males	Asian	0	0.0%
	Black	1	33.3%
	White	0	0.0%
	Hispanic	0	0.0%
	AK Native	0	0.0%
	Total	**3**	**100.0%**
Registerable Sex Offenses			
Females	Asian	0	0.0%
	Black	0	0.0%
	White	0	0.0%
	Hispanic	0	0.0%
	AK Native	0	0.0%
Males	Asian	0	0.0%
	Black	0	0.0%
	White	0	0.0%
	Hispanic	0	0.0%
	AK Native	2	100.0%
	Total	**2**	**100.0%**
Traffic/Driving			
Females	Asian	0	0.0%
	Black	0	0.0%
	White	1	3.6%
	Hispanic	0	0.0%
	AK Native	2	7.1%
Males	Asian	1	3.6%
	Black	0	0.0%
	White	20	71.4%
	Hispanic	0	0.0%
	AK Native	4	14.3%
	Total	**28**	**100.0%**
Weapons			
Females	Asian	0	0.0%
	Black	0	0.0%
	White	0	0.0%
	Hispanic	0	0.0%
	AK Native	0	0.0%
Males	Asian	1	12.5%
	Black	0	0.0%
	White	3	37.5%
	Hispanic	1	12.5%
	AK Native	2	25.0%
	Unknown	1	12.5%
	Total	**8**	**100.0%**
Total All		**740**	**100.0%**

3948

Focus 2008
Information About Groups of Particular Interest

Notes:
Includes information about all offenders incarcerated in Alaskan and out-of-state institutions, CRC's, treatment centers, and those under electronic monitoring and offsite supervision who are entered into the OTIS database.
Consists of a snapshots of offenders incarcerated and entered into the OTIS database on December 31, 2008.
Alaska Native race category includes a small number of Native Americans not indigenous to Alaska.
Information about offenses is the most serious charge only.
Offense classes are semi-arbitrary.

3949

Alaska Natives

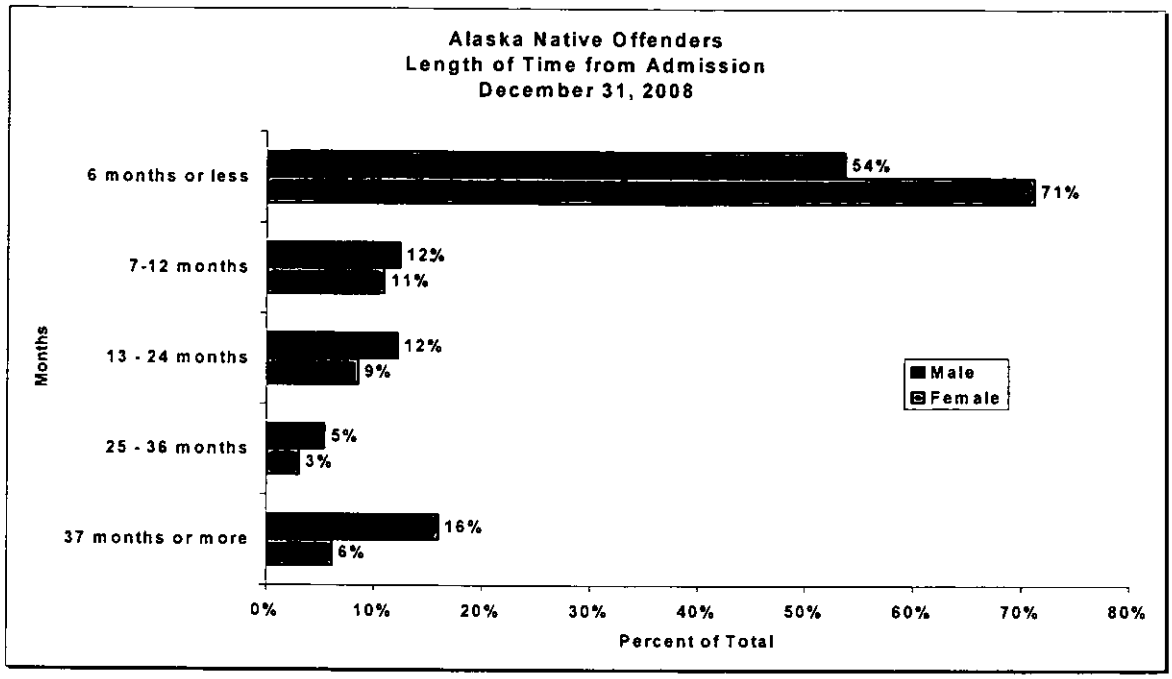
Notes:
Includes information about all offenders listed within the OTIS database as Indian or Alaska Native.
Includes information about a small number of Native Americans who are not indigenous to Alaska.

3950

Distribution of Alaska Natives
December 31, 2008

In-State Institutions	Female	Male	Total
Anchorage CCE	3	119	122
Anchorage CCW	-	127	127
Anvil Mountain CC	3	77	80
Fairbanks CC	12	80	92
Hiland Mountain CC	94	-	94
Ketchikan CC	2	17	19
Lemon Creek CC	3	79	82
Mat-Su Pretrial	2	8	10
Palmer Minimum CC	-	63	63
Palmer Medium CC	-	81	81
Point MacKenzie CF	-	33	33
Spring Creek CC	-	206	206
Wildwood CC	-	93	93
Wildwood Pretrial	3	8	11
Yukon-Kuskokwim CC	2	104	106
Total	*124*	*1,095*	*1,219*
Out-of-State Institutions			
Red Rock CC - Arizona	-	307	307
Federal Bureau of Prisons	-	2	2
Total	-	*309*	*309*
CRC's			
Akeela House	-	1	1
Cordova Center	7	35	42
Glacier Manor	6	10	16
Glennwood Center	4	9	13
Midtown Center	-	13	13
North Star Center	2	31	33
Parkview Center	-	20	20
Seaside Center	13	35	48
Tundra Center	1	52	53
Total	*33*	*206*	*239*
Special Offsite Programs			
Anchorage Electronic Monitoring	5	13	18
Fairbanks Electronic Monitoring	2	3	5
Total	*7*	*16*	*23*
Total All	**164**	**1,626**	**1,790**

3951



Demographic Information for Alaska Native Offenders
December 31, 2008

Age Group (Years)	Female	Male	Total
19 and Under	8	54	62
20 - 24	30	291	321
25 - 29	38	331	369
30 - 34	22	218	240
35 - 39	17	201	218
40 - 44	23	179	202
45 - 49	13	158	171
50 - 54	6	106	112
55 - 59	4	52	56
60 - 64	2	16	18
65 and over	1	20	21
Total	**164**	**1,626**	**1,790**
Mean Age	***33.94***	***35.21***	***35.10***
Median Age	***31.96***	***33.06***	***32.93***
Length of time from admission			
6months or less	117	876	993
7 months - 12 months	18	203	221
13 months - 24 months	14	199	213
25 months 36 months	5	88	93
37 months or more	10	260	270
Total	**164**	**1,626**	**1,790**
Mean Length (months)	***9.77***	***20.87***	***19.86***
Median Length (months)	***2.00***	***5.00***	***5.00***

3952

Offense Classifications of Alaska Native Offenders
December 31, 2008

Offense Level	Female	Male	Total	Pct
Felony	104	1,268	1,372	76.6%
Misdemeanor	56	355	411	23.0%
Violation	4	3	7	0.4%
Total	**164**	**1,626**	**1,790**	**100.0%**
Alcohol				
Attempt Furnish Liquor to Minor	-	1	1	
Drinking in Public	-	2	2	
Driving While Intoxicated	7	31	38	
Drunk Person on Licensed Premise	-	2	2	
Felony DWI - 2+ Priors w/in 5 Yrs	12	64	76	
Felony Refusal of Chem Test- 2+ P	-	2	2	
Furnish Alcohol to a Minor	-	7	7	
License or Permit Required	-	2	2	
Manuf/Sell Alcohol w/o license	-	3	3	
Minor Consuming/Possessing Alcoh	5	7	12	
Prohibition of Importation after Elec	1	1	2	
Refuse Chemical Test	-	1	1	
Send/Bring Alcohol to Dry Area	1	-	1	
Total	**26**	**123**	**149**	**8.3%**
Drugs				
Attempted Misconduct - Controlled	-	2	2	
Misconduct -Controlled Substance 2	1	3	4	
Misconduct -Controlled Substance 3	5	7	12	
Misconduct -Controlled Substance 4	5	20	25	
Misconduct -Controlled Substance 5	1	1	2	
Misconduct -Controlled Substance 6	-	1	1	
Total	**12**	**34**	**46**	**2.6%**
Person				
Assault 1	4	33	37	
Assault 2	3	58	61	
Assault 3	7	78	85	
Assault 4	11	128	139	
Assault	7	23	30	
Attempted Assault 1	-	1	1	
Attempted Murder 1	-	17	17	
Attempted Murder 2	-	1	1	
Attempted Robbery 1	-	1	1	
Child Abuse	1	-	1	
Coercion	-	4	4	
Contributing to the Delinquency Min	-	2	2	

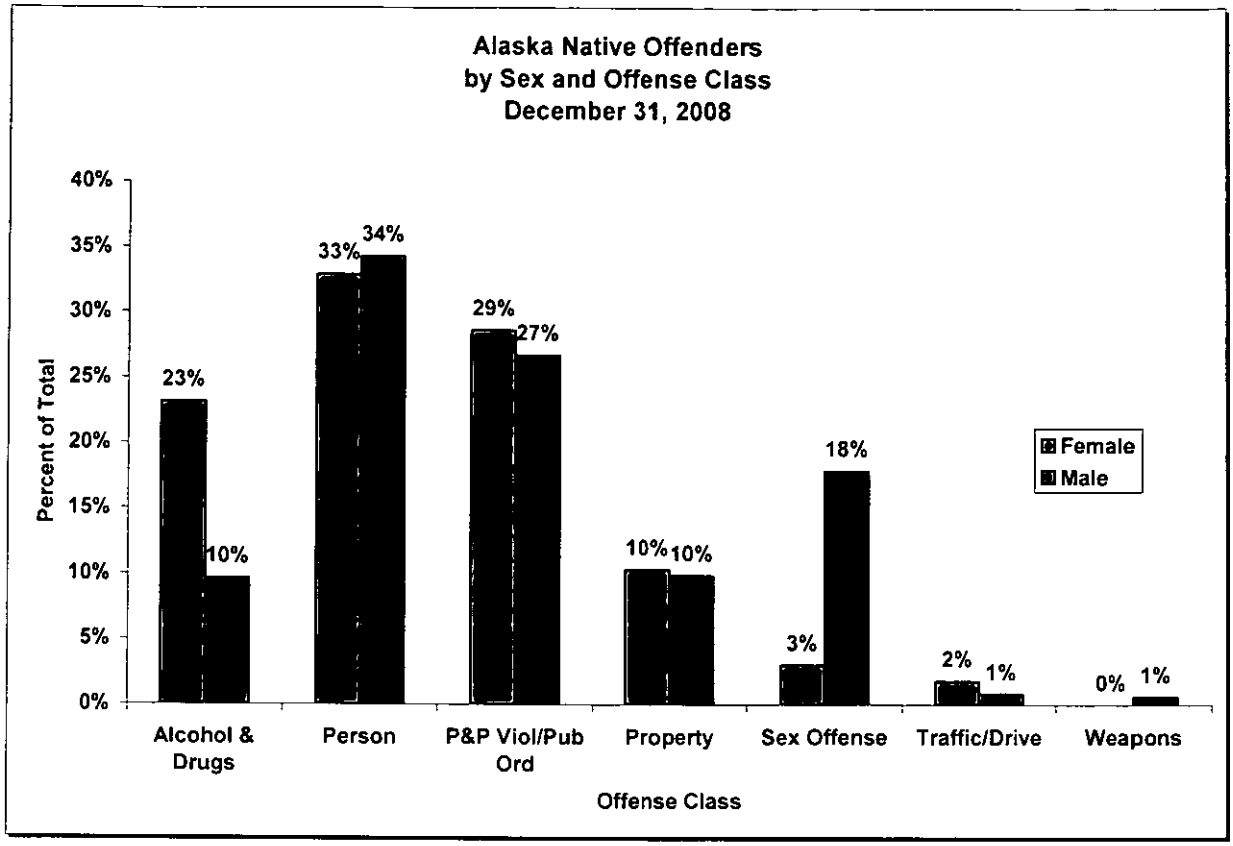
3953

Person	Female	Male	Total	Pct
Criminal Nonsupport	-	1	1	
Criminally Negligent Homicide	-	3	3	
DV Assault	2	14	16	
Kidnapping	-	13	13	
Manslaughter	7	15	22	
Murder 1	2	49	51	
Murder 2	7	78	85	
Reckless Endangerment	1	5	6	
Robbery 1	2	19	21	
Robbery 2	-	15	15	
Total	**54**	**558**	**612**	**34.2%**
Property				
Arson 1	1	4	5	
Arson 2	-	1	1	
Attempted Arson 1	-	1	1	
Attempted Theft 3	-	1	1	
Attempted Vehicle Theft 1	-	2	2	
Burglary 1	1	31	32	
Burglary 2	-	11	11	
Conceal Merch - Value $500+	-	1	1	
Criminal Impersonation 1	-	2	2	
Criminal Mischief 2	-	1	1	
Criminal Mischief 3	1	11	12	
Criminal Mischief 4	1	7	8	
Criminal Mischief 5	-	1	1	
Criminal Trespass 1	1	4	5	
Criminal Trespass 2	2	3	5	
Forgery 1	-	1	1	
Forgery 2	1	3	4	
Scheme to Defraud	1	-	1	
Theft 2	5	31	36	
Theft 3	-	8	8	
Theft	-	1	1	
Theft by Shoplifting	1	2	3	
Vehicle Tampering	-	1	1	
Vehicle Theft 1	2	31	33	
Vehicle Theft 2	-	2	2	
Total	**17**	**161**	**178**	**9.9%**
Public Order/Administration				
Bribery	-	1	1	
Contempt of Court	1	2	3	
Disorderly Conduct	1	5	6	
Escape 2	-	15	15	
Escape 3	-	2	2	
Escape 4	-	4	4	

3954

Public Order/Administration	Female	Male	Total	Pct
Failure Satisfy Judgement	1	4	5	
Failure to Appear	3	14	17	
Failure to Comply	-	2	2	
Failure to Reg as Sex Offender 1	1	6	7	
Failure to Reg as Sex Offender 2	-	1	1	
Federal Offense	1	1	2	
Leaving Scene of Accident	1	1	2	
Making a False Report	3	5	8	
Promoting Contraband 2	-	2	2	
Resist/Interfere Arrest	-	2	2	
Resist/Interfere Officer	1	-	1	
Tampering w/ Physical Evidence	-	3	3	
Unlawful Contact 1	-	1	1	
Unlawful Evasion 1	1	1	2	
Urinating in Public	-	1	1	
Violate Conditions of Release	2	30	32	
Violate DV Restraining Order	2	7	9	
Total	**18**	**110**	**128**	**7.2%**
Parole/Probation Violations				
Parole Violation	2	69	71	
Probation Violation	27	256	283	
Total	**29**	**325**	**354**	**19.8%**
Non-Registerable Sex Offenses				
Indecent Exposure 2	-	1	1	
Practicing Prostitution	4	-	4	
Total	**4**	**1**	**5**	**0.3%**
Registerable Sex Offense				
Attempted Sex Abuse 1	-	4	4	
Attempted Sex Abuse Minor 2	-	9	9	
Attempted Sex Abuse Minor 3	-	1	1	
Attempted Sex Assault 1	-	5	5	
Attempted Sex Assault 2	-	4	4	
Attempted Sex Assault 3	-	3	3	
Incest	-	1	1	
Indecent Exposure 1	-	1	1	
Indecent Exposure 2	-	1	1	
Sex Abuse Minor 1	-	50	50	
Sex Abuse Minor 2	-	60	60	
Sex Abuse Minor 3	-	7	7	
Sex Assault 1	-	87	87	
Sex Assault 2	1	43	44	
Sex Assault 3	-	13	13	
Solicitation Sex Abuse 1	-	1	1	
Total	**1**	**290**	**291**	**16.3%**

3955



Traffic/Driving	Female	Male	Total	Pct
Drive w License Canc/Susp/Rev/Li	2	6	8	
Fail to Stop at Direction of Officer	1	5	6	
Reckless Driving	-	2	2	
Valid Operators License Required	-	1	1	
Total	**3**	**14**	**17**	**0.9%**
Weapons				
Misconduct - Weapons 2	-	4	4	
Misconduct - Weapons 3	-	6	6	
Total	**-**	**10**	**10**	**0.6%**
Total All	**164**	**1,626**	**1,790**	**100.0%**

3956

Juveniles

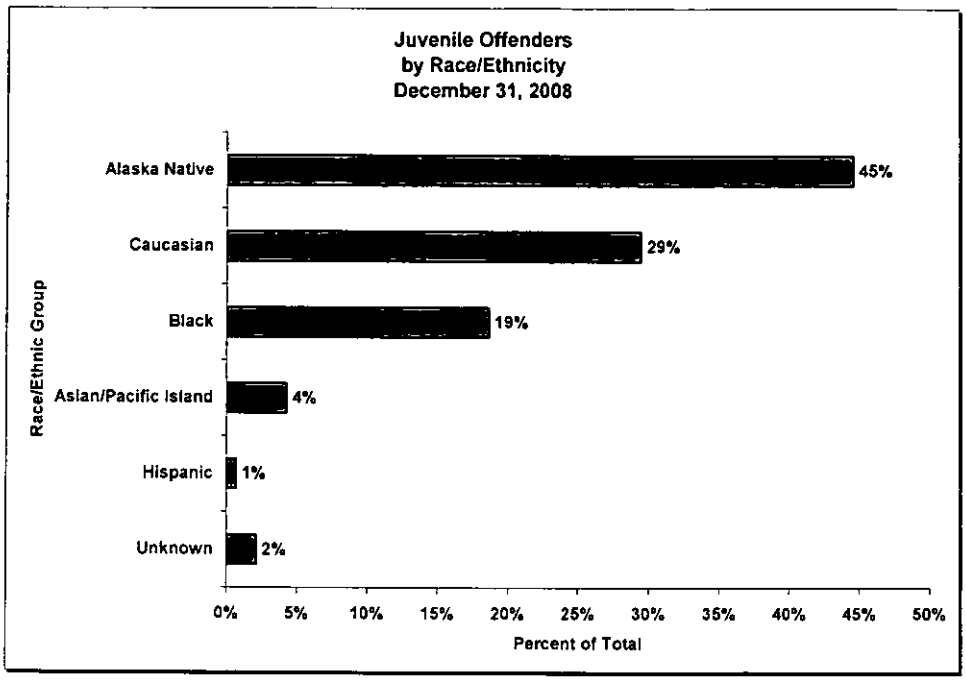
Notes:
Includes information about all offenders who are less than 20 years old.
A small number of Native Americans who are not indigenous to Alaska are included in the Alaska Native category.

3957

Distribution of Juvenile Offenders
December 31, 2008

In-State Institutions	Female	Male	Total
Anchorage CCE	0	19	19
Anchorage CCW	0	12	12
Anvil Mountain CC	0	15	15
Fairbanks CC	1	11	12
Hiland Mountain CC	6	0	6
Ketchikan CC	1	3	4
Lemon Creek CC	1	6	7
Mat-Su Pretrial	0	2	2
Palmer Minimum CC	0	1	1
Palmer Medium CC	0	9	9
Point Mackenzie CF	0	3	3
Spring Creek CC	0	14	14
Wildwood CC	0	4	4
Wildwood Pretrial	1	3	4
Yukon-Kuskokwim CC	0	6	6
Total	*10*	*108*	*118*
Out-of-State Institutions			
Red Rock CC - Arizona	0	1	1
Total	*0*	*1*	*1*
CRC's			
Cordova Center	1	2	3
Glacier Manor	1	2	3
North Star Center	0	1	1
SeasideCenter	4	3	7
Tundra Center	0	3	3
Total	*6*	*11*	*17*
Special Offsite Programs			
Anchorage Electronic Monitoring	0	3	3
Total	*0*	*3*	*3*
Total All	**16**	**123**	**139**

3958



Demographic Information for Juvenile Offenders
December 31, 2008

Ethnicity	Female	Male	Total
Alaska Native	8	54	62
Asian/Pacific Island	1	5	6
Black	0	26	26
Caucasian	6	35	41
Hispanic	0	1	1
Unknown	1	2	3
Total	**16**	**123**	**139**
Age (years)			
16	0	2	2
17	0	9	9
18	6	39	45
19	10	73	83
Total	**16**	**123**	**139**
Mean Age (years)	***19.08***	***19.10***	***19.10***
Median Age (years)	***19.24***	***19.24***	***19.24***
Length of Time From Admission			
Under 1 month	11	38	49
1 month to 6 months	4	58	62
7 months to 12 months	1	12	13
12 months and over	0	15	15
Total	**16**	**123**	**139**
Mean Length (months)	***0.81***	***4.31***	***3.91***
Median Length (months)	***< 1***	***1.00***	***1.00***

3959

Offense Classifications of Juvenile Offenders
December 31, 2008

Offense Level	Female	Male	Total	Pct
Felony	9	95	104	74.8%
Misdemeanor	5	28	33	23.7%
Violation	2	0	2	1.4%
Total	**16**	**123**	**139**	**100.0%**
Alcohol				
Driving While Intoxicated	1	4	5	
Minor Consuming	3	2	5	
Persons Under 21 on Alcohol Premises	0	1	1	
Prohibition of Importation After Election	1	0	1	
Total	**5**	**7**	**12**	**8.6%**
Drugs				
Misconduct - Controlled Substance 2	1	0	1	
Misconduct - Controlled Substance 4	1	1	2	
Total	**2**	**1**	**3**	**2.2%**
Person				
Assault 1	0	10	10	
Assault 2	0	2	2	
Assault 3	0	5	5	
Assault 4	0	6	6	
Attempted Murder 1	0	3	3	
Conspiracy Robbery 1	0	1	1	
DV Assault	0	1	1	
Manslaughter	0	3	3	
Murder 1	0	2	2	
Murder 2	1	0	1	
Reckless Endangerment	0	1	1	
Robbery 1	0	10	10	
Robbery 2	0	3	3	
Total	**1**	**47**	**48**	**34.5%**
Property				
Attempted Theft 3	0	1	1	
Attempted Vehicle Theft 1	0	1	1	
Burglary 1	0	8	8	
Burglary 2	0	1	1	
Criminal Mischief 4	0	1	1	
Criminal Trespass 1	0	1	1	
Forgery 2	0	1	1	
Theft 1	0	1	1	
Theft 2	2	6	8	
Theft 3	0	1	1	
Vehicle Theft 1	0	3	3	
Total	**2**	**25**	**27**	**19.4%**

3960

Public Order/Administration				
Failure to Satisfy Judgement	0	1	1	
Failure to Appear	1	2	3	
Leaving Scene of Accident	1	0	1	
Perjury	0	1	1	
Resist/Interfere w/ Arrest	0	1	1	
Violate Conditions of Release	1	3	4	
Total	**3**	**8**	**11**	**7.9%**
Parole/Probation Violations				
Parole Violation	0	1	1	
Probation Violation	2	12	14	
Total	**2**	**13**	**15**	**10.8%**
Registerable Sex Offenses				
Attempted Sex Abuse 1	0	1	1	
Possess Child Pornography	0	1	1	
Promote Prostitution 1	1	0	1	
Sex Abuse Minor 1	0	5	5	
Sex Abuse Minor 2	0	3	3	
Sex Assault 1	0	2	2	
Sex Assault 2	0	1	1	
Total	**1**	**13**	**14**	**10.1%**
Traffic/Driving				
Drive with License Susp/Canc/Rev/Lim	0	2	2	
Fail to Stop at Direction of Officer 1	0	1	1	
Reckless Driving	0	1	1	
Total	**0**	**4**	**4**	**2.9%**
Weapons				
Misconduct - Weapons 2	0	3	3	
Misconduct - Weapons 3	0	2	2	
Total	**0**	**5**	**5**	**3.6%**
Total All	**16**	**123**	**139**	**100.0%**

3961

Seniors

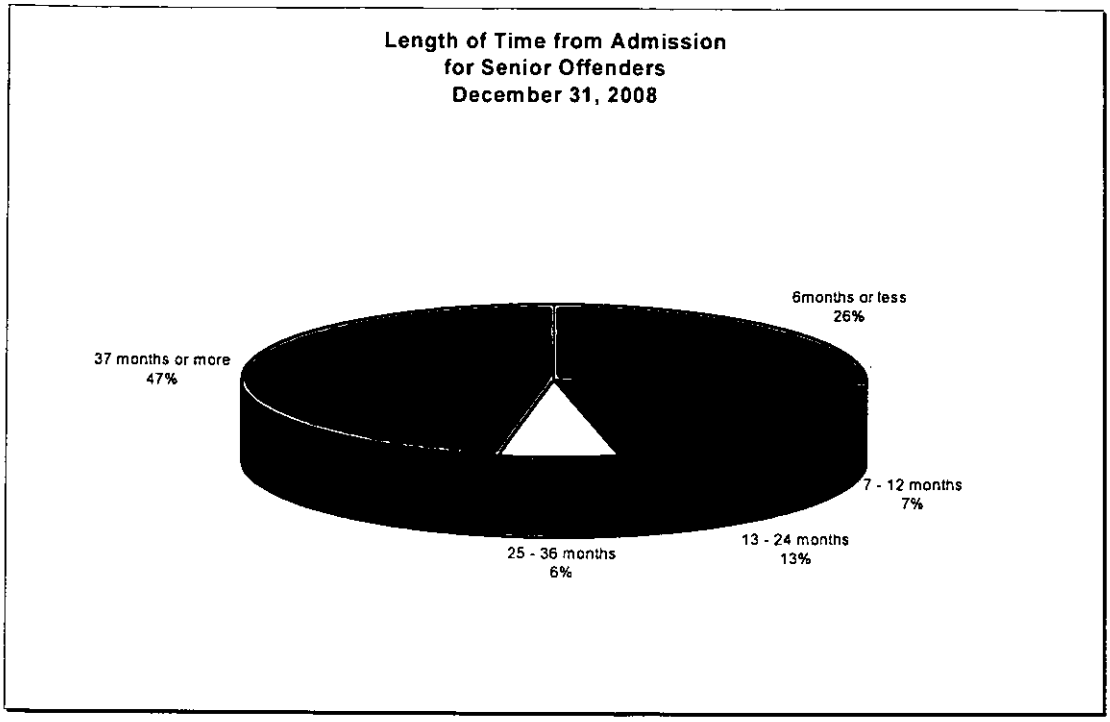
Notes:
Includes information about all offenders in the OTIS database who are 60 years old or older,
Alaska Native race category includes a small number of Native Americans not indigenous to Alaska.

3962

Distribution of Senior Offenders
December 31, 2008

In-State Institutions	Female	Male	Total
Anchorage CCE	-	10	10
Anchorage CCW	-	11	11
Fairbanks CC	2	9	11
Hiland Mountain CC	4	-	4
Ketchikan CC	-	-	-
Lemon Creek CC	-	3	3
Mat-Su PreTrial	-	1	1
Palmer Minimum CC	-	7	7
Palmer Medium CC	-	6	6
Point MacKenzie CF	-	-	-
Spring Creek CC	-	12	12
Wildwood CC	-	9	9
Wildwood PreTrial	-	4	4
Yukon-Kuskokwim CC	-	4	4
Total	*6*	*76*	*82*
Out-of-State Institutions			
Red Rock CC - Arizona	-	58	58
Federal Bureau of Prisons	-	2	2
Total	-	*60*	*60*
CRC's			
Glennwood Center	-	2	2
Total	-	*2*	*2*
Special Offsite Programs			
Anchorage Electronic Monitoring	-	3	3
Fairbanks Electronic Monitoring	1	-	1
Total	*1*	*3*	*4*
Total All	**7**	**141**	**148**

3963



Demographic Information for Senior Offenders
December 31, 2008

Ethnicity	**Female**	**Male**	**Total**
Asian/Pacific Island	1	2	3
Black	1	8	9
Caucasian	2	92	94
Hispanic	-	3	3
Alaska Native	3	36	39
Total	**7**	**141**	**148**
Age Group (Years)			
60 - 64	5	77	82
65 - 69	1	46	47
70 - 74	1	11	12
75 - 79	-	6	6
80 and over	-	1	1
Total	**7**	**141**	**148**
Mean Age	***63.24***	***65.29***	***65.19***
Median Age	***61.51***	***64.17***	***64.09***
Length of time from admission			
6months or less	4	35	39
7 months - 12 months	-	11	11
13 months - 24 mon	2	17	19
25 months 36 months	-	9	9
37 months or more	1	69	70
Total	**7**	**141**	**148**
Mean Length (months)	***24.14***	***67.52***	***65.47***
Median Length (months)	***2.00***	***35.00***	***31.50***

3964

Offense Classifications of Senior Offenders
December 31, 2008

Offense Level	Female	Male	Total	Pct
Felony	4	129	133	89.9%
Misdemeanor	3	12	15	10.1%
Total	**7**	**141**	**148**	**100.0%**
Alcohol				
Driving While Intoxicated	-	2	2	
Felony DWI - 2+ Priors w/in 5 Yrs	-	5	5	
Felony Refusal of Chemical Test	-	1	1	
Total	**-**	**8**	**8**	**5.4%**
Drugs				
Misconduct-Controlled Substance 2	-	1	1	
Misconduct-Controlled Substance 3	-	1	1	
Misconduct-Controlled Substance 4	-	2	2	
Total	**-**	**4**	**4**	**2.7%**
Driving				
Drive w/ Lic Canc/Susp/Rev/Lim	1	1	2	
Total	**1**	**1**	**2**	**1.4%**
Person				
Assault 1	-	5	5	
Assault 2	-	1	1	
Assault 3	-	3	3	
Assault 4	1	-	1	
DV Assault	-	1	1	
Attempted Murder 1	-	1	1	
Endanger Vulnerable Adult 1	-	1	1	
Kidnapping	-	3	3	
Manslaughter	-	5	5	
Murder 1	-	27	27	
Murder 2	1	8	9	
Robbery 1	-	2	2	
Total	**2**	**57**	**59**	**39.9%**

3965

Property	Female	Male	Total	Pct
Burglary 1	-	1	1	
Criminal Trespass	-	2	2	
Scheme to Defraud	-	1	1	
Theft 2	2	-	2	
Total	**2**	**4**	**6**	**4.1%**
Parole/Probation Violations				
Parole Violation	-	9	9	
Probation Violation	2	5	7	
Total	**2**	**14**	**16**	**10.8%**
Public Order/Administration				
Contempt of Court	-	1	1	
Escape 4	-	1	1	
Failure to Appear	-	2	2	
Federal Offense	-	2	2	
Fugitive From Justice	-	1	1	
Tampering w/ Physical Evidence	-	1	1	
Violate Conditions of Release	-	1	1	
Violate DV Restraining Order	-	1	1	
Total	**-**	**10**	**10**	**6.8%**
Registerable Sex Offenses				
Attempted Sex Abuse 1	-	2	2	
Attempted Sex Abuse Minor 2	-	1	1	
Online Enticement of a Minor	-	1	1	
Possess Child Pornography	-	2	2	
Sex Abuse Minor 1	-	19	19	
Sex Abuse Minor 2	-	8	8	
Sex Assault 1	-	8	8	
Sex Assault 2	-	1	1	
Sex Assault 3	-	1	1	
Total	**-**	**43**	**43**	**29.1%**
Total All	**7**	**141**	**148**	**100.0%**

3966

Sex Offenders

Notes:
Includes information about all offenders in the OTIS database who have listed as their most serious charge an offense that would unambiguously identify them as a registerable sex offender.

3967

Distribution of Sex Offenders
December 31, 2008

In-State Institutions	Female	Male	Total
Anchorage CCE	-	22	22
Anchorage CCW	-	46	46
Anvil Mountain CC	-	9	9
Fairbanks CC	-	19	19
Hiland Mountain CC	7	-	7
Ketchikan CC	-	4	4
Lemon Creek CC	-	21	21
Mat-Su Pretrial	-	7	7
Palmer Minimum CC	-	31	31
Palmer Medium CC	-	31	31
Spring Creek CC	-	87	87
Wildwood CC	-	27	27
Wildwood Pretrial	-	7	7
Yukon-Kuskokwim CC	-	24	24
Total	*7*	*335*	*342*
Out-of-State Institutions			
Red Rock CC - Arizona	-	227	227
Total	-	*227*	*227*
CRC's			
Seaside Center	-	1	1
Tundra Center	-	1	1
Total	-	*2*	*2*
Total All	**7**	**564**	**571**

3968

Demographic Information for Sex Offenders
December 31, 2008

Ethnicity	Female	Male	Total
Asian/Pacific Island	1	11	12
Black	1	25	26
Caucasian	4	223	227
Hispanic	-	9	9
Alaska Native	1	290	291
Unknown	-	6	6
Total	**7**	**564**	**571**

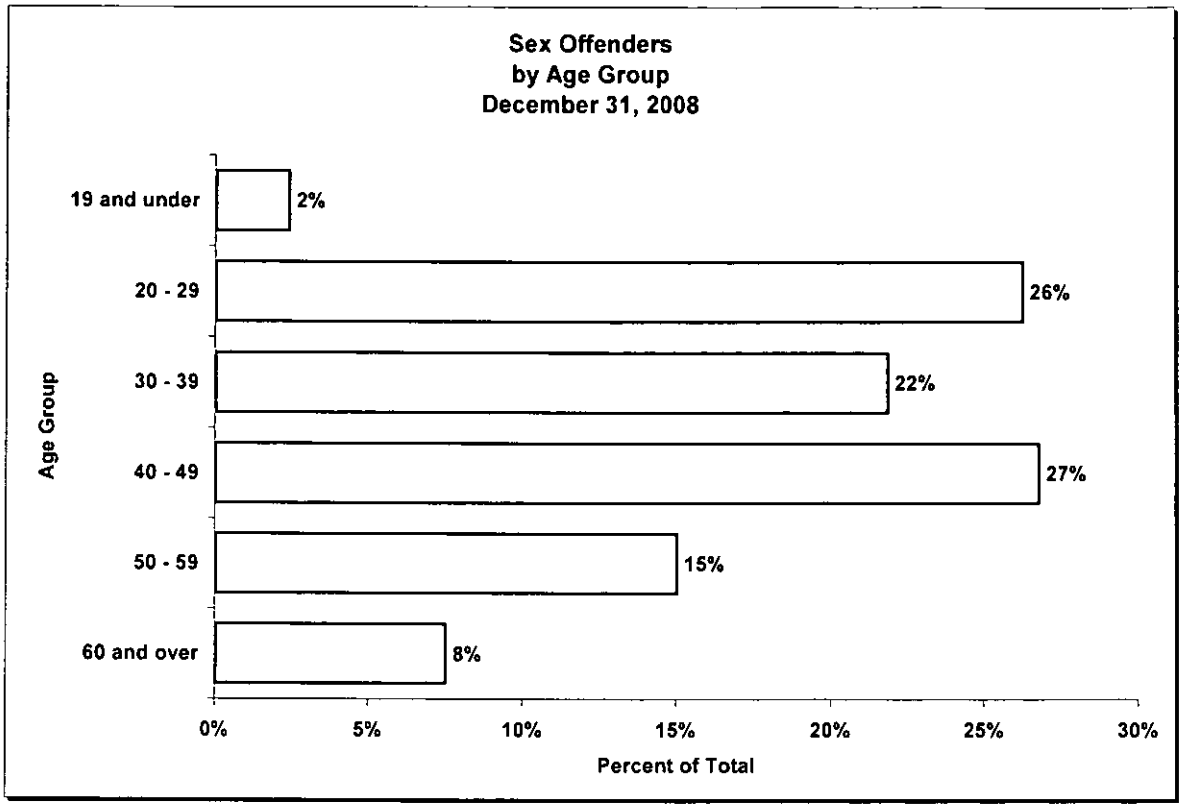
Age Group (Years)	Female	Male	Total
19 and Under	1	13	14
20 - 24	1	86	87
25 - 29	-	63	63
30 - 34	1	48	49
35 - 39	3	73	76
40 - 44	-	80	80
45 - 49	1	72	73
50 - 54	-	52	52
55 - 59	-	34	34
60 - 64	-	22	22
65 and over	-	21	21
Total	**7**	**564**	**571**
Mean Age	***34.23***	***39.88***	***39.81***
Median Age	***37.39***	***39.79***	***39.70***

Length of time from admission			
6 months or less	2	127	129
7 months - 12 months	2	82	84
13 months - 24 months	2	100	102
25 months 36 months	-	71	71
37 months or more	1	184	185
Total	**7**	**564**	**571**
Mean Length (months)	***21.86***	***35.04***	***34.88***
Median Length (months)	***9.00***	***21.00***	***20.00***

Offense Classifications for Sex Offenders
December 31, 2008

Offense Level	Female	Male	Total	Pct
Felony	7	554	561	98.2%
Misdemeanor	-	10	10	1.8%
Total	**7**	**564**	**571**	**100.0%**

3969



Registerable Sex Offenses	Female	Male	Total
Attempted Sex Abuse 1	-	14	14
Attempted Sex Abuse Minor 2	-	14	14
Attempted Sex Abuse Minor 3	-	2	2
Attempted Sex Assault 1	-	10	10
Attempted Sex Assault 2	-	6	6
Attempted Sex Assault 3	-	3	3
Distribute Child Pornography	-	5	5
Incest	-	1	1
Indecent Exposure 1	-	2	2
Indecent Exposure 2	-	2	2
Online Enticement of a Minor	-	1	1
Possess Child Pornography	-	16	16
Promote Prostitution 1	1	-	1
Sex Abuse Minor 1	2	143	145
Sex Abuse Minor 2	1	114	115
Sex Abuse Minor 3	1	10	11
Sex Assault 1	-	151	151
Sex Assault 2	2	51	53
Sex Assault 3	-	18	18
Solicitation Sex Abuse 1	-	1	1
Total	7	**564**	**571**

3970

Substance Abusers

Notes:
Includes information about all offenders in the OTIS database who have listed as their most serious charge an offense related to alcohol or drugs.

3971

Distribution of Substance Abuse Offenders
December 31, 2008

	Alcohol			Drugs		
In-State Institutions	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Anchorage CCE	1	19	20	-	19	19
Anchorage CCW	-	16	16	-	28	28
Anvil Mountain CC	-	2	2	-	-	-
Fairbanks CC	2	18	20	-	5	5
Hiland Mountain CC	26	-	26	57	-	57
Ketchikan CC	-	-	-	-	1	1
Lemon Creek CC	1	11	12	1	14	15
Mat-Su Pretrial	2	9	11	1	8	9
Palmer Minimum CC	-	24	24	-	11	11
Palmer Medium CC	-	33	33	-	28	28
Point MacKenzie CF	-	16	16	-	14	14
Spring Creek CC	-	19	19	-	31	31
Wildwood CC	-	40	40	-	28	28
Wildwood Pretrial	2	16	18	1	11	12
Yukon-Kuskokwim CC	-	5	5	-	-	-
Total	*34*	*228*	*262*	*60*	*198*	*258*
Out-of-State Institutions						
Red Rock CC - Arizona	-	36	36	-	47	47
Federal Bureau Prisons	-	-	-	-	2	2
Total	-	*36*	*36*	-	*49*	*49*
CRC's						
Akeela House	-	-	-	1	-	1
Clitheroe Center	-	3	3	2	2	4
Cordova Center	9	19	28	5	3	8
Glacier Manor	4	10	14	2	4	6
Glennwood Center	1	13	14	4	9	13
Midtown Center	-	7	7	-	-	-
North Star Center	1	19	20	1	6	7
Parkview Center	-	20	20	-	6	6
Seaside Center	5	6	11	-	5	5
Tundra Center	-	6	6	-	-	-
Total	*20*	*103*	*123*	*15*	*35*	*50*
Special Offsite Programs						
Anchorage Electronic Monitoring	13	41	54	3	11	14
Anchorage CRC Monitoring	-	1	1	-	-	-
Fairbanks Electronic Monitoring	1	9	10	1	2	3
Total	*14*	*51*	*65*	*4*	*13*	*17*
Total All	**68**	**418**	**486**	**79**	**295**	**374**

3972

Demographic Information for Substance Abuse Offenders
December 31, 2008

	Alcohol			Drugs		
Ethnicity	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Asian/Pacific Island	1	10	11	2	8	10
Black	2	20	22	6	56	62
Caucasian	35	254	289	59	189	248
Hispanic	2	11	13	0	6	6
Alaska Native	26	123	149	12	34	46
Unknown	2	0	2	0	2	2
Total	**68**	**418**	**486**	**79**	**295**	**374**
Age Group (Years)						
19 and Under	5	7	12	2	1	3
20 - 24	7	40	47	10	42	52
25 - 29	14	58	72	13	79	92
30 - 34	11	55	66	10	46	56
35 - 39	12	48	60	9	25	34
40 - 44	4	86	90	15	30	45
45 - 49	6	60	66	17	39	56
50 - 54	5	38	43	2	20	22
55 - 59	4	18	22	1	9	10
60 - 64	-	5	5	-	3	3
65 and over	-	3	3	-	1	1
Total	**68**	**418**	**486**	**79**	**295**	**374**
Mean Age	***34.88***	***38.91***	***38.35***	***36.81***	***35.59***	***35.85***
Median Age	***33.31***	***40.17***	***38.76***	***37.76***	***33.01***	***33.73***
Length of time from admission						
6 months or less	50	257	307	40	119	159
7 months - 12 months	10	66	76	15	64	79
13 months - 24 months	8	73	81	13	48	61
25 months 36 months	-	17	17	6	36	42
37 months or more	-	5	5	5	28	33
Total	**68**	**418**	**486**	**79**	**295**	**374**
Mean Length (months)	***4.35***	***7.19***	***6.80***	***10.60***	***14.88***	***13.97***
Median Length (months)	***1.50***	***4.00***	***3.00***	***6.00***	***10.00***	***9.00***

3973

Offense Classifications of Substance Abuse Offenders
December 31, 2008

Alcohol

Offense Level	Female	Male	Total	Pct
Felony	39	291	330	67.9%
Misdemeanor	25	123	148	30.5%
Violation	4	4	8	1.6%
Total	**68**	**418**	**486**	**100.0%**
Offenses				
Attempted Furnish Liquor to Minor	-	1	1	
Drinking in Public	-	2	2	
Driving While Intoxicated	23	108	131	
Drunk Person on Licenses Premises	-	2	2	
Felony DWI - 2+ Priors w/in 5 Yrs	37	264	301	
Felony Refusal of Chem Test- 2+ Priors	-	14	14	
Furnish Alcohol to Minor	-	7	7	
License or Permit Required	-	2	2	
Manuf/Sell Alcohol w/o lic	-	2	2	
Manufacture, Sell, Offer for Sale	-	2	2	
Minor Consuming/Possessing Alcohol	5	8	13	
Persons Under 21 on Alcohol Premises	-	1	1	
Prohibition of Importation after Election	2	2	4	
Refuse to Submit to Chem Test	-	3	3	
Send/Bring Alcohol to Dry Area - Lg Amt	1	0	1	
Total	**68**	**418**	**486**	

Drugs

Offense Level	Female	Male	Total	Pct
Felony	76	291	367	98.1%
Misdemeanor	3	4	7	1.9%
Total	**79**	**295**	**374**	**100.0%**
Offenses				
Attempted MICS 2	3	18	21	
Attempted MICS 3	-	3	3	
Attempted MICS 4	1	0	1	
Misconduct - Controlled Substance 1	1	5	6	
Misconduct -Controlled Substance 2	12	69	81	
Misconduct - Controlled Substance 3	17	64	81	
Misconduct - Controlled Substance 4	44	132	176	
Misconduct - Controlled Substance 5	1	3	3	
Misconduct - Controlled Substance 6	-	1	1	
Total	**79**	**295**	**374**	

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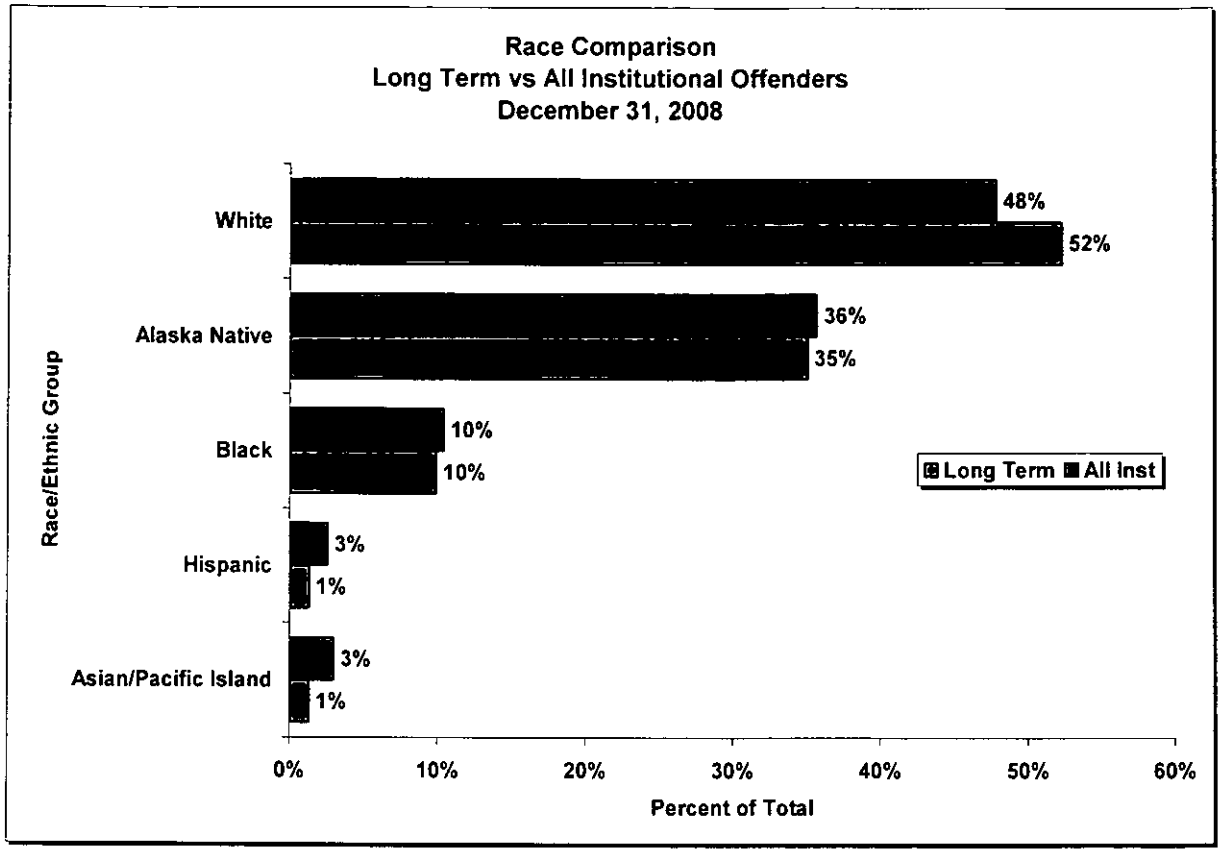
Long Term Offenders

Notes:
Includes information about all offenders in the OTIS database who have been in continuous DOC cutody for ten (10) years or more.
Alaska Native race category includes a small number of Native Americans not indigenous to Alaska.

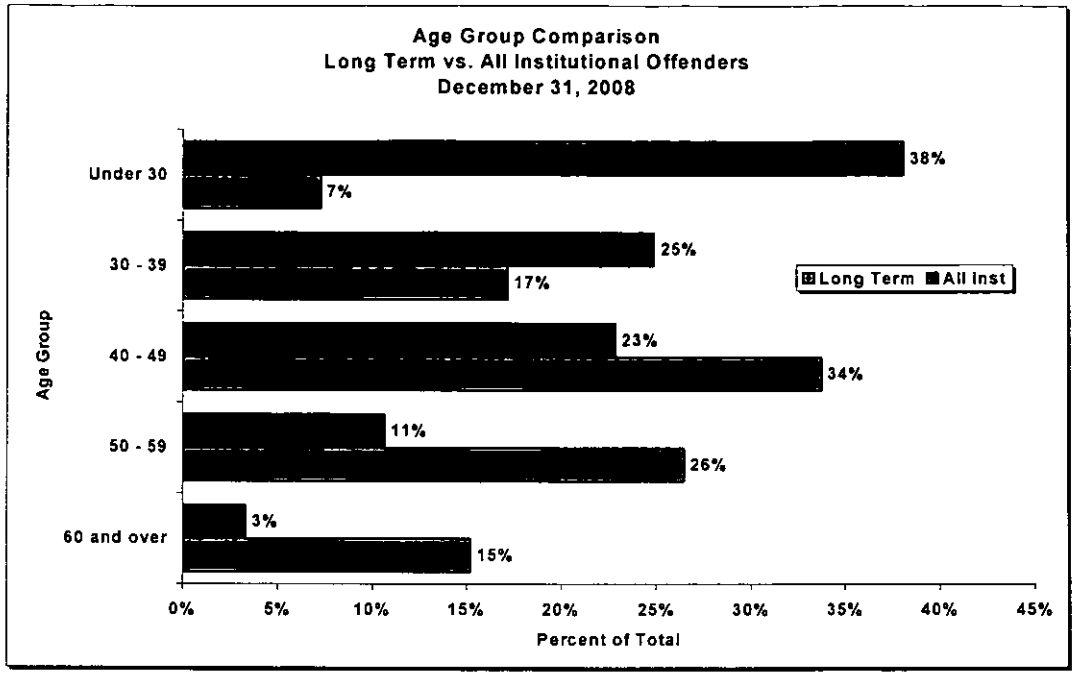
3975



Distribution of Long Term Offenders
December 31, 2008

In-State Institutions	Female	Male	Total
Anchorage CCE	1	2	3
Anchorage CCW	-	1	1
Hiland Mountain CC	9	-	9
Lemon Creek CC	-	1	1
Palmer Minimum CC	-	3	3
Palmer Medium CC	-	3	3
Pt. MacKenzie CF	-	2	2
Spring Creek CC	-	48	48
Wildwood CC	-	2	2
Total	*10*	*62*	*72*
Out-of-State Institutions			
Red Rock CC - Arizona	-	73	73
Federal Bureau of Prisons	1	3	4
Total	*1*	*76*	*77*
CRC's			
Glennwood Center	-	2	2
Total	-	*2*	*2*
Total All	**11**	**140**	**151**

3976



Demographic Information for Long Term Offenders
December 31, 2008

	Female	Male	Total
Ethnicity			
Asian/Pacific Island	-	2	2
Black	1	14	15
Caucasian	6	73	79
Hispanic	-	2	2
Alaska Native	4	49	53
Total	**11**	**140**	**151**
Age Group (Years)			
19 and Under	-	-	-
20 - 24	-	-	-
25 - 29	-	11	11
30 - 34	1	8	9
35 - 39	3	14	17
40 - 44	2	14	16
45 - 49	4	31	35
50 - 54	-	26	26
55 - 59	-	14	14
60 - 64	-	14	14
65 and over	1	8	9
Total	**11**	**140**	**151**
Mean Years	***45.03***	***48.12***	***47.90***
Median Years	***43.89***	***48.35***	***47.95***

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Length of time from admission (years)			
10 to 14	9	61	70
15 to 19	-	31	31
20 to 24	1	26	27
25 and over	1	22	23
Total	**11**	**140**	**151**
Mean Years	***13.26***	***17.55***	***17.24***
Median Years	***11.00***	***16.29***	***15.50***

Offense Classifications of Long Term Offenders
December 31, 2008

Offense Level	Female	Male	Total	Pct
Felony	11	140	151	100%
Total	**11**	**140**	**151**	**100%**
Person				
Attempted Assault 1	-	1	1	
Attempted Murder 1	-	8	8	
Kidnapping	-	6	6	
Murder 1	5	66	71	
Murder 2	6	37	43	
Robbery 1	-	3	3	
Total	**11**	**121**	**132**	**87%**
Public Order/Administration				
Tampering w/ Physical Evidence	-	1	1	
Total	**-**	**1**	**1**	**1%**
Registerable Sex Offenses				
Attempted Sex Abuse 1	-	1	1	
Sex Abuse Minor 1	-	2	2	
Sex Abuse Minor 2	-	3	3	
Sex Assault 1	-	12	12	
Total	**-**	**18**	**18**	**12%**
Total All	**11**	**140**	**151**	**100%**

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Probation and Parole

Notes:
Includes information about all probationers and parolees under the supervision of the Division of Probation and Parole who are entered into the OTIS database.
Consists of a snapshot of probationers and parolees entered into the OTIS database on or before December 31, 2008.
Alaska Native race category includes a small number of Native Americans not indigenous to Alaska.

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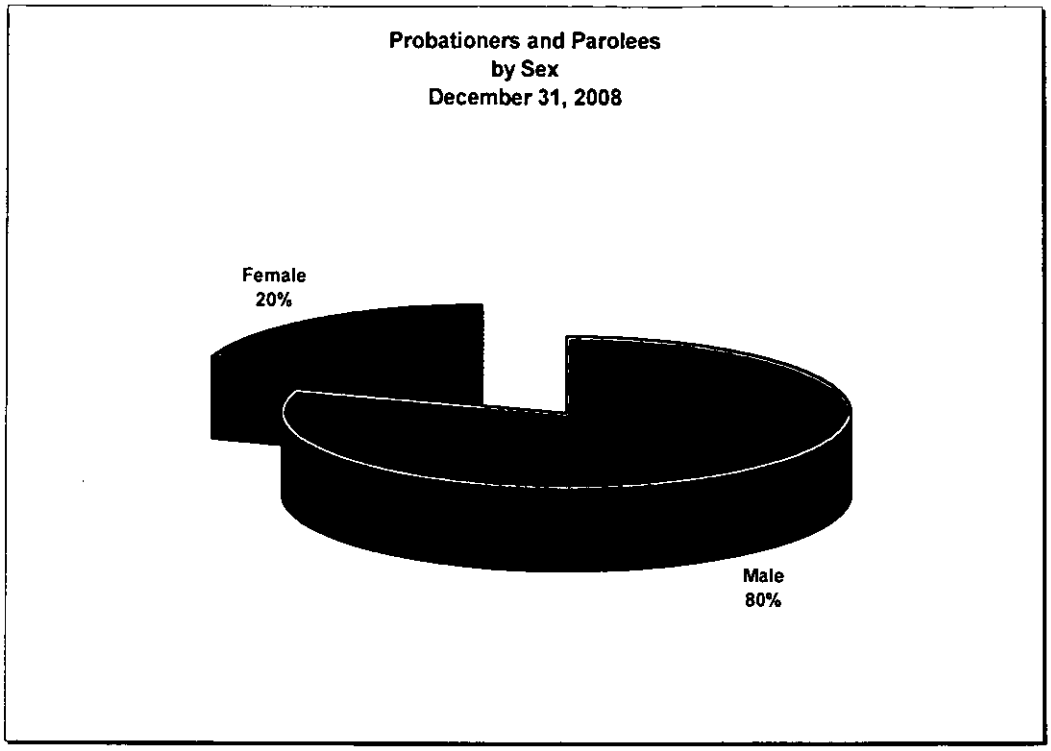

Supervising Authority for Probationers/Parolees Under Supervision on December 31, 2004-2008

	Females					Males					All				
Offices	**08**	**07**	**06**	**05**	**04**	**08**	**07**	**06**	**05**	**04**	**08**	**07**	**06**	**05**	**04**
Anchorage	557	480	473	463	458	2,189	2,075	1,966	1,923	1,828	2,746	2,555	2,439	2,386	2,286
Barrow	10	7	4	6	8	33	34	41	45	64	43	41	45	51	72
Bethel	19	15	23	27	27	213	212	232	261	236	232	227	255	288	263
Dillingham	12	8	10	5	1	82	68	71	64	60	94	76	81	69	61
Fairbanks	127	154	145	134	130	564	538	592	557	553	691	692	737	691	683
Juneau	55	47	52	55	53	203	214	235	221	205	258	261	287	276	258
Kenai	112	127	98	75	62	404	470	384	308	262	516	597	482	383	324
Ketchikan	40	32	31	24	29	106	110	118	123	139	146	142	149	147	168
Kodiak	15	15	15	20	24	85	89	86	69	68	100	104	101	89	92
Kotzebue	13	21	26	22	13	71	78	101	99	91	84	99	127	121	104
Nome	9	12	13	8	14	48	65	66	58	89	57	77	79	66	103
Palmer	173	157	132	110	114	600	564	470	408	425	773	721	602	518	539
Sitka	13	19	21	27	25	60	63	59	68	62	73	82	80	95	87
Total All	**1,155**	**1,094**	**1043**	**976**	**958**	**4,658**	**4,580**	**4,421**	**4,204**	**4,082**	**5,813**	**5,674**	**5,464**	**5,180**	**5,040**

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Demographic Information for Probationers/Parolees Under Supervision on December 31, 2004-2008

	Females					Males					All				
Ethnicity	**08**	**07**	**06**	**05**	**04**	**08**	**07**	**06**	**05**	**04**	**08**	**07**	**06**	**05**	**04**
Asian/Pac Is	44	37	35	31	31	187	185	153	142	129	231	222	188	173	160
Black	78	64	69	70	76	440	417	408	388	386	518	481	477	458	462
Hispanic	21	19	14	12	13	138	138	138	122	105	159	157	152	134	118
AK Native	282	273	273	256	241	1,198	1,173	1,200	1,216	1,213	1,480	1,446	1,473	1,472	1,454
White	698	669	623	566	550	2,640	2,604	2,466	2,269	2,189	3,338	3,273	3,089	2,835	2,739
Unknown	32	32	29	41	47	55	63	56	67	60	87	95	85	108	107
Total	**1,155**	**1,094**	**1043**	**976**	**958**	**4,658**	**4,580**	**4,421**	**4,204**	**4,082**	**5,813**	**5,674**	**5,464**	**5,180**	**5,040**
Age Group															
19 & Under	15	14	18	15	12	73	89	98	106	101	88	103	116	121	113
20-24	194	193	176	149	142	808	775	795	783	773	1,002	968	971	932	915
25-29	205	179	175	156	148	861	859	713	679	615	1,066	1,038	888	835	763
30-34	169	168	161	166	160	597	590	577	547	561	766	758	738	713	721
35-39	173	146	152	141	128	563	548	575	540	548	736	694	727	681	676
40-44	129	149	130	131	154	560	545	569	543	549	689	694	699	674	703
45-49	131	123	117	115	110	455	468	494	483	456	586	591	611	598	566
50-54	91	75	65	55	60	348	342	289	252	241	439	417	354	307	301
55-59	30	26	25	29	28	211	209	163	138	128	241	235	188	167	156
60-64	10	16	16	14	11	99	81	77	79	59	109	97	93	93	70
65 & over	8	5	8	5	5	83	74	71	54	51	91	79	79	59	56
Total	**1,155**	**1,094**	**1043**	**976**	**958**	**4,658**	**4,580**	**4,421**	**4,204**	**4,082**	**5,813**	**5,674**	**5,464**	**5,180**	**5,040**
Mean Age	***36.08***					***36.83***					***36.68***				
Median Age	***34.79***					***34.85***					***34.82***				

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CRITICAL CONDITION

AFRICAN-AMERICAN YOUTH IN THE JUSTICE SYSTEM

Foreword by

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FOREWORD

By Hilary O. Shelton, Washington Bureau Director, NAACP

Recent events in Jena, Louisiana, have brought attention to critical issues facing the African-American community including the issues of racial disparities in the justice system, trying children in adult court, and the heinous practice of placing children in adult jails and prisons. The "Jena Six" cases captured the nation's attention when six teens faced overly aggressive prosecution and extended incarceration for fighting with a white classmate after a series of racial incidents that included the hanging of nooses in a tree at the local high school. One defendant, Mychal Bell, was jailed in an adult facility for nine months before being initially freed. Thousands converged in Jena on September 20, 2007 to demonstrate their outrage and as of this writing, the Jena Six are still being processed in the criminal justice system.

Unfortunately, the Jena Six cases are not isolated incidents but reflect larger system failures by the justice system. It is difficult for any American of conscience to say with conviction that our current legal system is operating with the creed "equal justice under the law." Shameful stories of disparate treatment from across the country prompted the NAACP to declare a national "State of Emergency" that requires immediate action by local and state authorities as well as the U.S. Department of Justice and the U.S. Congress.[1] This policy brief renews that call to action by presenting the latest data on African-American youth in the justice system.

It is well documented that African-American youth are treated more harshly by the justice system than white youth, for the same offenses, at all stages in the justice system. The National Council on Crime and Delinquency recognized that African-American youth face a "cumulative disadvantage" in the justice system (where the disparities grow deeper as a youth penetrates the justice system) in their landmark 2000 report, *And Justice for Some*, updated and reissued in 2007.[2] Disparities start at the beginning, when a decision is made to arrest a child or let him or her go with a warning: African-American youth make up 30% of those arrested while they only represent 17% of the overall youth population.[3] At the other extreme end of the system, African-American youth are 62% of the youth prosecuted in the adult criminal system, and are nine times more likely than white youth to receive an adult prison sentence.[4]

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There is no simple answer to the question of why African-American youth are being treated so poorly, and so unequally. Racial profiling, targeting patrols in certain low-income neighborhoods, and racial bias within the justice system all contribute to the stark disparities confirmed in this policy brief. However, the disparity in treatment between African-American youth and white youth by the court system is both a civil rights and racial justice issue that cannot continue to go unaddressed. It has been two decades since Congress first recognized these disparities through the Juvenile Justice and Delinquency Prevention Act (JJDPA). On this twentieth anniversary, we need a long-term commitment from the U.S. Congress and from the Administration that adequate resources will be provided to eradicate these inequities and ensure that "justice and equality" are not just empty words.

The decision to transfer youth to the adult criminal system – the most disparate point in the justice system – is really a decision about whether a youth is "redeemable" and should be rehabilitated by the juvenile justice system, or considered "unsalvageable" and prosecuted in the adult criminal system forever to be branded with an adult court conviction. As this brief shows, African-American youth have been disproportionately deemed unsalvageable by federal and state laws.

The NAACP opposes any policies, statutes, or laws that increase the number of youth transferred to the adult criminal justice system and the number of youth held in adult jails and prisons. Our organization's policy in opposition to the transfer of youth to the adult criminal justice system is included with this brief demonstrating our commitment to changes in federal and state law and practice. We are committed to working with other civil rights and children's rights organizations to try to put an end to all of the practices that result in the disparities in how children are treated when they become involved with the justice system.

We need to address these grave concerns now, in a coordinated effort that recognizes the seriousness of the problem and that our collective future is threatened. We must put ourselves in the shoes of our children, the ones who have been prosecuted as adults, placed in an adult jail or prison, children with adult convictions, whose future has effectively been abandoned by our system. The status of our children in the justice system is in critical condition. We must do better.

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- **"Overrepresentation"** exists when, at various stages of the justice system, the proportion of a certain population exceeds its proportion in the general population.
- **"Disparity"** refers to a situation in which different groups have different probabilities that certain outcomes will occur. Disparity may in turn lead to overrepresentation.
- **"Discrimination"** refers to differential decision-making among juvenile justice professionals affecting different groups of youth based on their gender, racial, and/or ethnic identity.

I. OVERVIEW

The juvenile justice system was originally enacted for the very purpose of separating youth from adult criminals; however, during the 1980s and 1990s every state except Nebraska enacted "get tough" juvenile policies making it easier to try youth as adults by: lowering the age at which juveniles can be prosecuted as adults; greatly expanding the categories of crimes for which youth are automatically prosecuted in criminal court; giving prosecutors the exclusive authority to decide which juveniles are charged as adults; and limiting the discretion of judges to overturn decisions by prosecutors and law enforcement officials.[5] As a result of these laws, thousands of African-American youth are prosecuted in the adult criminal justice system every year.

There are three primary ways children are sent to adult court (see Figure 1). Forty-six states have *judicial waiver*, the traditional path to the adult system wherein a juvenile court judge makes a decision to transfer a youth's case to adult court after considering several factors (e.g., age, offense, services available in the juvenile system).[6] In contrast to a judicial decisionmaker, the *prosecutorial discretion* transfer mechanism (also known as direct file) allows the prosecutor a choice between filing the case in juvenile or adult court, usually depending on cases that meet certain offense or offender criteria. Fifteen states

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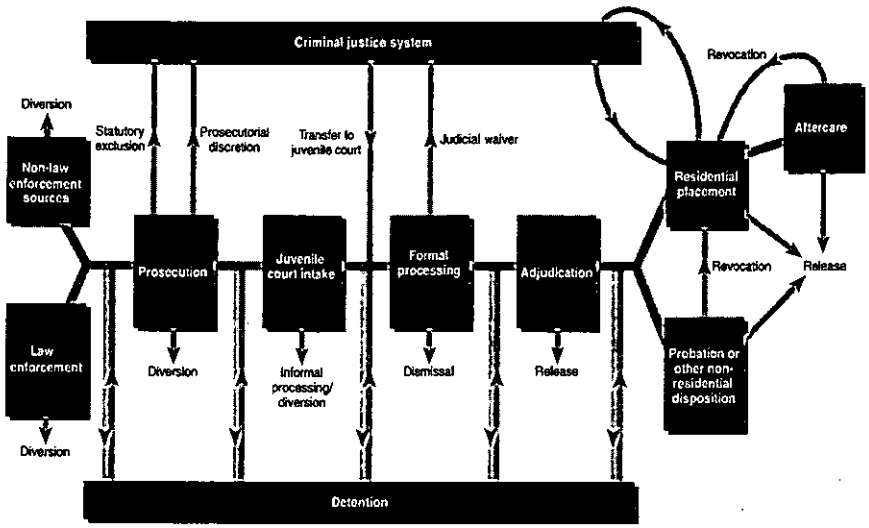
grant prosecutors full discretion to decide whether certain cases will be tried in the adult system.[7] Finally, *statutory exclusion* (also known as automatic waiver or legislative waiver) provisions expressly prohibit the juvenile court from hearing certain types of cases. For example, thirteen states currently require all youth ages 16 or 17 (depending on the state) to be tried in the adult criminal system regardless of how minor the offense.[8] Twenty-nine states have mandatory transfer policies for certain violent offenses.[9] Thirty-four states have "once an adult, always an adult" provisions requiring that youth who have been tried or convicted as adults be prosecuted in the adult system for any subsequent offense.[10]

FIGURE 1: JUSTICE SYSTEM CASE PROCESSING[11]



When youth are prosecuted in the adult system, they are deprived of rehabilitative opportunities including education, mental health services, and other age-appropriate services that make it more likely that the youth will become a law-abiding productive citizen. In addition, youth prosecuted in the adult system can be held in adult jails and prisons where they are at great risk of assault, abuse, and suicide. Since enactment of these laws, new research has called into question the efficacy of these laws.

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In 2007, the U.S. Centers for Disease Control and Prevention's Task Force on Community Preventive Services found that youth who are tried as adults are, on average, 34% more likely to commit crimes than youth retained in the juvenile justice system. The Task Force also found that transfer to the adult criminal justice system typically increases rather than decreases rates of violence among transferred youth. As a result, the Task Force recommended against "laws or policies facilitating the transfer of juveniles from the juvenile to the adult judicial system."[12]

In August 2008, the Office of Juvenile Justice and Delinquency Prevention, the federal agency dedicated to juvenile justice issues at the U.S. Department of Justice, released, *Juvenile Transfer Laws: An Effective Deterrent to Delinquency?*, a bulletin finding that laws making it easier to transfer youth to the adult criminal court system have little or no general deterrent effect on crime (i.e., transfer laws do not prevent youth from engaging in criminal behavior). On the contrary, youth transferred to the adult system are more likely to be rearrested and to reoffend than youth who committed similar crimes, but were retained in the juvenile justice system. According to the bulletin, higher recidivism rates are due to a number of factors including:

- Stigmatization/negative labeling effects of being labeled as a convicted felon;
- Sense of resentment and injustice about being tried as an adult;
- Learning of criminal mores and behavior while incarcerated with adults;
- Decreased access to rehabilitation and family support in the adult system; and
- Decreased employment and community integration opportunities due to a felony conviction.[13]

With clear evidence that transfer laws do not protect public safety and are harmful to youth, this policy brief examines the racial disparities in the adult system and is intended to serve as a resource for federal and state policymakers, juvenile justice professionals, and others interested in reforming state and federal laws. The brief begins with a discussion of demographics and disparities in education, health care, child welfare, and economic opportunity that contribute to delinquency and the cycle of incarceration that disproportionately affects the African-American community. Second, this brief examines the self-reported criminal behaviors of African-American and white youth,

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and compares them to more traditional criminal justice statistics to show that African-American youth are not disproportionately committing crimes to justify the current disparities. Third, this brief takes an in-depth look at the disproportionate treatment that African-American youth receive at all major decision points in the justice system. Fourth, this brief looks at national initiatives aimed at reducing disparities and highlights recent law and policy changes that are helping African-American youth. Finally, the brief concludes with a series of recommendations for federal and state policymakers to address the pervasive racial disparities in the juvenile and adult criminal justice systems and minimize the negative impact of transfer laws on African-American youth.

II. DEMOGRAPHICS

Approximately 38 million African-American[i] people live in the United States, comprising 13% of the total population.[14] Black people live in every state of the country, and the states with the highest African-American populations are southern states and states with large urban centers (see Tables 1 and 2). In 2006, the vast majority (89%) of African Americans lived in urban settings, compared to 73% of whites.[15] Similarly, 90% of poor blacks live in urban areas.[16]

The African-American population is relatively young: 41% percent of African-Americans are under age 25, versus 34% of the total U.S. population. There are 5,325,000 African-American youth ages 10 to 17 in the United States, making up 16% of that age group overall.[17]

[i] The terms "African American" and "black" are used interchangeably. The terms "youth of color" or"minority youth" refer to black, Latino, Asian and Native-American youth.

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TABLE 1. AFRICAN-AMERICAN POPULATION, 2006[18]

Top 10 Highest Proportion States			
State	Number	Percentage of State Population that is African American.	Percentage of National African American Population
District of Columbia	329,000	57%	1%
Mississippi	1,081,000	37	3
Louisiana	1,358,000	32	4
Georgia	2,800,000	30	7
Maryland	1,657,000	30	4
South Carolina	1,253,000	29	3
Alabama	1,212,000	26	3
North Carolina	1,921,000	22	5
Delaware	178,000	21	0
Virginia	1,520,000	20	4

TABLE 2. AFRICAN-AMERICAN POPULATION, 2006[19]

Top 10 Highest Population States			
State	Number	Percentage of State Population that is African American	Percentage of National African American Population
New York	3,353,000	17%	9%
Florida	2,864,000	16	7
Texas	2,805,000	12	7
Georgia	2,800,000	30	7
California	2,445,000	7	6
Illinois	1,928,000	15	5
North Carolina	1,921,000	22	5
Maryland	1,657,000	30	4
Virginia	1,520,000	20	4
Michigan	1,444,000	14	4

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III. RISK AND PROTECTIVE FACTORS

Too many African-American youth are exposed to risk factors known to be common precursors to delinquency, including poverty, unemployment, school failure, unstable families, and neighborhoods plagued by violence. While the statistics below highlight the magnitude of disadvantage threatening the development of black children, it is important to remember that the majority of black youth are not involved with the juvenile or criminal justice systems. Sometimes these startling statistics may inadvertently reinforce stereotypes that African-American youth, particularly poor urban black boys, are prone to violence and criminal activity simply because they are considered "at risk."

Poverty. One in three African-American children under age 18 (35%) was living in poverty in 2007, more than three times the proportion of white youth (10%).[20] While the poverty status of African-American youth has improved dramatically since 1992, when nearly half (47%) of all black children were in poverty, poverty rates have not fallen fast enough.[21] Recent data have shown that poverty rates have not declined since 2001.[22]

Both the juvenile and adult justice systems disproportionately affect people with low incomes. Not only are poor youth more vulnerable to contact with law enforcement, but their families are less likely to be able to afford legal representation to protect them from penetrating further into the system. White youth are twice as likely as African-American youth to be able to retain private counsel. African-American youth whose families disproportionately have limited income are often provided indigent defense by lawyers who carry high case loads with meager resources.[23]

Families and the Impact of Incarceration. While many children are successfully raised by single parents and extended families, research shows that youth living without both parents are at increased risk for delinquency.[24] In 2006, 65% of African-American children under age 18 were not living with both parents, versus only 26% of white children.[25] Mass-incarceration has significant consequences for children and families in the African-American community. An estimated 1.7 million children had parents who were incarcerated in federal or state

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prison in 2007. Black children were seven and a half times more likely than white children to have a parent in prison.[26] Recent estimates are that 20% of all black children have a father with an incarceration history.[27] In 2006, one in every nine black men ages 20 to 34 was incarcerated, along with one out of every 100 black women ages 35 to 39.[28] If these trends continue, one in three black males born today can expect to spend time in prison during his lifetime.[29]

Education. There is a strong relationship between the education a child receives and his or her future life success. Negative educational outcomes, such as dropping out, being suspended, or being expelled increase the likelihood that youth will have contact with the juvenile or criminal justice system. Students who are suspended are more than twice as likely to be incarcerated than students who have never been suspended.[30] African-American youth are disproportionately suspended and expelled: in 2003, in grades K through 12, 20% of black students were suspended and 5% were expelled, compared to 9% and 1%, respectively, for white students.[31]

Dropping out of school triples the likelihood that a person will be arrested.[32] Without a high-school diploma or GED, youth transitioning into adulthood have significant difficulties obtaining employment or further education. Three-quarters of white students, but only half of black students, graduate from high school after four years.[33] In many of the nation's large urban districts, graduation rates for black youth are even lower (30% to 40% range).[34] Research demonstrates that increasing high school graduation rates would decrease violent crime by 20% and drug and property crimes by more than 10%. Economists have calculated that each black male who graduates from high school is associated with a savings to the criminal justice system of more than $55,000 (the estimate accounts for the expense of trials, sentencing, and incarceration).[35]

There are some signs of improvement in the education of African Americans. Black elementary school students have made significant improvements in test scores,[36] and black high school students participate in after-school activities at the same rate as white students.[37] African-American enrollment in undergraduate degree-granting institutions has also increased by 40% in the past decade.[38] In fact, blacks in 2007 made up 13% of the fall enrollment in degree-granting undergraduate institutions, about equal to their proportion of the total pop-

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ulation.[39] With the increasing value of a college degree on the job market, high post-secondary enrollment is a promising sign.

Employment: The lack of employment opportunities for both young African Americans and their parents substantially increases the risk of exposure to the justice system by encouraging participation in the illicit economy. In 2006, half of African-American children lived in a family in which no parent had full-time, year-round employment, versus only one-quarter of white children who lived in the same kind of family.[40] Eleven percent of African-American youth and young adults were unemployed in the years 2005 to 2007, almost twice the percentage of unemployed whites (6%) in that age group.[41]

Criminal justice system involvement also dramatically limits employment opportunities. Most states allow employers to deny jobs to anyone with a criminal record. In fact, in most states employers can deny jobs to people who were arrested but never convicted of a crime.[42] One study of employers found that more than 60% of employers probably would not hire an applicant with a criminal record.[43] Another study found that having a criminal record led to a 50% reduction in employment opportunities for white applicants, and a 64% reduction for African-American applicants.[44] Employers in a growing number of professions, including home health care, nursing, education, eyeglass dispensing, plumbing, and even barbering, are barred by state licensing agencies from hiring people with a wide range of criminal convictions, even convictions that are unrelated to the job or license sought.[45]

Health. The health disparities that begin before birth and continue throughout the lifespan for African Americans may also be linked to delinquency. African-American mothers often fail to receive adequate prenatal care, which resulted in 2005 a black infant mortality rate that was more than twice the rate for white children.[46] Black children are also at higher risk of exposure to environmental toxins which compromise proper development and impair cognitive functioning. From 2001 to 2004, black children ages 1 to 5 were more than twice as likely as white children in this age group to have elevated blood lead levels.[47] Many black children also have inadequate access to the health services they need either because they lack health insurance, or because their coverage is not sufficient. Twelve percent of African-American children (versus 7% of white children) did not have health

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insurance in 2007.[48] HIV poses a severe problem in the African-American community, especially for youth. In 33 states studied by the Centers for Disease Control and Prevention in 2006, black youth accounted for 70% of new HIV/AIDS cases diagnosed among adolescents ages 13 to 19.[49]

Despite longstanding health disparities between whites and African Americans, some indicators have shown improvement for African-American youth. Between 1991 and 2005, the birth rate for black teenagers ages 15 to 17 dropped 60% (from 86 to 35 per 1,000 females).[50] According to 2005 data, the child-death rate and the teen-death rate have also both fallen since 1999.[51]

School and Community Safety. Community supports are instrumental in helping African-American youth overcome significant challenges and avoid justice system involvement. Many African-American children live in unsafe communities or attend schools where parents fear for their children's safety. A 2003 national survey of parents of black children found that 32% did not feel that they lived in a supportive neighborhood, versus only 13% of parents of white children who felt this way. Thirty-one percent of African-American parents, versus only 8% of white parents, believed their child is never or only sometimes safe in their community or neighborhood.[52]

Even though there are no significant differences in the proportions of black and white students who report being threatened or injured with a weapon on school property, African-American youth and parents are more afraid of violence in their schools.[53] According to the 2005 National Crime Victimization Survey, 9% of African-American students and 4% of white students reported they were afraid of being attacked at school.[54] One-quarter of parents of African-American children believe that their child is never or only sometimes safe at school, as opposed to 6% of white parents.[55]

Gangs. Gang violence has garnered much attention in recent years even though estimates from law enforcement suggest that no more than 1% of all youth ages 10 to 17 are gang members.[56] In a 2005 survey of students ages 12 to 18, 37% of African Americans reported that gangs were present at their schools, versus only 17% of white students.[57] Self-report surveys conducted from 1997 to 2001 find that 12% of African Americans reported gang membership, versus 7% of

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whites.[58] Law enforcement estimates find greater racial discrepancies in gang membership than measures that directly survey youth. According to the 2004 National Youth Gang Survey, law enforcement agencies estimate that 37% of gang members are African American, as opposed to 8% white.[59] U.S. Sentencing Commission data from 2003 to 2006 also show that gang-related crime laws are disproportionately applied to minorities. Between 60% to 75% of individuals convicted under current gang-related statutes are minorities, even though minority groups only make up 33% of the general U.S. population.[60]

Part of the difficulty in addressing gang violence is that current research and policy solutions often fail to distinguish between serious gang behaviors and the minor, fleeting involvement characteristic of most gang members. In fact, the majority of youth "age out" of gang-related activities. Research demonstrates that half to two-thirds of gang members are affiliated for one year or less and are not members "for life."[61] Overly reactive and punitive responses to gang membership, such as gang databases or mandatory sentencing laws, may actually increase the likelihood that a youth remains in a gang. According to a 2007 report from the Justice Policy Institute, increased arrests and longer sentences actually create more cohesive and stronger gang identification.[62]

Victimization. Research has shown that childhood exposure to violence leads to an increased risk of being arrested for violent crime.[63] Being abused or neglected as a child increases the likelihood of arrest as a juvenile by 59%, as an adult by 28%, and for a violent crime by 30%.[64] African-American youth are almost twice as likely as white youth to be the victims of child maltreatment.[65] Black children make up 15% of the child population but 23% of child maltreatment victims[66] and 32% of the foster care population.[67] In addition to high rates of child abuse, African-American youth ages 16 to 19 are more likely than blacks of any other age group to be victims of violent crime. They are more than twice as likely as white youth in the same age group to be the victims of serious violent crimes including rape, sexual assault, robbery, and aggravated assault.[68] Black youth are nearly 15 times more likely than are white youth to die from homicide.[69] In fact, homicides accounted for 25% of deaths of African-Americans ages 10 to 17, the second leading cause of death for that age group in 2005.[70]

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IV. CRIMINAL ACTIVITY REPORTED BY AFRICAN-AMERICAN YOUTH

Self-report surveys help answer the question of whether African-American youth commit more crimes than white youth. Traditional criminal and delinquency statistics (e.g., arrest rates or court processing data) tell us only how government agencies respond to youth who have been arrested or brought to the attention of the authorities. To the extent that other factors or biases influence outcomes in the juvenile justice system, the official data may be open to multiple interpretations.[71] For example, an increase in juvenile arrest rates for drug-abuse violations may reflect increasing drug use, greater police monitoring, changing laws and policies, or a combination of factors. In contrast, self-report data (participants anonymously report on their own experiences and actions) reveal behavior that is never reported or detected by law enforcement and is more likely to reflect actual levels of criminal activity. Recognizing the importance of self-report data, the Centers for Disease Control and Prevention has surveyed the nation's youth since 1991 using the National Youth Risk Behavior Surveillance System (YRBSS). [72]

Drug and Alcohol Use. According to the 2007 YRBSS survey, African-American youth report lower rates than white youth of most drug- and alcohol-related behavior (see Table 3). These results have been largely consistent since 1991, when the YRBSS began.[73] The finding of lower rates of drug use for black youth has also been replicated in other self-report studies.[74] This finding has especially important implications because of the disproportionate rate at which African Americans are arrested and detained for drug violations, discussed in the following section.

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TABLE 3. SELF-REPORTED DRUG- AND ALCOHOL-RELATED RISK BEHAVIOR, 2007[75]

Risk Behavior	Black Students (%)	White Students (%)
Lifetime alcohol use (had at least one drink of alcohol during their life)	69	76
Episodic heavy drinking (had five or more drinks of alcohol within a couple of hours on at least one occasion during the last 30 days)	13	30
Lifetime cigarette use (ever tried cigarette smoking, even one or two puffs)	50	50
Lifetime marijuana use (used marijuana one or more times during their life)	40	38
Lifetime cocaine use (used any form of cocaine, including powder, crack, or freebase one or more times during their life)	2	7
Lifetime inhalant use (sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during their life)	9	14
Lifetime hallucinogenic drug use (used hallucinogenic drugs such as LSD, acid, PCP, angel dust, mescaline, or mushrooms one or more times during their life)	2	9
Lifetime methamphetamine use (used methamphetamines [also called speed, crystal, crank, or ice] one or more times during their life)	2	5
Lifetime ecstasy use (used ecstasy [also called MDMA] one or more times during their life)	4	6

Note: Shaded boxes are statistically significant differences based on t-test analyses, $p < .05$.

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TABLE 4. SELF-REPORTED VIOLENT AND DELINQUENT BEHAVIOR OF SECONDARY SCHOOL STUDENTS, 2007[76]

Risk Behavior	Black Students (%)	White Students (%)
In a physical fight (one or more times during the past 12 months)	45	32
Carried a weapon (for example, a gun, knife, or club during the past 30 days)	17	18
Carried a weapon on school property (for example, a gun, knife, or club during the past 30 days)	6	5
Carried a gun (during the past 30 days)	6	4

Note: Shaded boxes are statistically significant differences based on t-test analyses, $p < .05$.

TABLE 5. LIFETIME PREVALENCE OF SELF-REPORTED VIOLENT AND DELINQUENT BEHAVIOR BY AGE 17, 1997-2001[77]

Risk Behavior	Black Students (%)	White Students (%)
Vandalism (damaged or purposely destroyed property that did not belong to you)	33	39
Theft of less than $50	38	44
Theft of more than $50	15	12
Drug selling (ever sold or helped sell marijuana, hashish, or other hard drugs such as heroin, cocaine, or LSD)	13	17
Assault (attacked someone with the idea of seriously hurting them)	36	25
Carry a handgun	15	16
Runaway (left home, at least overnight, without parents permission)	18	21

Note: Shaded boxes are statistically significant differences based on t-test analyses, $p < .05$.

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Violent and Delinquent Behavior. According to the YRBSS survey and another self-report survey, the National Longitudinal Survey of Youth (NLSY) conducted by the U.S. Bureau of Labor Statistics, racial discrepancies exist in offending and these differences vary by offense (see Tables 4 and 5). In both surveys, African-American youth report that they are more likely than white youth to commit assault and be involved in serious physical altercations. However, white youth report that they are more likely to commit drug infractions, including both use and distribution, than are black youth. Black and white youth are equally likely to report carrying weapons, findings that have been largely consistent since the YRBSS began in 1991.[78]

The self-report data indicate that African-American youth are not disproportionately committing crimes or engaging in delinquent behavior to warrant the disparities currently seen in the justice system. In fact, with the exception of assaults and thefts of more than $50, white youth consistently report engaging in more criminal behavior than black youth.

V. DISPARITIES IN THE JUVENILE JUSTICE SYSTEM

Congress first recognized the vast disparities in treatment between African-American and white youth in 1988 when the federal Juvenile Justice and Delinquency Prevention Act (JJDPA) required states to address the disproportionate confinement of minority youth (i.e., when the proportion of a minority group's youth in a state's secure facilities exceeded their proportion in the population) in their State plans. Four years later, Congress elevated the issue to a "core requirement" of the Act, meaning that federal funding eligibility was tied to compliance. In 2002, Congress broadened the requirement from a focus on disproportionate minority "confinement" to disproportionate minority "contact" with any part of the juvenile justice system. The "DMC" requirement now requires that states address disparities at each contact point (i.e., decisions to arrest, detain, charge, sentence, etc.) to maintain compliance with the law. Despite twenty years of explicit acknowledgement of the problem and some progress in specific jurisdictions, African-American youth continue to be overrepresented at most stages in the justice system.[79]

As African-American youth are disproportionately arrested compared to their proportion of the overall population, they are overrepresented at most stages of case processing.[80] This overrepresentation persists in further stages of the system regardless of how they are treated at other points in case processing. To identify precisely which justice system contact points contain disparities, a new tool, the Relative

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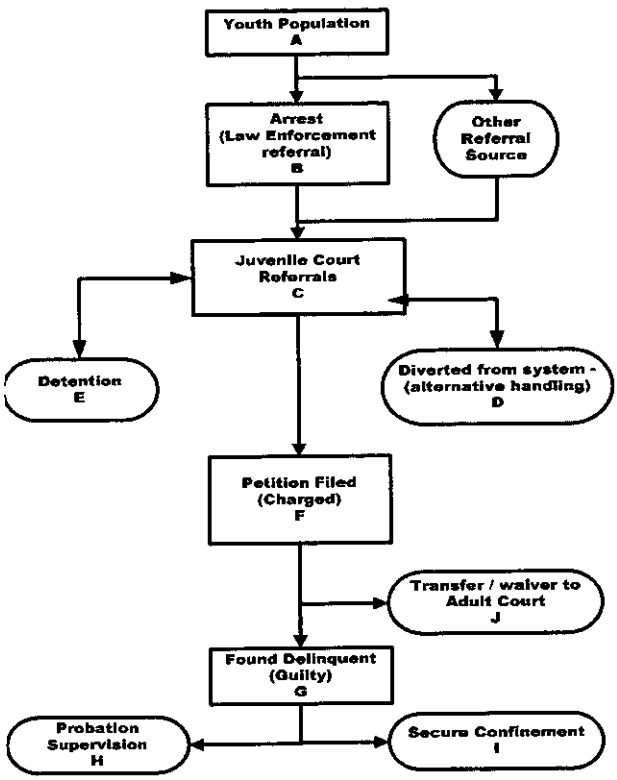
Rate Index (RRI) was developed. The Relative Rate Index measures disparities at each of the contact points where DMC may occur in the juvenile justice system (see Figure 2). Since youth prosecuted in the adult system via prosecutorial or statutory waivers don't have contact with the juvenile court, data is currently not available at the national level for those types of transfer mechanisms.

FIGURE 2: RELATIONSHIP OF DATA ELEMENTS FOR RELATIVE RATE INDEX CALCULATIONS[81]



The RRI "controls" for the disparities at arrest or other points in the system by comparing what happens at a particular decision point to the rates at the previous point in the system. For example, the RRIs for arrests are based on the differences in rates between points B and A, and the RRIs for whether a youth is adjudicated delinquent are based on the differences in rates between points G and F. An RRI that is greater than 1 indicates that black youth are more likely than white

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youth to be at that contact point; an RRI of less than 1 indicates that black youth are less likely than white youth to be at that contact point. Table 6 contains the absolute rates for African-American and white youth at each point of contact, as well as the RRI (shaded column) comparing the two groups. African-American youth are more than twice as likely to be arrested as white youth. After referral, white youth are 50% more likely than African-American youth to be diverted before adjudication, and African-American youth are 40% more likely than white youth to be detained before adjudication.

TABLE 6. RATES AND RELATIVE RATE INDICES (RRIS) FOR ALL DELINQUENCY OFFENSES, 2005[82]

Rate	All	White	Black	Black / White RRI
Juvenile arrests per 1,000 persons in population	56.2	49.1	101	2.1
Cases referred per 100 juvenile arrests	88.8	84.3	98.5	1.2
Cases diverted per 100 cases referred	26.6	29.6	20.7	0.7
Cases detained per 100 cases referred	21.7	19.3	26.5	1.4
Cases petitioned per 100 cases referred	55.5	52.2	61.9	1.2
Cases adjudicated per 100 cases petitioned	66	68.4	61.7	0.9
Probation cases per 100 adjudicated cases	60.9	63.1	56.5	0.9
Placement cases per 100 adjudicated cases	22.4	20.7	25.5	1.2
Cases judicially waived per 100 cases petitioned	0.8	0.7	0.8	1.1

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The disparities in treatment are exacerbated when considering specific offenses (see Table 7). The disparities are greatest in arrest rates for person offenses, for which African Americans are nearly four times more likely than whites to be arrested. For property and drug offenses, black youth are twice as likely to be arrested. The disparities in detention, diversion, and waiver to the adult court are greatest for drug offenses. White youth are twice as likely as black youth to be diverted before adjudication for a drug offense. African-American youth are more than twice as likely as white youth to be detained pre-adjudication for a drug offense. In addition, African Americans are 40% more likely than whites to be waived to adult court for a drug offense.[83]

TABLE 7. AFRICAN AMERICAN RELATIVE RATE INDICES BY OFFENSE CATEGORY, 2005[84]

RELATIVE RATES: Black	Total Delinquency Offenses	Person Offenses	Property Offenses	Drug Law Violations	Public Order Offenses
Arrest rate	2.1	3.6	1.9	2.0	1.7
Referral rate	1.2	0.9	1.1	0.8	1.5
Diversion rate	0.7	0.7	0.7	0.5	0.8
Detention rate	1.4	1.1	1.4	2.1	1.3
Petitioned rate	1.2	1.2	1.2	1.4	1.1
Adjudicated rate	0.9	0.9	0.9	0.9	0.9
Probation rate	0.9	0.9	0.9	0.8	0.9
Placement rate	1.2	1.2	1.2	2.0	1.1
Waiver rate	1.1	1.2	0.6	1.4	0.7

Note: Person offenses include, but are not limited to, homicide, assault, rape, and robbery. Property offenses include burglary, theft, and arson. Drug offenses include trafficking and possession. Public order offenses include weapons possession offenses.

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Compared to the self-report data discussed previously, the findings in Table 7 strongly suggest the presence of biases in the juvenile justice system's treatment of African-American youth. Whereas the self-report data suggest that African-American youth are roughly 40% more likely to be involved in a physical fight or assault, they are over 300% more likely to be arrested for aggravated assault and other assaults.[85] Even though white youth are more likely to report using drugs and 30% more likely to report selling drugs, African-American youth are more than twice as likely to be arrested and detained for drug offenses.[86]

Arrest Rates. After a peak in juvenile arrests in the mid 1990s, the juvenile arrest rate for all youth has remained near a 25-year low according to 2006 data.[87] However, while the arrest rate for white youth decreased 9% from 2001 to 2006, the arrest rate for black youth increased by 7% during this same this time period.[88] From 2001 to 2006, arrest rates of black youth increased 50% for robbery; almost 40% for curfew, loitering, and weapons violations; and almost 30% for disorderly conduct.[89] Although African-American youth were 17% of the population in 2005, they represented 30% of children arrested in the U.S.[90] In fact, the overall RRI for arrests of African-American youth in 2006 remained at the highest point in a decade.[91]

Most African-American youth are arrested for nonviolent crimes (see Table 8). The five most common offenses for which African-American youth are arrested are "other" assaults (i.e., not aggravated assaults), disorderly conduct, larceny-theft, drug abuse violations, and curfew and loitering laws. With the exception of alcohol-related offenses, black youth are disproportionately arrested for every offense.

TABLE 8. JUVENILE ARREST RATES BY RACE, 2006[92]

Offense, sorted by highest rate	Black (per 100,000 youth ages 10-17)	White (per 100,000 youth ages 10-17)	Relative Rate Index (RRI)
Total including suspicion	12179	5773	2.1
Other assaults	1753	566	3.1
Disorderly conduct	1524	469	3.3
Larceny-theft	1502	735	2.0
Drug abuse violations	1069	519	2.1
Curfew and loitering law violations	1054	369	2.9
Runaways	519	304	1.7
Burglary	477	214	2.2
Aggravated assault	463	131	3.5
Robbery	436	43	10.2
Vandalism	407	358	1.1
Weapons carrying, possessing, etc.	316	112	2.8
Motor vehicle theft	272	72	3.8
Liquor laws	124	495	0.2
Arson	27	25	1.1
Drunkenness	24	57	0.4
Forcible rape	21	8	2.5
Murder and nonnegligent manslaughter	14	2	7.0
Driving under the influence	13	71	0.2

Referral. Once a youth is arrested, law enforcement officers make the decision about whether to refer the case to juvenile court or divert the case out of the court system. Youth can also be referred to juvenile

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court by means other than arrest, such as through schools, social services, or family members. After arrest, African-American youth are 20% more likely than white youth to be referred to juvenile court.

At least for drug and person offenses, the overrepresentation of African-American youth at the stage of arrest seems to be slightly corrected at the referral stage. According to the RRIs from 2005, black youth arrested for drug and person offense arrests were less likely than white youth to be referred to court, suggesting that many black youth were unnecessarily arrested for their offenses. In contrast, black youth were 50% more likely than white youth to be referred for a public order offense, and 6% more likely to be referred for property offenses.[93]

Juvenile court intake. After referral to juvenile court, a youth's case may be dismissed, handled informally, or a petition may be filed in the juvenile court for formal intervention. A large proportion of juvenile cases are handled informally (44% in 2004),[94] in which case they may be dismissed if the youth consents to and complies with a set of conditions. After referral, African-American youth were 20% more likely to have their cases petitioned to the juvenile court for formal handling. Another way of looking at the data is that in 2005, white youth were nearly 50% more likely to have their case diverted to an alternative program than were African-American youth. The disparity in cases petitioned was greatest for drug law violations, for which African Americans were 40% more likely to be petitioned, and whites were twice as likely as blacks to have their drug cases diverted.[95]

Detention. Many youth are detained while waiting for trial, in both secure detention facilities and non-secure placements like group homes. When youth are detained, their lives are interrupted. According to the Justice Policy Institute report, *The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities:*

> [Youth] can spend anywhere from a few days to a few months in locked custody. At best, detained youth are physically and emotionally separated from the families and communities who are the most invested in their recovery and success. Often,

> detained youth are housed in overcrowded, understaffed facilities—an environment that conspires to breed neglect and violence. [In addition,] detention has a profoundly negative impact on young people's mental and physical well-being, their education, and their employment. One psychologist found that for one-third of incarcerated youth diagnosed with depression, the onset of the depression occurred after they began their incarceration, and another suggests that poor mental health, and the conditions of confinement together conspire to make it more likely that incarcerated teens will engage in suicide and self-harm... the experience of detention may make it more likely that youth will continue to engage in delinquent behavior, and that the detention experience may increase the odds that youth will recidivate, further compromising public safety.[96]

African-American youth in 2005 were 40% more likely than white youth to be detained after arrest.[97] The disparity was greatest for drug law violations, for which African Americans were more than twice as likely to be detained.[98] As a result of these disparities, in many detention centers across the country the majority of youth locked up are African American. Nationally, African-American youth comprised 43% of youth detained in detention centers in 2006.[99]

African Americans are overrepresented in the number of youth detained in detention centers in every offense category: black youth make up 60% of the youth detained for drug trafficking, 43% of those detained for non-trafficking drug offenses, 44% of those detained for theft, 53% of those detained for weapons possession, and 34% of those detained for status offenses (youth such as runaways and truants whose activities would not be illegal but for their age).[100] One-third of the African-American females detained in detention centers in 2006 were held for technical violations or status offenses.[101]

There is evidence to suggest that many youth are unnecessarily detained before trial. In 2004, of African-American youth who were

detained, only 20% were placed in juvenile facilities following their adjudication, while 26% were released, 33% were given probation, and 19% were treated with other penalties such as fines, restitution, or community service.[102]

As the majority of African-American youth are detained for nonviolent offenses, it is likely that they could be better served with community-based services or other alternatives to detention.

Adjudication. A juvenile court "adjudication" is analogous to an adult court "conviction." In both cases a hearing is held to determine whether the person committed the alleged offense. In 2005, African Americans were slightly less likely than whites to be found guilty (have their cases adjudicated delinquent) once petitioned (RRI 0.9).[103] This holds almost equally across all offense categories. Based on these RRIs, it appears that the juvenile court hearing process does not exacerbate racial disparities, but may actually correct for disparities in previous stages. It may be that juvenile court judges at this stage are identifying youth who could have been more appropriately handled informally or diverted out of the juvenile justice system.

Youth Committed to Residential Placement. After a youth has been adjudicated (i.e., found guilty), the court develops a "disposition" (the equivalent to an adult court "sentence") to identify the necessary services and sanctions for the child to be rehabilitated. Possible dispositions for delinquent youth range from the most severe punishment of incarceration in a youth correctional facility to placement in other non-secure residential facilities such as group homes or treatment facilities, or lesser sanctions such as probation, fines, restitution, or community service. The vast majority of delinquency cases do not result in an incarceration sentence or out-of-home placement; only 10% of black adjudicated youth and 8% of white adjudicated youth are removed from their homes.[104] However, black youth are more likely to receive the harshest sentence, incarceration, after being found guilty. African-American youth are 23% more likely than white youth to be removed from home, and black youth are twice as likely to be removed from home for drug offenses.[105]

The majority of African-American youth who were placed outside of their homes (e.g., secure facility, residential treatment facility, or group home) were not being held for violent offenses. In 2006, more than

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60% of committed black youth had been found guilty of nonviolent offenses, including 24% committed for property offenses, 10% for drug offenses, 10% for public order offenses, 12% for technical violations, and 5% for status offenses. [106]

VI. DISPARITIES IN THE ADULT CRIMINAL JUSTICE SYSTEM

Although there is no national data system that collects data on youth transferred to the adult system, researchers estimate that as many as 200,000 youth are prosecuted as adults each year.[107] All available evidence indicates that African Americans are overrepresented in the population of youth tried as adults.

The only national data available on youth tried in the adult system is data on youth transferred to the adult system via judicial waiver. In 2005, 7,000 youth were transferred via judicial waivers, and 39% of these youth were African-American.[108] According to the 2005 RRIs, African-American youth were only 13% more likely than whites in 2005 to be waived to the adult court once petitioned (RRI 1.1). Black youth were much less likely than whites to be waived for property offenses (RRI 0.6) and public order offenses (RRI 0.7) and much more likely to be waived for drug law violations (RRI 1.4).[109] However, these RRIs significantly underestimate the racial disparities of youth transferred to the adult system because judicial waiver represents a very small portion of youth tried in the adult system.

In 2007, the Campaign for Youth Justice commissioned a study by Jolanta Juszkiewicz, Ph.D., to learn more about the characteristics of youth in the adult system. *To Punish a Few: Too Many Youth Caught in the Net of Adult Prosecution,* provides the most in-depth look at the issue of youth in the adult system through the lens of 40 jurisdictions from all the major regions of the country (West, Midwest, South, and Northeast) using the most recent available data from 1998.[110] The study analyzed data collected by the Bureau of Justice Statistics as part of the Juvenile Defendants in Criminal Courts, Survey of 40 Counties, 1998 (JDCC) program. The JDCC consisted of cases involving juveniles prosecuted for felony offenses in criminal courts in 40 large, urban jurisdictions. All the cases involving juveniles that were filed for felony offenses during calendar year 1998 in the state criminal courts were selected for the study. Please note that the study examined only felony cases, not misdemeanors, and did not include youth automatically transferred to the adult system via a reduced age of juvenile court jurisdiction. The key findings of *To Punish a Few* with respect to African-American youth are:

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Youth of color are disproportionately impacted by transfer policies. The overwhelming majority of cases (83%) that were filed in adult courts involved youth of color. African-American youth constituted 62% of the youth, and Latino youth were 19%. With the exception of two counties in the study, youth of color constituted between 60% and 100% of all youth prosecuted as adults in the 40 counties included in the study.

Most African-American youth do not receive the benefit of a juvenile court judge individually evaluating their case, but are transferred to the adult system via statutory exclusion or prosecutorial waiver mechanisms. Half (49.2%) of all cases involving African-American youth were filed in criminal court as a result of statutory exclusion. A third (31.9%) of cases were filed as a result of direct file/prosecutorial discretion. Only 18.9% were judicial waiver cases where a judge could make an individual decision after a hearing.

Many African-American youth tried in the adult system are not convicted, suggesting that cases brought against these youth are not very strong. More than 40% of all African-American youth prosecuted in adult court did not receive an adult court conviction (versus only 27.3% of white youth). A third of the youth (27.7%) were not convicted at all, and 12.7% were returned to juvenile court. In fact, African-American youth were more likely than other racial/ethnic groups to have their cases transferred back to juvenile court. This finding is disturbing because many youth will have been subject to detention in an adult facility, discussed below. In addition, African-American youth charged as a result of statutory exclusion laws or a direct file provision were much less likely to be convicted than youth transferred to adult court via judicial waiver (see Figure 3).

Similar to youth in the juvenile justice system, disparities vary by type of offense. Out of all youth cases in adult court, African-American youth accounted for 87% of those charged with drug offenses; 48% of those charged with property offenses; 59% of those charged with property offenses; and 63% of those charged with public order offenses.

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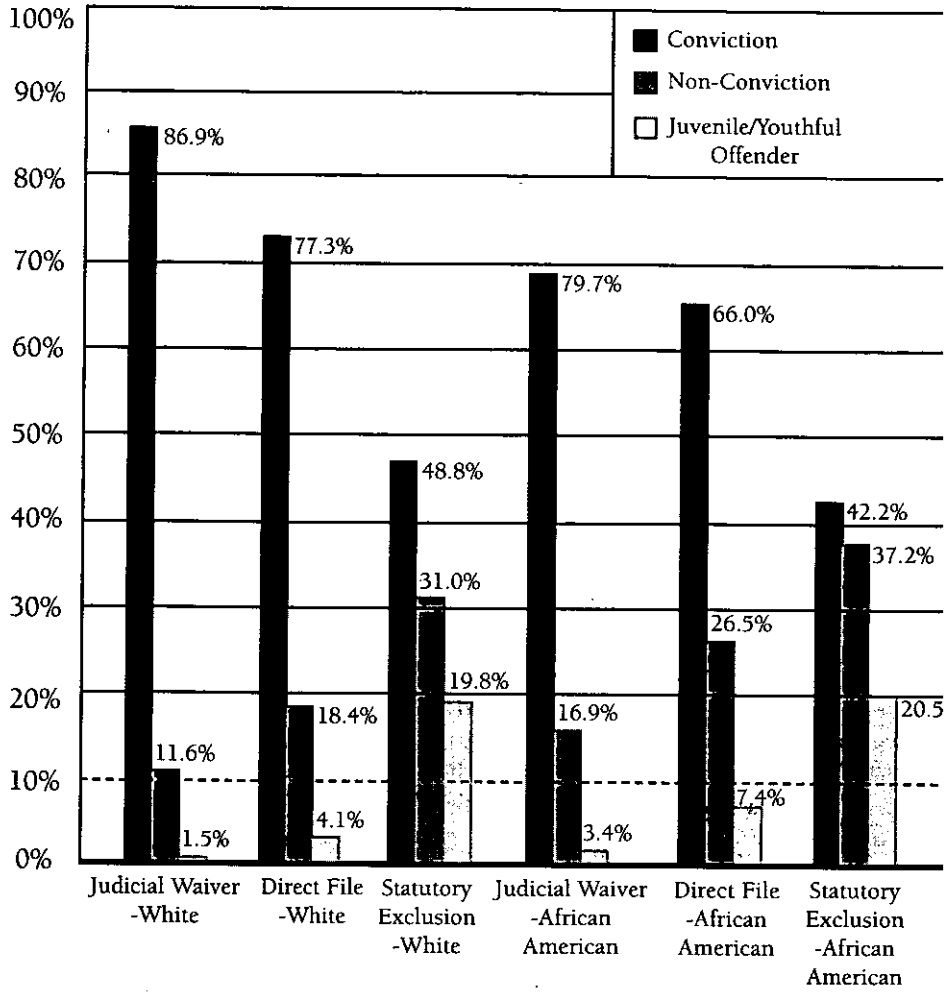
FIGURE 3: FINAL DISPOSITION BY FILING MECHANISM FOR AFRICAN-AMERICAN AND WHITE JUVENILE DEFENDANTS IN CRIMINAL COURTS, 1998



Drug cases were filed against African-American youth at nearly 5 times the rate of white youth. More than one-fifth (21.4%) of all African-American youth tried in adult court were charged with a drug offense, and one-quarter of these youth were charged with a drug offense that did not include sales or manufacturing (i.e., drug possession or possession of drug paraphernalia). More African-American youth charged with drug offenses were detained pretrial than white

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youth (86.2% of white youth with drug charges were released versus 65.8% of African-American youth).

Most youth prosecuted in the adult system are not serious violent offenders. A common misperception about youth transferred to the adult system is that the majority are charged with the most serious violent offenses of rape and murder. However, the top five offenses (75% of all cases) of African-American youth tried in adult court were for crimes that are regularly handled in juvenile courts: robbery (33.2%); assault (18.2%); drug sales/manufacture (16.1%); burglary (5.7%); and other drug offenses (5.3%).

African-American youth are routinely incarcerated in adult jails. Overall, a higher proportion of white youth were released pretrial (59.8%) than any other racial/ethnic categories. Only half (50.5%) of African-American youth were released pretrial. Of the African-American youth detained pretrial, 65.4% were held in adult jails and only 34.6% were held in juvenile facilities (72% of white youth were held in adult jails pretrial).

Most youth convicted in adult court do not receive an adult prison sentence, and most sentenced to adult prison are not convicted of a violent offense. The majority of African-American youth (55.5%) convicted in adult court do not receive an adult prison sentence. Of the African-American youth convicted in adult court, 44.5% received an adult prison sentence, 24.6% received probation, 16.6% were sentenced to jail, 10.3% received a juvenile sanction or bootcamp, and 4% were released for time served.

The majority of African-American youth (57.6%) sentenced to adult prison were not sentenced for a violent offense. Of the African-American youth sentenced to adult prison: 43.4% had a violent offense charge, 24.8% had a property offense charge; 12.5% had a drug offense charge; and 7.9% had a public order offense charge.

Racial disparities in youth serving time in adult prison. According to a report by the National Council on Crime and Delinquency, *And Justice for Some*, nearly three-quarters of youth admitted to adult prisons were youth of color in 2002 (the most recent data available). For every 10 youth admitted to adult prison, six were black youth. The rate of commitment to adult prison was more than nine times higher

for black youth than for white youth.[111] The five states with the highest prison commitment rates for African-American youth were Wisconsin (155 per 100,000), Oregon (143 per 100,000), South Carolina (101 per 100,000), North Carolina (101 per 100,000) and South Dakota (97 per 100,000).[112]

Racial disparities are also observed for youth serving life without parole sentences. According to a 2005 report by Human Rights Watch and Amnesty International, black youth are serving life without parole sentences at a rate that is ten times higher than white youth. African-American youth constitute 60% of the youth offenders serving life without parole sentences nationwide, compared with 29% of white youth.[113]

VII. PROMISING APPROACHES TO ADDRESSING DMC

Jurisdictions that have a commitment to reducing racial and ethnic disparities have demonstrated the ability to move toward more equitable treatment of youth of color as they move through and out of the justice system. Successful approaches to addressing DMC are targeted and tailored to the specific state, county, city or region; however, these approaches share some consistent commonalities including:

- *Strengthened leadership* through creation of DMC committees and focused state efforts on addressing the problem.
- *Collection and monitoring of state data* to improve states' ability to assess and address the root causes of DMC in their state.
- *Standardized and objective screening instruments* used by decision-makers, such as judges, to eliminate subtle stereotypes and biases.
- *Community-based prevention, intervention, and diversion* efforts to eliminate biases and encourage diversion of youth out of the juvenile justice system.
- *Community empowerment* by engaging communities at the local level to assist with DMC reduction activities.
- *Efforts to increase cultural sensitivity* (e.g., training) to make system stakeholders more sensitive to the needs of minority youth.
- *Legislative changes* to reduce the disparate impact of state laws. [114]

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Nationwide Initiatives to Reduce DMC

There are several nationwide efforts aimed at reducing disparities. For the past fifteen years, the Juvenile Detention Alternatives Initiative (JDAI), a project of the Annie E. Casey Foundation, has demonstrated that jurisdictions can safely reduce reliance on secure detention and generally strengthen their juvenile justice systems through a series of inter-related reform strategies. From the beginning, JDAI recognized that juvenile detention reform efforts must reflect the reality that minority youth bear the brunt of policies that lead to arrest, referral, detention, adjudication, and imprisonment of young people.[115] JDAI is now being replicated in over 80 jurisdictions across the country.

A key partner in the JDAI initiative is the W. Haywood Burns Institute, an organization working to reduce the overrepresentation of youth of color in juvenile justice systems since 2001.[116] The Burns Institute works with over 21 local jurisdictions across the country to reduce racial disparities in their juvenile justice systems by improving decision-making, court processes, and alternatives to incarceration. The Burns Institute provides technical assistance to jurisdictions prepared to implement institutional changes to remedy disparities. The Burns Institute engages traditional and non-traditional stakeholders in a data-driven examination of their policies and practices, followed by a remedial plan aimed at measurable results. A key component of reducing racial disparities is the use of effective, culturally-appropriate neighborhood-based programming that primarily serves communities of color.

The John D. and Catherine T. MacArthur Foundation began making grants in the field of juvenile justice in 1996. Since then, the foundation has launched Models for Change, an effort to create successful and replicable models of juvenile justice system reform through targeted investments in key states.[117] The Center for Children's Law and Policy's (CCLP) coordinates the DMC activities in each of the four Models for Change states (Illinois, Louisiana, Pennsylvania, and Washington).[118] CCLP staff work in Allegheny, Berks, and Philadelphia counties in Pennsylvania; on statewide policy in Illinois; in Jefferson and Rapides parishes in Louisiana; and in two counties and with state officials in Washington. In these sites, CCLP staff conduct quantitative and qualitative research to understand the racial and

ethnic disparities and learn how decisions are made at the local level, recommend interventions based on their analyses, and monitor the implementation of interventions. In addition, CCLP manages the DMC Action Network, a network of 12 sites across the country working to achieve sustainable reductions in racial and ethnic disparities in the juvenile justice system.

Reducing Racial Disparities without Compromising Public Safety in Illinois

In the early 1980s, Illinois was one of the first states to adopt a "tough on crime" approach by passing laws to automatically try youth in adult court for a range of offenses, including drug offenses. Illinois' drug transfer laws required that 15- and 16-year-olds be automatically tried as adults for drug offenses that occurred within 1,000 feet of schools or public housing. This automatic transfer provision prohibited judges from making individual determinations about whether children accused of certain drug offenses should remain in the juvenile justice system.

These policies subsequently proved to be racially biased as research demonstrated that of all youth transferred in 2003, 99% were minorities, and 92% were African-American. The overwhelming disproportionate impact on minority youth made the law "the most racially biased drug transfer law in the Nation."[119] Fueled by concern over the growing number of minority youth in adult court charged with nonviolent drug offenses, on August 12, 2005, Governor Blagojevich signed PA-94-0574 into law, repealing Illinois' nearly 20 year policy of automatically transferring youth charged with drug offenses to adult court.[120]

Nearly four years later, automatic transfers in Cook County have gone down by more than two-thirds without any corresponding increase in juvenile caseloads. The first year after PA 94-0574, the number of youth automatically transferred in Cook County went down by approximately two-thirds, from 361 in 2003 to 127 in 2005-2006. There was no corresponding increase in juvenile court petitions or judicial waivers to adult court. This same rate of reduction held steady in the second year, with the number of youth automatically transferred in Cook County declining again to 103 in 2006-2007 without a corresponding increase in juvenile court petitions or judicial waivers to adult court. The absence of any increase in juvenile

court caseloads after the law went into effect demonstrates that the rollback of Illinois' drug transfer law had no detrimental effect on public safety.[121]

Illinois was one of the first states to allow automatic transfer of youth, was one of the first to re-think its policies, and is now demonstrating that there are more fair and appropriate ways to treat youth who do not include transferring drug offenders to adult court. Illinois is continuing to reassess other aspects of their transfer policies as well. Legislation is pending in the Illinois Legislature to allow 17-year-olds facing misdemeanor charges to be returned to juvenile court jurisdiction. The legislation would also create a task force to review increasing the age of jurisdiction for youth charged with felonies.

Raising the Age of Juvenile Court Jurisdiction in Connecticut

Connecticut currently locks up more children in adult prisons than any other state in the nation. Approximately 425 youth are held in adult prisons in Connecticut each year. This is mainly because Connecticut is one of only three states that tries all 16- and 17-year-olds as adults – even those youth accused of minor and nonviolent offenses. Nearly 8,000 youth in Connecticut enter the adult court system each year, the vast majority for nonviolent crimes (96% of the 16- and 17-year-old youth arrested were charged with nonviolent crimes). The law has a disproportionate impact on youth of color. Although African-Americans represent only 13% of the youth population, more than 82% of youth held in adult corrections were youth of color. [122]

Deprived of the rehabilitative focus of the juvenile system, youth prosecuted in the adult system are denied appropriate services, given limited educational and employment opportunities, and exit the adult system with the stigma of a criminal conviction. In response to these concerns, two symbiotic efforts were started – a "Raise the Age CT" campaign coordinated by the Connecticut Juvenile Justice Alliance (CTJJA) and the Juvenile Jurisdiction Planning and Implementation Committee (JJPIC), a legislatively-mandated committee comprised of key stakeholders – were formed with the goal of raising the age of juvenile court jurisdiction in the state. The combined efforts of legislators, state agencies, law enforcement officials, judicial officers, advocacy and grassroots organizations, and parents and family members led the Connecticut state legislature to unanimously pass Public Act 07-4 in June 2007 returning 16- and 17-year-olds to juvenile court jurisdiction.[123]

4014

Although the law will not take effect until January 1, 2010, Connecticut has a strong plan for changing the policies that have negatively impacted African-American youth. The youth who will be returned to the juvenile justice system will have access to improved diversion programs, regional youth courts, and new services and supports to ensure that they are successful.

Dismantling the School to Prison Pipeline in Clayton County, Georgia

In 2003, community leaders in Clayton County, Georgia, voiced concerns about the numbers of children being sent to juvenile court by schools. Between 1993 and 2003, juvenile court referrals had jumped from about 200 to more than 1,100 each year largely as a result of school-based referrals. Even though serious school safety issues had not increased (felony referrals from schools were constant), school-based referrals were almost a quarter of all juvenile court referrals.

Troubled by these numbers, community leaders from schools, law enforcement, the juvenile court, the district attorney's office, child-serving programs, parents and other stakeholders came together in 2003 to explore ways to improve school safety and reduce referrals to court.

After several months, the group developed a collaborative agreement now referred to as the School Offense Protocol. This protocol zeros in on low-level misdemeanor offenses like disorderly conduct and affray, which had accounted for a majority of school referrals in Clayton County. For those offenses, the protocol establishes a system of graduated sanctions to standardize consequences for youth.

Everyone has seen tremendous gains from the School Offense Protocol. School Resource Officers (SROs) are no longer required to spend time arresting students for every minor infraction. As a result, school-based referrals of African Americans have been reduced by 46 percent.

An important lesson from Clayton County is that new sources of funding were not needed to reduce racial disparities, rather it required local leaders to come together and think about the best way to use existing resources more efficiently. Schools in Clayton County are not only safer places to learn as a result of the protocol, but now that fewer students are being referred to juvenile court, instructional time has increased and graduation rates are expected to improve as well.[124]

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VIII. POLICY RECOMMENDATIONS

To address the pervasive racial disparities in the juvenile and adult criminal justice system, and minimize the negative impact of transfer laws on African-American youth as documented in this policy brief, federal and state policymakers should take immediate action.

Congress should:

- Strengthen the "Disproportionate Minority Contact (DMC)" core requirement of the Juvenile Justice and Delinquency Prevention Act (JJDPA) by giving states specific guidance on action steps to reduce disparities such as identifying and analyzing key decision points to determine where disparities exist, collecting data, developing a work plan, and publicly reporting on progress.

- Close the loophole allowing youth charged as adults to be housed in adult jails. The "Jail Removal" and "Sight and Sound" core requirements of the JJDPA should be expanded to apply to youth who are charged in the adult system. In addition, states should be encouraged to house youth convicted in adult court in juvenile facilities, rather than adult prisons.

- Fully fund the JJDPA so that these recommendations can be effectively implemented by states.

- Invest in significant data collection efforts to identify and track youth prosecuted in the adult criminal system.

- Support proposals, including Representative Robert C. "Bobby" Scott's Youth PROMISE Act, that will effectively prevent crime before it occurs and provide intervention programs to redirect youth already involved with the juvenile or adult criminal justice systems toward law-abiding and productive futures.

- Repeal provisions of federal laws that make it more difficult for youth convicted in the adult system to reintegrate into the community successfully (e.g., limitations on the eligibility of financial aid for college, food stamps, or Medicaid).

- Oppose legislation that increases the transfer of youth to the adult criminal system.

- Oppose legislation that adds additional mandatory minimum sentences (e.g., gang enhancements).

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- Oppose legislation that increases the likelihood that youth will be incarcerated instead of receiving appropriate community-based treatment and services.

State Policymakers should:

- Reduce racial and ethnic disparities of youth tried in the adult criminal system in their state by identifying and bringing together stakeholders, collecting accurate and timely data, developing a work plan, and publicly reporting on progress.
- Immediately stop housing young people in adult jails and prisons.
- Increase the age of juvenile court jurisdiction to 18.
- Substantially reduce the prosecution of youth in adult court by providing judges with sole discretion to make the decision on whether or not to prosecute a youth in adult court.
- Invest in quality and effective legal counsel for youth.
- Redirect resources from incarceration to developmentally-appropriate and cost-effective treatment and services for youth.
- Reduce barriers to employment by sealing or expunging arrests that never led to conviction and conviction records after an appropriate period of time has lapsed.
- Repeal state laws (e.g., employment, voting, and other restrictions for people with criminal histories) that make it more difficult for youth convicted in the adult system to reintegrate into the community successfully.
- Enact laws that recognize a youth's ability to mature and be rehabilitated by permitting individualized reassessments of youth serving long sentences in the adult system (e.g., establishing a juvenile clemency board).

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NAACP Resolution*
Opposition to Transfer of Youth to the
Adult Criminal Justice System

WHEREAS the NAACP has previously resolved that prevention and rehabilitation are vital components of any juvenile justice policy, and that equal protection to youthful offenders be guaranteed under the law; and

WHEREAS youth of color receive more punitive treatment than their white peers for the same offenses at all stages of the justice system; and

WHEREAS African-American youth are disproportionately represented in cases transferred to adult court, representing 16% of the youth population but 35% of youth judicially transferred, and 58% of youth committed to state prison; and

WHEREAS, African-American youth are five times more likely than white youth to be charged in adult court for a drug offense; and

WHEREAS the adult criminal justice system is punitive and not rehabilitative by nature, resulting in youth being denied programming such as education, mental health treatment, and employment skills training which are essential to proper development; and

WHEREAS the historical role of the juvenile system is to rehabilitate and treat youthful offenders while holding them accountable and maintaining public safety, and it is therefore better equipped to work with youth than the adult criminal justice system; and

WHEREAS an average of 7,500 youth are held in adult jails each day in America, many of whom will be adjudicated back to the juvenile system or will not be convicted; and

WHEREAS there exists serious human rights concerns, as well as physical and emotional health concerns, for housing youth in adult jails as youth are 36 times more likely to commit suicide in an adult jail than in a juvenile detention facility, and youth comprise 21% of all substantiated victims of inmate-on-inmate sexual violence although they are only 1% of the jail population; and

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WHEREAS public safety is compromised, when youth transferred to the adult court are 34% more likely to reoffend than youth of a similar background and offense type treated in the juvenile system according to the federal Centers for Disease Control; and

WHEREAS the use of statutes or procedures that automatically exclude youth from the juvenile court without an assessment of individual circumstances by a judge denies youth basic fairness, and contradicts public opinions polls revealing that 92% of the U.S. public disagrees with such policies; and

WHEREAS the collateral consequences of an adult charge or conviction may cause youth to be denied opportunities to obtain education, employment, federal assistance, and voting rights, thereby creating further obstacles to rehabilitation.

THEREFORE, BE IT RESOLVED that the NAACP strongly opposes any policies, statutes, or laws that increase the number of youth transferred to the adult criminal justice system and the number of youth held in adult jails and prisons; and

THEREFORE, BE IT RESOLVED that the NAACP will work to end the practice of youth being tried in the adult criminal justice system and to ensure that young people are appropriately adjudicated in ways that enhance community rehabilitation, safety and stability; and

THEREFORE, BE IT RESOLVED that the NAACP strongly supports reforms that effectively reduce the overrepresentation and disparate treatment of African-American youth among youth who are prosecuted, detained, sentenced, and incarcerated as adults; and

THEREFORE BE IT FINALLY RESOLVED that the NAACP supports the creation and maintenance of programs and services that address the educational, health, mental health, and vocational needs of youth currently in and exiting from the juvenile and adult criminal justice systems.

*NAACP Resolution approved at the July 2008 National Convention.

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[104] Stahl, A., Finnegan, T., and Kang, W. (2007). "Easy Access to Juvenile Court Statistics: 1985-2004." Retrieved from: http://ojjdp.ncjrs.gov/ojstatbb/ezajcs/

[105] Puzzanchera, C. and Adams, B. (2008). National

Disproportionate Minority Contact Databook. Developed by the National Center for Juvenile Justice for the Office of Juvenile Justice and Delinquency Prevention. Retrieved from: http://ojjdp.ncjrs.gov/ojstatbb/dmcdb/

[106] Sickmund, M., Sladky, T.J., Kang, W., & Puzzanchera, C. (2008). "Easy Access to the Census of Juveniles in Residential Placement." Retrieved from: http://ojjdp.ncjrs.gov/ojstatbb/ezacjrp/

[107] Campaign for Youth Justice. (2007). *The Consequences Aren't Minor: The Impact of Trying Youth as Adults and Strategies for Reform.*

[108] Puzzanchera, C. and Adams, B. (2008). National Disproportionate Minority Contact Databook. Developed by the National Center for Juvenile Justice for the Office of Juvenile Justice and Delinquency Prevention. Retrieved from: http://ojjdp.ncjrs.gov/ojstatbb/dmcdb/

[109] Ibid.

[110] Juszkiewicz, J. (2007, October). *To Punish A Few: Too Many Youth Caught in the Net of Adult Prosecution.* Washington, D.C.: Campaign for Youth Justice.

[111] The National Council on Crime and Delinquency. (2007, January). *And Justice for Some: Differential Treatment of Youth of Color in the Justice System.*

[112] Ibid.

[113] Human Rights Watch. (2005). *The Rest of Their Lives: Life Without Parole for Child Offenders in the United States.*

[114] Office of Juvenile Justice and Delinquency Prevention. (2004, September). *Disproportionate Minority Confinement 2002 Update.*

[115] *See* Hynton Hoytt, E., et.al. (2001). Reducing Racial Disparities in Juvenile Detention. *Pathways to Juvenile Detention Reform, Volume 8.* The Annie E. Casey Foundation.

[116] *See* The W. Haywood Burns Institute website, www.burnsinstitute.org

[117] *See* The Models for Change website, http://www.modelsforchange.net/

[118] *See* The Center for Children's Law and Policy website,

http://www.cclp.org/

[119] Ziedenberg, Jason. (2002, May). *Drugs and Disparity: The Racial Impact of Illinois' Practice of Transferring Young Drug Offenders to Adult Court.* Washington, DC: Building Blocks for Youth.

[120] Illinois Juvenile Justice Initiative. (2008, June). *Changing Course: A Review of the First Two Years of Transfer Reform in Illinois.* John D. and Catherine T. MacArthur Foundation, Models for Change.

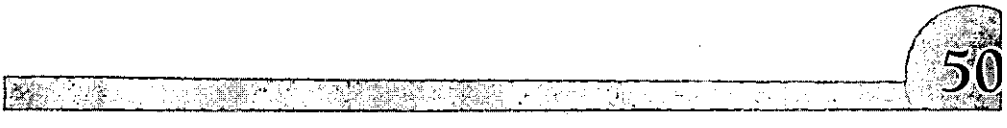
[121] Ibid.

[122] Arya, N., Augarten, I., & Rao, Y. (Forthcoming). *The Connecticut Success Story: Raising the Age of Juvenile Court Jurisdiction.* Washington, DC: Campaign for Youth Justice.

[123] It is important to note that the law raising the age of jurisdiction did not alter other transfer provisions. Therefore, 16 and 17 year-old offenders who have committed Class A or Class B felonies which are termed "seriously violent" offenses will continue to be automatically transferred to the adult criminal justice system and transferred back to the juvenile justice system based on decisions made by judges and prosecutors. Traffic offenses will also be excluded from juvenile court jurisdiction as well.

[124] Sherrod, M.L., Huff, B., & Teske. S. (2008, June 1). Childish Behavior, Criminal Behavior. *The Huntsville Times.:* and Juvenile Detention Alternatives Initiative. (2006, July). Clayton County reduces school-based referrals of African-American youth by 46%. *JDAI News: Newsletter of the Juvenile Detention Alternatives Initiative.* The Annie E. Casey Foundation.

4031


50

The Campaign for Youth Justice would like to gratefully acknowledge our funders who support our work, including the Annie E. Casey Foundation, the Chasdrew Fund, the Eckerd Family Foundation, the John D. and Catherine T. MacArthur Foundation, the Open Society Institute, the Public Welfare Foundation, and individual anonymous donors.

We would also like to thank the National Council on Crime and Delinquency, the Center for Children's Law and Policy, the W. Haywood Burns Institute, and all of the dedicated people and partners who worked on the Building Blocks for Youth Initiative, a multi-year initiative from 1999 to 2005, whose groundbreaking research and efforts to reduce racial disparities in the justice system paved the way for this policy brief.

4033

SB 70

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Labor and Commerce
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/30/09

Health and Social Services Committee considered SENATE BILL NO. 70

SB 70 NATUROPATHS

"An Act relating to naturopaths and to the practice of naturopathy; establishing an Alaska Naturopathic Medical Board; authorizing medical assistance program coverage of naturopathic services; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHSS	2/26/09	✓			1
DCCED	3/12/09	✓			2

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	✓			
	PASKVAN			X	
	THOMAS	✓			
CHAIR: Betty J. Davis	DAVIS	✓			

Alaska State Legislature

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716 W. 4th Ave
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Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
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Fax: (907) 465-3756
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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 70, 26-LS0354\A

"An Act relating to naturopaths and to the practice of naturopathy; establishing an Alaska Naturopathic Medical Board; authorizing medical assistance program coverage of naturopathic services; and providing for an effective date."

Sponsor Statement

Expanded naturopathic practice helps bridge the shortage of primary care physician in Alaska

SB 70 greatly expands the practice of naturopathy in Alaska to establish its own board; to perform minor surgery; and to administer prescription drugs, vaccinations, hormones, and medical devices that are on the formulary approved by the department under AS 08.45.005. While there are only about 40 practicing naturopaths in Alaska, they claim that their education and experience qualifies them at least partially to bridge the growing shortage of primary care physicians in Alaska. Naturopaths state that their basic science education is similar to that of allopathic and osteopathic physicians (MDs and ODs) and point out that they already deal with many of the same patients whom they must refer to MDs for prescriptions and minor surgery; and that nurse practitioners and physician assistants already may obtain prescription endorsements. Importantly, SB 70 would also allow naturopaths to bill Medicare for patient services.

Alaska State Medical Association has opposed expanded naturopathic practice

Allopathic and osteopathic physicians in Alaska have for years opposed the expansion of naturopathic practice into "non-natural" areas of medical practice reserved to licensed physicians, including surgery and prescriptive drugs. Suggestions in recent years to place naturopaths under the Alaska State Medical Board have failed, perhaps due lack of interest, or increased expense, supervision, and liability required on the part of MDs, as well as lack of required malpractice insurance on the part of naturopaths. Primary care physicians claim this is not a turf war, but rather, a matter of public safety. They claim that naturopathic training programs do not provide the breadth and depth of education compared to medical and osteopathic medical schools; that naturopaths do not have the supervised postgraduate residency training for patient care, adverse medical effects, drug interactions, and patient safety prior to being licensed to practice independently; that recertification and continuing medical education is not the norm in naturopathy. SB 70 attempts to address some of those concerns.

A new Alaska Naturopathic Board

For purposes of expanding allowed practices and procedures of naturopaths and regulating the practice of naturopathic medicine in Alaska, SB 70 establishes an Alaska Naturopathic Board to the list of boards and professions under the Department of Commerce, Community, and Economic Development. The board will consist of three naturopaths, one licensed pharmacist, and one public member who may be a licensed physician. The department at board request will issue licenses and prescription endorsements, and will have authority to investigate and to discipline as required.

Minor surgery and prescription endorsement

SB 70 greatly expands the practice of naturopathy to include minor surgery, operative, electrical, and other methods of repair to superficial lacerations and abrasion or lesions, and removal of foreign bodies in superficial tissues; and allows the use of antiseptics and local anesthetics in connection with allowed procedures. The law prohibits naturopaths from performing major surgery, plastic surgery, and spinal and general anesthetics.

Additionally, SB 70 allows for the first time the new naturopathic board to request that the department issue a prescription endorsement to a naturopath licensed under this chapter who has practiced for five years; who has submitted proof of 60 hours of pharmacology education from an approved program; and who has met other requirements relating to administration and prescription of drugs, vaccinations, hormones, and medical devices which the board considers necessary. The prescription endorsement must be renewed every two years with proof of 15 hours continuing education.

35 hrs (typo, pg 7.0)

Medicare reimbursement

SB 70 adds "naturopathic services" to the list of services under AS 47.07.030(b) to allow Medicare reimbursement under state law. Allowing reimbursement to naturopaths for Medicare patients who wish to use the services of a naturopath or cannot find an allopathic or osteopathic physician who takes Medicare patients should improve patient care and expand naturopathic practice.

Naturopathic practice in other states

now 15 states

Thirteen states which license naturopaths and have instituted formulary laws include Arizona, Connecticut, Hawaii, Idaho, Kansas, Maine, Montana, New Hampshire, Oregon, Utah, Vermont, and Washington. Currently there are about 40 naturopaths practicing in Alaska, 802 in Washington, 715 in Oregon, 375 in Arizona, 210 in Connecticut, 117 in Vermont, 85 in Hawaii, 67 in Montana, 57 in New Hampshire, 27 in Maine, 18 in Utah, 11 in Kansas, and 8 in Idaho. While the scope of practice of Naturopathic Doctors varies from state to state, almost all deal to some extent with prescribing drugs. Of the 13 other states that license naturopaths, 9 of those states allow naturopaths to prescribe independently without any MD supervision or protocol. Arizona, which has the broadest formulary in the nation, allows naturopaths to prescribe all but IV medications, controlled substances except morphine, cancer chemotherapeutics, and antipsychotic drugs. At the same time, by contrast to many other states, naturopaths in Arizona are licensed under the state medical board with several other layers of control to protect the public. Kansas, which instituted licensure in 2003, requires MD supervision, and Maine requires collaboration with a physician for one year prior to independent prescribing. Massachusetts, on the other hand, refused in 2002 to license naturopaths at all after a two year intensive task force investigation and comparison to standard medical practice in 2002.

Conclusion

At a time when Alaska is experiencing a growing shortage of primary care physicians, as is true all over the country, SB 70 provides naturopaths as alternative caregivers with professional training, experience, and interest the healing arts. Naturopathic doctors focus on preventative care and in keeping patients healthy, and they usually rely much less than MDs on the use of drugs. Naturopaths seek prescriptive authority, among other reasons, to reduce the amount and combination of drugs patients are currently taking. Patients often turn to naturopathic doctors when traditional medicine has failed. Naturopaths regularly refer cases to MDs and ODs when deemed necessary, and it is expected under SB 70's expanded practice that they would continue to use professional judgment when in doubt. There are very few reported incidences of malpractice among naturopaths, but at the same time, there has been less opportunity for error in limited naturopathic practice. SB 70 is designed to reasonably expand the services of naturopaths only to areas collateral to the needs of their daily practice without infringing on the duties and responsibilities of medical doctors and osteopaths licensed by the State Medical Board.

LEGAL SERVICES
DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
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MEMORANDUM February 2, 2009

SUBJECT: Sectional Summary of SB 70 (Work Order No. 26-LS0354\A)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Alpheus Bullard
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds the Alaska Naturopathic Board to the list of boards and professions to which AS 08.01 applies.

Section 2. Adds the Alaska Naturopathic Board (board) to a list of boards that may request that the Department of Commerce, Community, and Economic Development (department) provide assistance and treatment to the boards' licensees who abuse alcohol, drugs, or other substances.

Section 3. Adds new sections to AS 08.45 (Naturopaths).

Sec. 08.45.003. Provides for the establishment and organization of the Alaska Naturopathic Board.

Sec. 08.45.005. Provides the duties and powers of the board.

Section 4. Amends AS 08.45.030 to provide that the board shall request the department to issue a license to practice naturopathy to an applicant who has provided satisfactory proof of the applicant's educational qualifications and paid the applicable fees.

Section 5. Amends AS 08.45.035(a) to provide that the board shall request that the department, and that the department may, issue a temporary license to practice naturopathy to an applicant who has provided satisfactory proof to the board of the applicant's qualifications and paid the applicable fees.

Section 6. Adds a new section to AS 08.45 defining the scope of practice of naturopaths.

Section 7. Amends AS 08.45.050 (Restrictions on the practice of naturopathy) to (1) allow a licensed naturopath under AS 08.45.056 to be able to prescribe certain substances and engage in minor surgery authorized under AS 08.45.045 and (2) prohibit a naturopath from using general or spinal anesthetics and administer ionizing radioactive substances for therapeutic purposes.

Section 8. Adds new sections to AS 08.45 (Naturopaths).

Sec. 08.45.056. Establishes a "prescription endorsement" allowing certain naturopaths to prescribe and administer certain prescription drugs and medical devices.

Sec. 08.45.058. Provides continuing education requirements.

Section 9. Amends AS 08.45.100 to provide that both the department and the board shall adopt regulations to implement AS 08.45.

Section 10. Adds a new section that provides what fees may be charged by the department under AS 08.45.

Section 11. Provides new definitions for AS 08.45.

Section 12. Adds naturopaths to the list of licensees whose practices are not limited by the statutes applicable to pharmacists in AS 08.80, as long as the naturopath is acting within the scope of the license or endorsement under AS 08.45.

Section 13. Adds naturopathic services to the list of services that are eligible for Medicare reimbursement under state law.

Section 14. Provides a definition of naturopathic services for AS 47.07 (Medical Assistance for Needy Persons).

Section 15. Adds a provision to uncodified law allowing the department to adopt regulations necessary to implement the Act.

Section 16. Adds a provision to uncodified law that provides transitional provisions governing the terms of the first members of the Alaska Naturopathic board.

Section 17. Adds a provision to uncodified law that provides for treatment of naturopathic licensees licensed before the effective date of the Act.

Section 18. Gives an immediate effective date to sec. 13 so that the regulations process can start before the rest of the bill takes effect (90 days after becoming law).

Section 19. Provides that the Act, except as provided in sec. 15, will take effect July 1, 2009.

TLAB:ljw
09-054.ljw

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB070
() Publish Date:

Identifier (file name): SB070-DHSS-MAA-02-26-09
Dept. Affected: DHSS
Title: Naturopaths
RDU: Health Care Services
Component: Medical Assistance Administration
Sponsor: Davis
Requester: Senate HSS
Component Number: 242

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual	150.0						
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**150.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	150.0						
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**150.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation would require the Medicaid program to cover naturopathy services. The Department does not anticipate increased expenditures of Medicaid services as naturopathy services would largely replace other covered services, and any increase in total covered services would be offset by payment of naturopaths at a lower rate than physicians. However, there would be a one-time cost to make system changes to the MMIS, the Department's Medicaid claims processing system. The Department is in the process of replacing its existing MMIS with a new system. Because this change would be made to the old system prior to replacement, it would not be eligible for matching federal reimbursement.

Prepared by: William J. Streur, Deputy Commissioner
Phone 279-7827
Division: Health Care Services
Date/Time 2/11/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/26/2009
DHSS Finance & Management Services

(Revised 9/10/2008 OMB)

4042

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 70
() Publish Date:

Identifier (file name): SB70-CED-CBPL-03-12-09
Dept. Affected: DCCED
Title: NATUROPATHS
RDU: Corp, Bus, & Prof Licensing (117)
Component: Corp., Bus., & Prof. Licensing
Sponsor: Senator Davis
Requester: Senate HSS
Component Number: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	28.3	0.0	28.3	28.3	28.3	28.3	28.3
Travel	5.6	0.0	5.6	5.6	5.6	5.6	5.6
Contractual	2.0	0.0	2.0	2.0	2.0	2.0	2.0
Supplies	0.5	0.0	0.5	0.5	0.5	0.5	0.5
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**36.4**	**0.0**	**36.4**	**36.4**	**36.4**	**36.4**	**36.4**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (1156)	**36.4**	**0.0**	**0.0**	**72.8**	**0.0**	**72.8**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other: RSS (1156)	36.4	0.0	36.4	36.4	36.4	36.4	36.4
TOTAL	**36.4**	**0.0**	**36.4**	**36.4**	**36.4**	**36.4**	**36.4**

Estimate of any current year (FY2009) cost: 5.9

POSITIONS

Full-time							
Part-time	1	0	1	1	1	1	1
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation amends AS 08.45 to establish the Alaska Naturopathic Medical Board and expands the scope of practice of naturopaths to allow prescriptive authority through a prescription endorsement, authority to perform minor surgery, and to require proof of continuing education prior to license renewal.

The program is required to cover its costs with licensing fees under AS 08.01.065, and revenue generated by program fees must cover its full operating costs.

A detailed analysis of costs follows.

Prepared by: Jennifer Strickler, Chief
Division: Corporations, Business and Professional Licensing
Phone (907) 465-2144
Date/Time 3/12/09 4:01 PM

Approved by: Emil Notti, Commissioner
Commerce, Community and Economic Development
Date 3/12/2009

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB 70

ANALYSIS CONTINUATION

Total PERSONAL SERVICES: $28.3
- One (1) Part-time Occupational Licensing Examiner position, Range 13, to staff the Board. A position is needed to support Board activities by keeping the official records and providing administrative support to the Board and the licensing program. The current licensing program is supported by a position that is assigned ten of the non-board licensing programs. Adding requirements to that position in support a Board is not realistic.

Total TRAVEL: $5.6
- The legislation establishes the Alaska Naturopathic Medical Board consisting of 5 members. In accordance with Section 3 of the bill, AS 08.45.003(b) requires the Board to meet at least twice a year. The estimated travel costs for 5 members and 1 staff will cover two meetings, assuming one held in Anchorage and one held in Juneau.

Total CONTRACTUAL: $2.0
- Contractual costs include public notices of meetings, regulations, legal review of regulations, communications, and printing expenses.

Total SUPPLIES: $0.5
- Supplies consists of standard operating desk top supplies (paper, etc.).

REVENUE: Revenue will be generated from license and endorsement fees. A majority of the fees will be collected biennially resulting from the biennial licensing period. The bill is set to take effect immediately upon passage. Current naturopath licenses are due to expire on March 31, 2010.

Current direct program costs average $5.9 annually; $11.8 biennially (representing the two-year licensing cycle). SB 70 is expected to increase costs by $36.4 annually, for a total direct program cost of $42.3 annually ($5.9 + $36.4); $84.6 over the biennial licensing cycle. Since fees are adjusted prior to the biennial license renewal period, fees will need to cover the biennial licensing costs every other year during renewal. Licensees are also expected to pay a share of division indirect costs per capita based on the number of current licensees, approximately $155.00 biennially.

At the end of FY08, there were 35 current licensees. The current 35 licensees can expect to pay license fees totaling $2,572 for the biennium ($84.6 divided by 35 = $2,417 + $155 program share of indirect), in comparison to the present biennial fee of $470.

License fees will be adjusted to cover actual expenses at the first renewal period following enactment of this bill.

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MEMORANDUM January 16, 2009

SUBJECT: Draft bill relating to the practice of Naturopathy
(Work Order No. 26-LS0354\A)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Alpheus Bullard TLAB
Legislative Counsel

This memorandum accompanies the work order described above.

I based the requested changes to Senate Bill 107 (Work Order No. 25-LS0702\O) of the 25th Legislature on an e-mail of December 17, 2008, from Dr. Emily Kane to Mr. Obermeyer. Despite permission from Tom, I was unable to speak to Dr. Kane to clarify the nature of the changes desired. Please review this draft carefully to ensure that it is consistent with your intent.

In addition to the changes that I interpreted Dr. Kane to request, I changed the draft's effective dates, and added provisions to ensure that naturopaths who are currently licensed in the state would maintain their license to practice despite the draft bill's amendments to the applicable preamendment licensing provision (AS 08.45.030) and that application for new licenses and license renewals would continue to be processed by the department until the board had established its application review procedures in regulations.

If my choices were made in error, if you have any questions, or if I can be of further assistance, please do not hesitate to contact me.

TLAB:ljw:plm
09-020.ljw

Enclosure

Emily A. Kane, ND LAc

Naturopathic Doctor
Alaska License № 22
Licensed Acupuncturist
Alaska License № 18

Jan 25, 2009

Dear Linda

I'm the main contact in Juneau tracking the progress of SB 70. I represent the Alaska Association of Naturopathic Physicians. I enjoyed working with Senator Davis last year and I'm very enthusiastic about the climate for bills such as this to get all the way through, making progress towards the goals of many legislators, of which Bettye is champion, to bring more healthcare relief to Juneau. As you might have seen in the packet of information (including a letter to Representative Herron, whom I'm trying to engage with Wes Keller, R-Wassila, to adopt the bill in the house as a committee bill) the AARP (American Association of Retired Persons) late last year conducted a survey of healthcare access in Alaska and published their conclusions: Alaska needs 200 more doctors ASAP. Simultaneously, the Alaska State Medical Society recently published a survey of Alaska MDs which more or less states these docs are "burned out" and not willing to practice family medicine.

If SB 70 is signed into law, the state would instantly have 40 more doctors who are seasoned family healthcare providers. This is 20% of what the AARP calls for. The governor, despite announcing hiring freezes and other budget cuts, has made clear her continued support of DeNali KidCare and other health promoting commitments. Money for healthcare is terrific, but Alaska also needs more primary care doctors.

Our bill requests that we be added to the ranks of Medicaid eligible providers, and opens our scope of practice (which our training largely prepares us for) to include basic, legend drugs (antibiotics, antihypertensives, glucose modulating medicine, etc) for those patients who need short-term drug therapy until we can turn them around, hopefully, with good diet, a working exercise plan, functional sleep, and an interest in being well. These will always be our primary tools of medicine.

Would you kindly keep me apprised of the HSS schedule for this bill? I would like to present testimony.

Best wishes,

Emily

Emily Kane
Vice Prez, AKANP

Cell 723.5599

418 Harris Street, Suite 329 Juneau, AK 99801
Phone: 907-586-3655 FAX: 907-586-4326 email: DoctorEm@aol.com

Subj: **DRAFT letter to Tom Obermeyer about SB 70. Kindly comment soon**
Date: 1/21/2009 10:51:39 P.M. Alaskan Standard Time
From: [redacted]
To: [redacted]
CC: [redacted]

Jan 21 2009

Dear Mr. Obermeyer,

I am very happy with SB 70. Thank you so much for your role in getting this moving. Wes Keller (co-chair with Bob Herron of House HSS) told me today he might request that the House version of the bill be adopted as a committee (HSS) bill. What do you think of that idea? Representative Munoz is also interested in sponsoring our bill, which would be another option. I anticipate that staff members or the legislators mentioned will be calling you with questions about the bill.

I have a few minor concerns with SB 70 and I hope this is the proper format in which to request changes. However, I don't want to hang up the scheduling of the bill for Senate HSS. Can small changes be negotiated on the floor? Or can you implement changes through Leg Legal before the committee hearing?

page 4, line 9
I would prefer that the word "previously" be deleted. For example, when I came to Alaska 15 years ago, I missed one of my 14 NPLEX exams by 1 point (the homeopathy portion -- not my strong point). I had to wait 6 months to re-take the exam, then got my license. The word "previously" in this context sounds to me as though it could make me ineligible for an Alaska ND license.

page 5, line 10
Since AS08.45.056 gives us prescription drugs, vaccinations and hormones, this sentence is obfuscating. I would prefer that line 10 be deleted, or modified to read "a narcotic" or "medical substances not permitted by the board."

page 5, line 15
I would prefer that this sentence be deleted. All national references to naturopaths trained in accredited schools call us "naturopathic physicians." My graduation diploma from Bastyr University (Seattle, WA) calls me a "naturopathic physician." All Alaska NDs passed their Naturopathic Physician Licensing Exams.

page 5, line 29
This is my most important concern with the language of the bill. Almost all the NDs in Alaska are in agreement that we are not interested in access to narcotics or chemotherapy, so I don't want to mandate the DEA registration -- which is expensive, as you know. Many nurse practitioners and even some MDs opt to not carry DEA registration. A DEA number is only needed when doctors (or nurse practitioners or PAs) want to prescribe narcotics or other controlled substances. I would prefer that the requirement for a DEA number be limited to those NDs who specialize in cancer care or pain management, and this stipulation could be legislated, or allocated to the Alaska Naturopathic Medical Board.

page 6, line 2
I believe the word "department" should be "board."

Thanks again for your attention. I look forward to your responses.
Best wishes,
Emily Kane ND

www.DrEmilyKane.com

Inauguration '09: Get complete coverage from the nation's capital.

AARP AK

Alaska News www.aarp.org/ak Winter 2008

Calendar

State Legislature Meets
Jan. 15 – April 13. To listen or watch real-time video and audio of "Gavel to Gavel Alaska," go to www.ktoo.org/gavel/stream.cfm.

2008 Iditarod Trail Sled Dog Race
Starts March 1, 10:00 a.m., 4th Avenue & D Street, Anchorage.

Alaska Permanent Fund Dividend
Application deadline is March 31. Go to www.pfd.state.ak.us/.

WGBH's "Caring for Your Parents"
This 90-minute documentary airs April 2 on your local PBS station.

Volunteer

Work in Alaska State Parks.
Volunteers receive valuable training and experience. Apply by April 1. Go to www.dnr.state.ak.us/parks/vip, or call Lynn Wibbenmeyer at 907-269-8708.

Become a child advocate.
Alaska's CASA program serves children in Anchorage, Fairbanks, Juneau and Mat-Su. Go to www.alaskacasa.org, or call LeeAnn Reicks at 907-269-3513.

Speak up for change.
Make sure health care and financial security are top issues in the 2008 elections. Visit www.aarp.org/ak for information on candidate forums across the state.

Rescue Alert

Health care is out of reach for too many Alaskans, especially fishermen and other seasonal workers, most of whom don't get health benefits.

LACK OF HEALTH INSURANCE is a big reason why Alaska leads the U.S. in state spending on health care per person—about $8,000. Then there's the doctor shortage. Alaska needs 200 more physicians, ASAP.

But the state also needs a new approach to making health care affordable. Our costs of care and insurance already exceed the U.S. average and are growing by 9 percent a year.

Everything would change if more Alaskans had health insurance, but 17 percent do not. Most seasonal and part-time employees never will, and they represent 35 percent of the workforce. Not surprisingly, Alaskans pay 13.6 percent more for premiums than if everyone had health coverage.

This is why state Sen. Hollis French (D-Dist. M) and Rep. Gabrielle LeDoux (R-Dist. 26) recently introduced bills that would provide vouchers enabling all Alaska residents to buy health insurance. "No longer can we wait for the federal government to take action on this important issue," they said.

Finding a solution to the health care dilemma is at the top of AARP's national agenda. Through its Divided We Fail initiative, AARP encourages elected officials and community and business leaders nationwide to develop bipartisan solutions to the pressing problems of health and financial security. Details are at www.dividedwefail.org.

Stay informed by visiting www.legis.state.ak.us/index.php. For the full report on which this story is based, read "Employer-Based Health Insurance" online at http://labor.state.ak.us/trends.

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Alaska's minimum wage is $7.15 an hour, placing it in the top tier among states and 22 percent above the federal minimum.

Jobseekers can power up their search via the state Labor Department's online database at http://alexsys.labor.state.ak.us.

TIME FOR A CHANGE?

HOW ABOUT THE MATANUSKA VALLEY?

The Family Health Center, the Valley's oldest Family Practice Group, is now recruiting for experienced full- or part-time Family Physicians.

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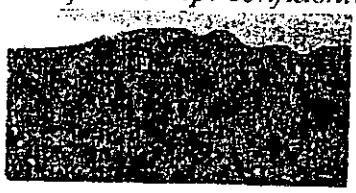

Physicians' Foundation releases survey of 12,000 U.S. physicians

A recent survey of about 12,000 physicians nationwide that included more than 800,000 data points offers a unique and valuable insight into the practices and mindsets of today's doctors.

The results, which were broadcast on CNN Nov. 18, paint a grim picture that could have drastic implications for the nation's healthcare debate:

- An **overwhelming majority** of physicians (78%) believe there is a shortage of primary care doctors in the United States today.
- **49%** of physicians (more than 150,000 doctors) said that over the next three years they plan to reduce the number of patients they see or stop practicing entirely.
- **94%** said the time they devote to non-clinical paperwork in the last three years has increased, and 63% said that the same paperwork has caused them to spend less time per patient.
- **60%** of doctors would not recommend medicine as a career to young people.
- **82%** of doctors said their practices would be "unsustainable" if proposed cuts to Medicare reimbursement were made.
- **Over 33%** of physicians have closed their practices to Medicaid patients and 12% have closed their practices to Medicare patients.
- **Only 17%** rated the financial position of their practices as "healthy and profitable."
- If they had the financial means, **45%** of doctors would retire today.
- "Patient relationships" rated highest on the list of things physicians find *satisfying* about medicine, while "reimbursement issues" and "managed care issues" rated the highest on the list of issues physicians find *unsatisfying* about medicine.
- **Only 6%** described the professional morale of their colleagues as "positive." **42%** said the professional morale of their colleagues is

(Continued on Back Page)

Need a doctor in the house?

ASMA keeps an updated list of physicians looking for a home and also an "Openings" list for those seeking help. Call Cassie at 562-0304.

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Heartbeat is published bimonthly for $15 per year by the Alaska State Medical Association, 4107 Laurel Street, Anchorage, AK 99508. POSTMASTER: Send address changes to above address. Phone: 907-562-0364. If your address changes, mail the label at right.

(Physicians' Foundation Survey, from Page 10)

either "poor" or "very low."

- 78% said medicine is either "no longer rewarding" or "less rewarding."
- 76% said they are either at "full capacity" or "overextended and overworked."

Combine these statistics with recent studies that medical schools are graduating fewer and fewer students who will choose to become primary care doctors -- and the future for both physicians and patients seems uncertain at best.

In the years ahead, the condition of America's primary care doctors as a profession will greatly affect the viability of our nation's healthcare system. A positive and functional system of practices and doctors will ensure a motivated workforce as well as encourage a new generation of quality physicians, while widespread physician disincentive could jeopardize the quality of our medical workforce as well as the number of physicians available to see patients.

In the words of one physician who responded to the survey, "Something has got to be done, and urgently, to assist physicians, especially primary care physicians" in order to maintain the viability of the medical profession and to ensure timely and effective access to the doctors on whom so many depend.

ABOUT THE SURVEY

"The Physicians' Perspective. Medical Practice in 2008" survey was funded and commissioned by the Physicians' Foundation. It was conducted between May and July of 2008 by physician search and consulting firm Merritt, Hawkins & Associates. It was mailed to virtually every physician engaged in active medical practice in the United States today. The total number of responses received was 11,950, with a margin of error of less than one percent.

ASMA Delegate Alex Maller, MD, serves on the Physicians' Foundation board as ASMA's representative.

Reminder!

All updates, new listings, and photos (with $20 photo fee for non-members) for the 2009 Medical Directory are due by Nov. 30! No exceptions!

Send to ASMA, 4107 Laurel St, Anchorage, AK 99508.
Please call 562-0364 if you have questions.

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Editorial

The Collapsing Health Care System

This editorial is being written just after the Dow Jones Industrial Average fell 778 points because of the failure to pass the $700 billion bailout bill. Another headline that appeared in the news today was that Medicaid costs will soon be spiraling out of control, primarily because of the increasing need for long-term care for the elderly and disabled. The presidential candidates have essentially stopped talking about their health care plans, because it is becoming clear that there will be little or no money for new programs and perhaps not enough money to continue some of the old programs. And we, the folks, worry that illness will mean bankruptcy.

A few weeks ago, the Associated Press reported that only two percent of graduating medical students plans to work in primary care internal medicine. Factors cited for the increasing preference for non-primary care specialties include high medical school debt, low insurance payments for office visits (when compared with various simple procedures), difficulty caring for the chronically ill and elderly with complex diseases (especially with the need to see so many patients per hour), and excessive amounts of paperwork. Because of the ongoing loss of front-line physicians, the American College of Physicians warned that the nation's primary care system is "at grave risk of collapse."

A study published September 2008 in the *New England Journal of Medicine* concluded that arthroscopic surgery for osteoarthritis of the knee (a procedure performed by highly paid specialists, some of whom decided not to go into primary care for the reasons cited above) doesn't do any good. Actually, we already knew that, because a 2002 study published in the same *New England Journal of Medicine* came to the same conclusion. But orthopedic surgeons continued performing the procedure about 250,000 times per year at a total cost of about $1.75 billion per year.

It was also reported recently that the use of insulin-sensitizing thiazolidinedione drugs, such as rosiglitazone (Avandia), which are used to treat diabetes, is associated with a two- to threefold increase in the risk of suffering an osteoporotic hip fracture. So, patients taking Avandia may eventually need to take alendronate (Fosamax) to keep their bones strong. Unfortunately, new research shows that the use of Fosamax is associated with a doubling of the risk of developing atrial fibrillation. So, the patient goes into atrial fibrillation, which is treated with amiodarone, which leads to severe pulmonary and hepatic toxicity, and now the patient is in real trouble and on the hook for serious medical bills. Brown rice, beans, chromium, and exercise would have been a lot cheaper and a much safer treatment for diabetes than Avandia.

It also turns out that some upstart drug company got the idea that it owns God's molecule, pyridoxal 5'-phosphate (PLP; the biologically active form of vitamin B6). Apparently, this company has spent money on research demonstrating that PLP is an effective treatment for cardiovascular disease. So, they have petitioned the Food and Drug Administration to have this vitamin declared a drug, so that only they will be allowed to sell it (no doubt at monopoly prices).

All of these stories are symptomatic of a system that has developed very large cracks and is on the verge of breaking.

In my 25 years of writing for the *Townsend Letter*, I have made many suggestions on how we could improve the public health and the health care system, while substantially reducing costs: Emphasize natural medicine. Tax unhealthful food and give a tax credit for healthful food, exercise equipment, and other health-promoting behaviors. Eliminate expensive defensive medicine and expensive malpractice insurance by reforming the tort system. Reconsider the wisdom of spending tens of thousands of dollars on intensive care for people in the last days of their lives. Stop performing expensive procedures that do not work. Emphasize home birth and other low-cost home remedies. Integrate mid-level practitioners (such as nurse practitioners and physician assistants) more fully into the system. Remind doctors that inexpensive older medicines often work just as well as newer, expensive ones.

When I made these suggestions, I did not believe they would be implemented, and most of them have not been. Our society was, and still is, too bound by the desire for money to hear the call of service and altruism. The medical student does not want to do primary care; the orthopedist does not want to stop doing lucrative but worthless operations; the drug companies do not want to stop pushing lucrative but dangerous drugs; and the upstarts want to usurp God's patents. As Paul said to Timothy, "the love of money is the root of all evil." But now, as the money threatens to dry up (the "liquidity crisis") or perhaps to sink the ship (necessitating a "bailout"), even the greedy will be forced to look elsewhere to find new roots.

Why does it take an earthquake, a hurricane, or a tsunami before we come to people's aid? If and when the next Great Depression hits, will we rediscover the joy of service?

Oh, people, look among you; it's there your hope must lie.[1]

Alan R. Gaby, MD

1. From "Rock Me on the Water," by Jackson Browne.

4051

NEWS BRIEFS

Naturopathic Physicians to Receive Same Academic Recognition as MDs

NDs will be classified by the federal government in the same professional category as allopathic medical doctors under a new system recently approved by the U.S. Department of Education (USDE). The change becomes effective in July 2008.

William Keppler, former NCNM president, represented accredited naturopathic medical colleges in the US on a USDE task force that reviewed professional degree categories in 2006. The Integrated Postsecondary Education Data System (IPEDS) task force accepted his proposal to classify NDs with allopathic medical doctors, and recommended that the USDE approve the change.

After months of review, the USDE established three levels of doctoral degrees, and placed NDs in the "Doctor's Degree – Professional Practice" category along with MDs, dentists, chiropractors, optometrists, osteopaths, podiatrists, pharmacists, veterinarians and lawyers. PhDs and other doctoral degrees requiring dissertations or original research form a second category in the new USDE classification system. The third category is for honorary doctoral degrees.

The degree reclassification formalizes the growing national acceptance of naturopathic medicine as a field of knowledge equivalent to allopathic medicine. After the approval came through in January, Dr. Keppler said the change is "vitally important. It places naturopathic physicians on a level playing field with other professional doctoral degrees."

Sources: NCNM, US Dept. of Education

can become members of the IAA and be listed on the Web site and mentioned in program materials.

The organization was established in 2006; some services may not yet be available. For more information, call 800-861-5587 or e-mail info@indoorairalliance.org.

Study Suggests Use of Alternative Medicine is on the Rise

A Thomson Medstat survey examined trends in use of alternative medicine in the US. The recently released key findings include:

- More than 37% of US households have sought some form of alternative medicine in the past 12 months.
- Alternative medicine use is most used among those with annual incomes of more than $100,000 (49.9%) and those with post-graduate degrees (49.6%).
- About 42% of respondents said their alternative treatments were at least partially covered by insurance.
- Nearly two-thirds (64.1%) said their physicians were aware of their use of alternative treatments. The study mentions that this is due in large part to "grassroots efforts among doctors to ask patients about their use of alternative treatments" (p. 3).
- The most common reason for using an alternative treatment: to promote general wellness (40.7%), followed by to treat an illness (32.5%), to supplement traditional care (10.2%) and to prevent an illness (9.9%).
- Herbal supplements (23%) and massage/chiropractic care (22%) are most commonly used types of alternative medicine, followed by mind and body practices.

The three patients received infusions of roughly 50g of vitamin C at a rate of 1g per minute four times a day for four weeks, according to Christopher G. Lis, vice president of research and development at CTCA.

This first phase of the trial will attempt to determine the optimal dose for patients and whether the treatment is safe and can be tolerated. Additional studies will be needed to demonstrate effectiveness of the treatment.

Researchers continue to look for non-smoking patients of at least 18 years of age who have been told:

- They have an advanced stage, solid tumor
- They have no other treatment options that provide a clinical benefit
- They have a life expectancy of at least three months
- They have no other, scheduled cancer therapy.

For patients to be considered for participation in the trial, e-mail christopher.lis@ctca-hope.com.

Beverages Account for One-Quarter of Daily Caloric Intake

The recently released *What America Drinks* study characterized beverage consumption patterns of Americans. Results indicate that more than 99% of Americans consume at least one beverage other than plain water on a daily basis. Total fluid intake averaged more than 11 cups daily.

On average, beverages accounted for 22% of total calories in one day. The analysis used data from more than 10,000 Americans age 4 years and older who participated in the U.S. National Health And Nutrition Examination Survey (NHANES) 1999-2000 and 2001-2002, and

WELLSPRING

Integrative Medical Center

January 21, 2009

Dear Alaskan Legislators:

I write in support of establishment of a Naturopathic Medical Board consisting of three (3) Naturopathic Doctors (ND), one (1) pharmacist and one (1) member of the public. This board is needed to assure the Alaskan public of safe naturopathic care complying with the regulations of ND practice in Alaska.

Wellspring, an Integrative Medical Center, located in Juneau, Alaska, has employed a naturopathic doctor for nine years. Patients constantly acknowledge their gratefulness for this option. However, he has been unable to fully practice his profession in Alaska because there in no ND Board overseeing the totality of his practice for which he was educated for four years, post-baccalaureate degree.

Please support this ND bill to improve wellness and health care for Alaskans, to increase access to ND care and to provide cost-effective options for our communities.

Please contact me if you have further questions.

Sincerely,

C. Trollan, ANP
Advanced Nurse Practitioner
Owner

2231 Jordan Avenue • Juneau, Alaska 99801 • Phone (907)789-1812 • Facsimile (907)789-7168

Identifying the Similarities and Differences:

An analysis of two medical training programs -- Bastyr University's Naturopathic Doctorate (ND) compared to the University of Washington's Medical Doctorate (MD) program

Admissions Criteria

Similarities -- Overall, a high degree of similarity exists between the programs.

- Both programs:
  - Expect applicants to have completed, but do not require completion of, a baccalaureate degree.
  - Encourage a strong background in the humanities and liberal arts.
  - Require a strong background in the sciences, including chemistry, biology, and physics.
    - While not required for admission, biochemistry is very strongly recommended.
  - Allow for waiving a limited number of academic requirements under exceptional circumstances.

Differences

- Medical College Admissions Test (MCAT):
  - Required for University of Washington (UW) medical school, taken no later than fall in the year prior to possible matriculation.
    - Under *exceptional* circumstances, GRE scores may be considered for admission, but MCAT must be taken prior to matriculation.
  - Not required for Bastyr University (BU) naturopathic medical school
- Required courses:
  - UW specifies science requirements by number of credit hours* for each:
    - Chemistry (18*), biology (12*), and physics (4*), plus additional "open" science credits (8*).
  - BU specifies science requirements by number of courses for each:
    - Chemistry (4, for science majors), physics (1, college level), algebra or pre-calculus (1, college level), and psychology (1, introductory course recommended).
    - Additionally, BU requires a minimum of 3 quarter credits in general biology for science majors, with a lab.
- Additional Notes:
  - UW provides mean statistics for the entering class 2004 – GPA 3.71, MCAT scores (Verbal 10.3; Physical Sciences 10.8; Biological Sciences 11.1 and mode of "Q" in writing) -- BU does not.
  - UW states:
    - "All candidates must demonstrate substantial academic ability in their major field as well as in the required science courses."
    - "Candidates should be proficient in the use of the English language and of basic mathematics, and are expected to have a basic understanding of personal computing and information technologies."
  - BU requires admissions committee review for all chemistry and biology courses not completed within 7 years of matriculation, and may require additional courses if deemed appropriate.
  - BU allows submission of test scores for prerequisite consideration as noted below:
    - AP, IB, CLEP, or GRE for math, psychology, or physics.
    - AP or IB for biology or chemistry.

*All credit hours stated for quarter calendar system, unless otherwise noted

Preclinical/Basic Sciences and Didactic Clinical Training

Similarities

- Both programs emphasize:
  - Anatomy, including gross (with cadaver dissection), histology, embryology and neuroscience
  - Physiology
  - Biochemistry
  - Pathology
  - Immunology and infectious disease
  - Clinical medicine – utilizing a systems-based approach, including
    - Cardiovascular, respiratory, endocrine/reproductive, urinary, musculoskeletal, skin and gastrointestinal systems
- Both programs include courses in:
  - Psychology
  - Pharmacology
  - Human Nutrition
  - Evaluation of medical research literature
  - Epidemiology and public health

Differences

- In some cases, both programs offer courses in a particular area, but one will emphasize it more heavily. For example:
  - BU more heavily emphasizes human nutrition, requiring four courses (12 credits*) to the UW's one (1 credit*).
  - BU more heavily emphasizes psychology/counseling, requiring five courses (12 credits*) to the UW's three (8 credits*).
  - UW more heavily emphasizes pharmacology, offering two courses (8 credits*) to BU's one (5 credits*).
- The BU didactic program includes a number of courses with no equivalent course at the UW. Examples of these include:
  - Naturopathic clinical theory and case analysis.
  - Specialty care for individuals at certain points in the life cycle, such as family medicine, pediatrics, and geriatrics
  - Overview courses in world traditional medical systems including Ayurvedic and Traditional Chinese Medicine
  - Traditional medical therapeutic approaches such as botanical, homeopathic, and physical medicine (i.e. massage, hydrotherapy, naturopathic manipulation).
  - More recent developments in natural health, including environmental medicine, clinical ecology, and clinical (orthomolecular) nutrition.
  - Medical law and practice management.
- Some courses offered at the UW as electives are required by BU, such as:
  - Medical ethics and the philosophy of healing/being a physician.
- Elective options:
  - BU provides a wide range of elective options for their ND students, and requires completion of 15 credits* for graduation. However, many are not all listed in BU's published curricular information.
  - The UW's published curricular information lists a minimum of 37 available elective credits* by course name and number. It remains unclear exactly how many elective credits are required for graduation and whether or not additional courses are offered but not listed.

Clinical Training

Similarities

- Both programs emphasize training in the clinical setting, where the student receives practical, hands-on training from licensed practicing physicians.

Differences

- BU naturopathic students complete a total of 25 shifts, all in the outpatient setting. The only specialized shifts completed are in physical medicine (4 shifts). Three shifts are completed as preceptorships, with independently practicing physicians.
- UW medical students complete 10 rotations of varying lengths in numerous areas of specialized as well as general medicine. Some of these are in the outpatient setting, others in an inpatient setting. In total, they complete a total of 58 weeks of these rotations, with the greatest emphasis on general medicine (12 weeks).
- All inpatient setting rotations such as surgery and trauma/emergency medicine are required by UW, but unavailable to BU naturopathic students (or with very limited availability as preceptoships).
- UW students are required to complete a rotation in obstetrics and gynecology; BU students complete rotations in childbirth only if enrolled in the separate midwifery program.
- UW students may complete elective rotations in rural/underserved community medicine; BU students may volunteer in these programs away from school (although preceptorship credits may be available).

Licensure Examinations

- Both MD and ND licensure require successful completion of a two-step examination process, one covering basic or pre-clinical sciences, and a second covering clinical sciences.
  - MD students complete the United States Medical Licensure Examination (USMLE) Part I at some point prior to their last year, and the USMLE Part II during their final year of enrollment at UW.
  - ND students complete the Naturopathic Physician Licensure Examination (NPLEX) Basic Sciences exams after their second academic year; and the Clinical Sciences exams post-graduation.

Sources

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- http://www.washington.edu/students/crscat/humbio.html Accessed 5 April 2005
- http://www.bastyr.edu/academic/naturopath/curriculum.asp?track=4 Accessed 6 April 2005
- http://biomed.uaa.alaska.edu/A_Z/Curriculum.htm Accessed 7 April 2005

Assuring Safe Naturopathic Medical Practices for Alaskans White Paper

Alaska Association of Naturopathic Physicians, Inc.

Alaska Association of Naturopathic Physicians, Inc.

Dedicated to the preservation of quality naturopathic medicine for all Alaskans

Assuring Safe Naturopathic Medical Practices for Alaskans

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Alaska Association of Naturopathic Physicians, Inc.

Assuring Safe Naturopathic Medical Practices for Alaskans

Executive Summary

Introduction:

Naturopathic Medicine is a traditional system of health care that blends centuries-old knowledge of effective, natural therapies with current scientific advances in the treatment of patients. The scope of practice of naturopathic doctors includes all aspects of natural medicine.

According to a recent editorial in the Anchorage Daily News, there is a severe doctor shortage in Alaska (see Appendix A: Doctor Shortage). They cite a report from the Alaska Physician Supply Task Force that found we would need an increase of 28% (375 doctors) in order to catch up with the lower 48. In the rural areas, the situation is even bleaker with one in six positions unfilled.

Alaska first licensed naturopathic doctors in 1987 (see Appendix B: History of Naturopathic Licensing in Alaska). In January, 2004, the Alaska Association of Naturopathic Physicians proposed legislation to the 23rd Alaska State Legislature that would have expanded the scope of practice for naturopathic doctors in Alaska. The purpose of this legislation was threefold:

1. To provide our patients with an integrated approach to medical care that draws from the best of conventional and alternative medicine without the barrier to optimal care created when well-trained naturopathic physicians are prohibited from prescribing appropriate medications, which they have been trained to prescribe (see Appendix C: Health Care Is Changing).

2. To calibrate our licensing law in accord with current trends in other states that license naturopathic physicians (see Appendix D: States' Prescriptive Authority and Minor Surgery Scope of Practice for Licensed Naturopathic Doctors).

3. To update our law to allow naturopathic physicians in Alaska a scope of practice commensurate with modern naturopathic education (see Appendix E: Comparison of Naturopathic and Major Medical Schools).

The proposed legislation easily passed in the Senate (19-1) but was stalled in the House in May, 2004. A re-written bill was passed that established a task force with representatives from the naturopathic, medical, nursing, pharmacist, physician's assistants professions to work with legislators in order to "...contribute to a better understanding of issues related to the safety and scope of the practice on naturopathy ..."[1]

In consultation with the task force and as we look at how naturopathic governance compares to other states (see Appendix G: Comparison of Naturopathic Governance), we have modified our scope of practice bill to include the following:

[1] SB 306, section 1.

1. Formation of an *Alaska Naturopathic Council* (see appendix H: Alaska Naturopathic Council) that would advise the Division of Corporations, Business and Professional Licensing on criteria for naturopaths seeking endorsement for prescription writing authority and a formulary of medications that naturopaths may prescribe.

2. Authorization to perform minor office procedures including repair of superficial lacerations and abrasions, superficial lesions and the removal of foreign bodies located in superficial tissues.

3. Establishment of continuing education requirements.

Naturopathic Education:

Naturopathic physicians licensed in Alaska have graduated from four year graduate level programs accredited by the Council on Naturopathic Medical Education and by their local accrediting agencies, all of which are federally recognized the US Department of Education. The USDE also recognizes the Liaison Committee on Medical Education that accredits medical education programs within the United States leading to the M.D. degree (see Appendix I: Accrediting Agencies).

Naturopathic physicians are obligated to keep up with changes in medicine and to critically and without bias evaluate methods which may be of benefit to their patients. In order to assure naturopathic doctors' prescriptive writing authority is up to date for all licensed doctors in Alaska, including those who graduated twenty or more years ago, naturopaths seeking such authority must fulfill certain criteria:

1. Completion of 60 hours training in pharmacology training based on the State of Arizona's program for naturopathic doctors (see Appendix J: Pharmacotherapeutics CE Program).

2. Once prescriptive authority has been granted, naturopathic physicians are required to acquire 30 hours of continuing education, half of which is instruction in pharmacology and phamacotherapeutics, every two years.

Alaska Naturopathic Council:

In states that allow naturopathic doctors to have prescription writing authority, most have a formulary of drugs that are permitted.

In the past year, Idaho and Washington State have formed advisory councils whose purpose is to advise their respective licensing authorities regarding appropriate formulary lists. These councils are multidisciplinary in nature. Washington's advisory council is comprised of pharmacists and naturopathic physicians; Idaho's is comprised of pharmacists, allopathic and naturopathic physicians.

Naturopathic Track Record of Safety

Fortunately, naturopathic physicians have been licensed in numerous other states for some time now and there is a track record of public safety which is impressive. (See Appendix K: Naturopathic Disciplinary Reports). Please note these reports include all complaints and disciplinary actions and are not restricted to complaints specific to prescription writing. However, it is important to recognize that unlike conventional providers, naturopathic providers see fewer patients per day (5-15 compared to 20-30). Naturopathic doctors typically spend more time with patients and, thus, get to know them better. They are inclined to use prescriptions as a last resort and are less likely to put people on multiple drug regimes than our conventional colleagues (see Appendix L: letter from Rick Chester, ND, RPh, LAc).

Why Now?

Alaskans are scrambling to find family doctors to address a wide variety of health care needs. Based on epidemiologic estimates, 20-30% of patients seen in a conventional provider's office are using alternative/complementary medicines.[2] Twenty percent of adults who take prescription medicine also rely on herbal products[3]; whether the provider knows or approves of this fact or not. Americans spend in excess of $10 billion annually on herbal and dietary supplements[4], often without the guidance of a health care professional or awareness of potential interactions with conventional therapies.

Naturopathic physicians have taken the lead on writing the texts on integrating the best scientifically validated complementary and alternative therapies along with conventional medicine[5]. This can be done safely to the benefit of the communities we serve.

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[2] Eisenberg, et al, *Unconventional medicine in the United State—prevalence, costs and patterns of use."* **N Engl J. Med** 1993, 328:246-252.

[3] Eisenberg, et al, *Trends in alternative medicine use in the United States, 1990-1997: Results of a follow-up national survey,* **JAMA**, 1998; 280: 1569-1575.

[4] Pizzorno, Joseph, *The path ahead: education, evolution and collaboration,* **Integrative Medicine,** vol. 3, #2, April/May, 2004, pg. 6.

[5] Including but certainly not limited to: Herb Contraindication and Drug Interactions, Francis Brinker, ND, Eclectic Publications, 1998; Encyclopedia of Natural Medicine, Joseph Pizzorno, ND and Michael Murray, ND, Prima Publishing, 1990; Clinical Botanical Medicine, Eric Yarnell, ND, Mary Ann Liebert, Inc, 2003; Women's Encyclopedia of Natural Medicine, Tori Hudson, ND, McGraw-Hill, 1999; Managing Menopause Naturally, Emily Kane, ND, Basic Health Media, 2004.

Anchorage Daily News (Published: October 8, 2006)

Doctor Shortage
No easy solution, but these steps should help in the long run.

The report from the Alaska Physician Supply Task Force is blunt: "Alaska has a shortage of physicians. ... The shortage is very likely to worsen over the next 20 years as the state's population increases and ages."

It would take another 375 doctors -- a 28 percent increase, right now -- to deliver Alaskans the same level of care as in the Lower 48. In rural Alaska, doctors are already scarce; one in six positions goes unfilled.

While the shortage is not yet a crisis, according to the task force, it does leave patients scrambling to find doctors and drives up recruitment costs for hospitals and health centers.

Alaska's doctor shortage was a long time developing, and it will take a long time to fix. There is no instant solution. Simply raising pay rates for doctors, as a free-market economist might suggest, won't work. Alaskans already spend about 40 percent more on medical care than Lower 48 residents, and there is still a doctor shortage.

To fix it, we don't have to wait for global warming to turn Alaska into a more hospitable destination for doctors. We don't have to invest tens of millions of dollars to start a medical school here (although the task force suggested that would be a wonderful idea). Some relatively modest, practical steps should eventually help, according to the task force.

Alaskans are guaranteed 10 slots a year at the University of Washington's highly acclaimed medical school through a tuition-reduction arrangement known as WWAMI. Students have an incentive to set up shop in Alaska when they graduate; otherwise they have to pay back their tuition savings.

The report says Alaska should find the funding needed to add 20 slots to the WWAMI program. Since the medical students spend their first year doing course work here at the University of Alaska Anchorage, UAA would need some more money as well to handle them.

Students who don't enter the highly competitive WWAMI program should be able to get state loans to cover the high cost of medical school. To encourage them to return to Alaska, the state could forgive a portion for each year the new doctor's practice in Alaska.

Another way to attract doctors is to expand on-the-job training slots in Alaska for third- and fourth-year medical students. Alaska hospitals offer training in some medical specialties, which helps encourage doctors to settle here. States typically help hospitals underwrite these medical training slots; Alaska should see how it can most cost-effectively invest in this area.

If there were a huge pool of doctors nationwide, Alaska would have an easier time of it. But there's a squeeze across the country, in part because years ago medical schools thought they saw a doctor glut coming and capped the production of new physicians. At the same time, other changes helped make medicine less attractive as a career -- the long, demanding hours, combined with constant pressure to control costs and administrative hassles from private insurers, HMOs and government.

So Alaska will have a tough time getting all the physicians we need in the coming years. If state leaders will follow the task force's recommendations, though, the job will be more manageable.

BOTTOM LINE: There's hope for dealing with Alaska's doctor shortage, but progress won't be quick.

Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix B: History of Naturopathic Licensing in Alaska

More than twenty years ago, the legal status of naturopathic physicians practicing in Alaska came to a head when the Alaska State Medical Board sent a notice to Patton Pettijohn, ND, to stop treating patients in his Anchorage office. There had never been a complaint filed against Dr. Pettijohn in the five years he had been treating patients in Alaska. However, because his naturopathic doctorate and his license were both from Oregon, their opinion was that he was practicing medicine without a license and he would have to stop. That was in September, 1984.

Licensing efforts in many states had become a consumer rights issue in the eighties. Consumers had a right to know that their health care provider had met rigorous standards for education, training and testing. Prior to this time, the Alaska's Attorney General had written a letter stating that, since the medical board refused to allow Dr. Cary Jasper to sit for the board exam; he could practice naturopathic medicine without a license and would not be under their jurisdiction. In 1986, the Alaska State Superior Court disagreed. The judge ruled that because there was no licensing for naturopathic physicians in Alaska, Dr. Pettijohn would fall under the jurisdiction of the medical board. He was forced to close his naturopathic office-a dark day for the profession in Alaska. Three other naturopathic physicians practicing in Alaska would have charges filed against them next. These four physicians, with overwhelming public support, lobbied the Alaska State Legislature to pass a naturopathic licensing bill. Within two months of the Pettijohn decision, Governor Bill Sheffield signed a law licensing naturopaths to practice in Alaska in May, 1986.

In January, 2004, the Alaska Association of Naturopathic Physicians proposed legislation to the 23rd Alaska State Legislature that would have expanded the scope of practice for naturopathic doctors in Alaska. The proposed legislation easily passed in the Senate (19-1) but was stalled in the House in May, 2004. A re-written bill was passed that established a task force with representatives from the naturopathic, medical, nursing, pharmacist, physician's assistants professions to work with legislators in order to "...contribute to a better understanding of issues related to the safety and scope of the practice on naturopathy ..."[1]

Licensing is still a consumer rights issue. Naturopathic physicians' focus on preventive measures lowers long term health costs. When a conventional prescription medication is indicated, having to make another appointment with another provider only presents an unnecessary barrier to appropriate care. The public has a right to access naturopathic medicine as a reliable health care option. Updating Alaska's naturopathic licensing law to reflect the current status of naturopathic medical education is in the best interests of communities throughout our great state.

[1] SB 306, section 1.

Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix C: Health Care is Changing

Patients are demanding to be seen as whole persons, not just a list of symptoms. They want time from their physicians, they want control over their own health, and they want preventive medicine, not quick fixes.

Modern medicine calls for doctors who know their science yet honor the body's innate wisdom to heal—doctors who function as teachers as well as healers, who acknowledge the value of time-honored traditional therapies and who recognize that, when given the chance, nature is the greatest healer of all.

The majority of patients who come for naturopathic care fall into one of four categories:

1. Patients who also see conventionally trained providers. We may be one of a cadre of providers including a medical doctor, a chiropractor, etc.
2. Patients for whom we are their primary care providers. Most of these patients respond well to interventions such as diet and lifestyle modification and natural therapies. Sometimes a higher level of intervention is required. In a perfect world, we could refer that patient to a provider with special expertise in this type of patient. However, it may be months before that patient can get in to see a specialist in Alaska. In the meantime, he or she may be walking around with dangerously high blood pressure, blood glucose, etc, and we need to be able to stabilize this patient in the interim.
3. Patients who are, for whatever reason, leery of conventional medicine and would not go to a conventional provider short of in an ambulance. Most of these patients would accept prescription medication from a naturopathic physician while we address the underlying causes of their conditions.
4. Patients who are already on multiple prescription medications and are having problems due to interactions and side effects. We need the flexibility to be able to adjust their dosages while we incorporate diet and lifestyle changes to reduce the need for prescription medications in a safe way.

Based on epidemiologic estimates, it may be that 20-30% of patients seen in a conventional provider's office are using alternative/complementary medicines.[1] Twenty percent of adults who take prescription medicine also rely on herbal products[2]; whether or not the prescriber knows or approves of this fact. Americans spend in excess of $10 billion annually on herbal and dietary supplements[3], often without the guidance of a health care professional or awareness of potential interactions with conventional

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[1] Eisenberg, et al, *Unconventional medicine in the United State—prevalence, costs and patterns of use."* **N Engl J. Med** 1993, 328:246-252.

[2] Eisenberg, et al, *Trends in alternative medicine use in the United States, 1990-1997: Results of a follow-up national survey,* **JAMA**, 1998; 280: 1569-1575.

[3] Pizzorno, Joseph, *The path ahead: education, evolution and collaboration,* **Integrative Medicine**, vol. 3, #2, April/May, 2004, pg. 6.

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therapies. Naturopathic physicians have taken the lead on writing the texts on integrating the best scientifically validated complementary and alternative therapies along with conventional medicine[4]. This can be done safely to the benefit of the medical community and, more importantly, for the communities we serve.

[4] Including but certainly not limited to: Herb Contraindication and Drug Interactions, Francis Brinker, ND, Eclectic Publications, 1998; Encyclopedia of Natural Medicine, Joseph Pizzorno, ND and Michael Murray, ND, Prima Publishing, 1990; Clinical Botanical Medicine, Eric Yarnell, ND, Mary Ann Liebert, Inc, 2003; Women's Encyclopedia of Natural Medicine, Tori Hudson, ND, McGraw-Hill, 1999; Managing Menopause Naturally, Emily Kane, ND, Basic Health Media, 2004.

Alaska Association of Naturopathic Physicians, Inc.

Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix D: States' Prescriptive Authority and Minor Surgery Scope for Licensed Naturopathic Doctors

State	Rx Authority[1]	Controlled Substances Act Schedules[2]					Minor Surgery
		I	II	III	IV	V	
Alaska	No						No
Arizona	Yes		x	x	x	x	Yes
California	Yes[3]			x	x	x	Yes
Connecticut	No						Yes
Hawaii	No						No
Idaho	Yes						Yes
Kansas	Yes						No
Maine	Limited[4]						Yes
Montana	Yes		x	x			Yes
New Hampshire	Limited						No
Oregon	Yes		x	x	x	x	Yes
Utah	Yes						Yes
Vermont	Limited[5]			x	x		No
Washington DC	In Progress						In Progress
Washington State	Yes			x	x		Yes
Puerto Rico	No						No

[1] Prescriptive authority is the ability to prescribe controlled substances as identified in schedules I-IV of the Controlled Substance Act (21 USC, Sections 801-971). Maine's law refers to the "legend" and "non-legend" classifications of the official United States pharmacopoeia, rather than to the Controlled Substance Act. "Legend" drugs are those for which a prescription is required by federal law. In 2005, Washington State added some schedule 3-5 drugs to "legend" drugs that naturopathic doctors may prescribe.

[2] The schedules of the Controlled Substance Act are available on the US Drug Enforcement Agency's website at www.usdoj.gov/dea/pubs/scheduling.html.

[3] Pursuant to California Code §3640.5, NDs may only prescribe controlled drugs under the supervision of a medical doctor.

[4] In Maine, NDs are permitted to prescribe "non-controlled legend drugs" only after a twelve-month period of review by an allopathic physician. Such drugs may only be from the following categories: homeopathic remedies, vitamins and minerals, hormones, local anesthesia and immunizations that are designated by rule.

[5] Vermont only allows NDs to prescribe only testosterone from schedule III and codeine from schedule IV.

Sources:
Burnham, *Legislative Research Report #05.074*, 1/6/2005, pg. 5

Hough, Dower & O'Neil, *Portrait of a Profession: Naturopathic Practice*, Center for the Health Professions, UCSF, 9/2001, pg. 27.

SB 1158, State of Idaho, 58th Legislature, 2005.

HB 1546, State of Washington, 59th Legislature, 2005.

Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix E: Comparison of Naturopathic and Major Medical Schools

	National	Bastyr	Southwest	John Hopkins	Yale	Stanford
Basic and Clinical Sciences: Anatomy, Cell Biology, Physiology, Pathology, Neuroscience, Clinical/Physical Diagnosis, Histology, Genetics, Biochemistry, Pharmacology, Lab Diagnosis, Pharmacognosy, Public Health, History, Philosophy, Ethics, Research and other coursework.	***1548***	***1639***	***1419***	***1771***	***1420***	***1383***
Clerkships (1) and Allopathic Therapeutics: Lecture and clinical instruction in Dermatology, Family Medicine, Psychiatry, Internal Medicine, Radiology, Pediatrics, Obstetrics, Gynecology, Neurology, Surgery (2), Ophthalmology and Clinical Electives.	***2244***	***1925***	***1920***	***3391***	***2891***	***3897***
Naturopathic Medicine:						
Advanced Naturopathic Therapeutics	–	44	20	–	–	–
Ayurvedic Medicine	–	22	20	–	–	–
Botanical Medicine	96	110	120	–	–	–
Therapeutic Nutrition (3)	144	132	130	–	–	–
Counselling (4)	144	143	100	–	–	–
Homeopathy	144	88	140	–	–	–
Hydrotherapy	48	39	40	–	–	–
Naturopathic Case Analysis/Management (5)	–	66	120	–	–	–
Naturopathic Manipulative Therapy	156	176	180	–	–	–
Naturopathic Philosophy	72	55	60	–	–	–
Oriental Medicine	72	33	200	–	–	–
Subtotals:	876	908	1130	0	0	0
Total Reported Hours:	***4668***	***4472***	***4469***	***5162***	***(+Thesis) 4311***	***5280***

1) Clerkships are estimated to be 40 hours of mixed lecture and clinical training.
2) Naturopathic physicians study minor surgery only.
3) No dedicated coursework in therapeutic nutrition appears in the college catalogs of Hopkins, Yale or Stanford; although they indicate that the subject is addressed in other courses.
4) Totals for Hopkins, Yale and Stanford included in psychiatry coursework.
5) Hours which also could be allocated to this category may be included elsewhere for some institutions because of terminology differences in the course.

Sources: 1996-97 *Curriculum Directory of the American Association of American Medical Colleges*
1995-96 Catalog of National College of Naturopathic Medicine
1996-98 Catalog of Bastyr University
1996-97 Catalog of Southwestern College of Naturopathic Medicine and Health Sciences

Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix F: Licensed Medical Professionals in Alaska

Licensed Practical Nurse (LPN)	9 months to 2 year practical nursing program, the 1 year program being the most common
Registered Nurse (RN)	One of the following: ❖ A two year Associate's degree ❖ A three year Diploma program (hospital based) ❖ A four year Bachelor's degree in Nursing ❖ A four year Bachelor's degree in another discipline and a three year Master's degree in Nursing ❖ A four year Bachelor's degree in another discipline and a four year Nursing doctorate program
Advanced Nurse Practitioner (ANP)	In addition to holding a license as an RN, an ANP completes one of the following: ❖ A nine month to two year certificate program in specialty ❖ A two year Master's degree certified in specialty
Physician's Assistant (PA)	Admission requirements to an accredited Physician's Assistant program vary, but many require 2 years of college and some work experience in the health care field. Programs are usually at least two years and are full time[1]. Credential's awarded include: ❖ Certificate of Completion ❖ Associate's degree ❖ Bachelor's degree ❖ Master's degree Must pass the certifying examination administered by the National Commission on Certification of Physician Assistants (NCCPA). Must work under the supervision of a physician.
UW Medical School	Applicants are expected but not required to have a Bachelor's degree. Encouraged to have a strong background in the humanities and liberal arts. Require a strong background in the sciences, including chemistry, biology and physics. While not required for admission, biochemistry is strongly suggested. Medical College Admissions Test (MCAT) required. Allows for waiving of a limited number of academic requirements under exceptional circumstances.[2] Followed by two to five years of post-graduate training in allopathic medical school, internship and residency. Must pass United States Medical Licensure Examination (USMLE).
Bastyr University Naturopathic Medical School	Applicants are expected but not required to have a Bachelor's degree. Encouraged to have a strong background in the humanities and liberal arts. Require a strong background in the sciences, including chemistry, biology and physics. While not required for admission, biochemistry is strongly suggested. Allows for waiving of a limited number of academic requirements under exceptional circumstances[3] MCAT not required. Followed by four to five year post-graduate training in naturopathic medical school; externship required for graduation; residency options becoming more available. Naturopathic Physicians Licensing Exam (NPLEX) Basic and Clinical Science Exams required.

[1] U.S. Department of Labor Bureau of Labor Statistics Occupational Outlook Handbook
[2] Source: http://www.uwmedicine.org/Education/MD/Program/Admissions/SelectionFactors.htm Accessed 4/13/2005.
[3] Source: http://www.bastry.edu/academic/naturopath/prereq.asp?sub=1 Accessed 4/13/2005.

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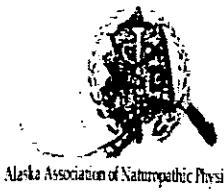

Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix F: Comparison of Naturopathic Governance

State	Licensing Authority	Membership	Continuing Education
Alaska	Division of Occupational Licensing	NA	None
Arizona	Naturopathic Physicians Board of Medical Examiners	3 NDs and 2 public members	15 classroom hours
California	Bureau of Naturopathic Medicine Advisory Council[1]	3 NDs, 3 MDs and 3 public members	60 hours every 2 years, 20 hours pharmacy
Connecticut	State Board of Naturopathic Examiners	2 NDs and 1 public member	None
District of Columbia	Advisory Committee on Naturopathic Medicine[2]	1 ND, 1 MD and the Director of Health or his or her designee	None
Hawaii	State Board of Examiners in Naturopathy	3 NDs and 3 public members	None
Idaho	Board of Naturopathic Medical Examiners	4 NDs and 1 public member	None
Kansas	Kansas State Board of Healing Arts[3]	5 MDs, 3 DOs, 1 podiatrist, 3 DCs and 3 public members	None
Maine	Board of Complementary Health Care Providers	2 NDs, 2 acupuncturists, 1 MD, 1 pharmacist and 1public member	37 hours annually, 7 pharmacy
Montana	Alternative Health Care Board	2 NDs, 2 midwives, 1 MD and 1 public member	15 credits annually, 5 pharmacology
New Hampshire	Naturopathic Board of Examiners	4 NDs, the commissioner of the DHSS, and 1 public member	150 hours every 3 years
Oregon	Board of Naturopathic Examiners	4 NDs and 1 public member	20 hours annually
Puerto Rico	Board of Examiners of Doctors of Naturopathy	3 NDs, 1 MD and 1 public member	36 hours annually
Utah	Naturopathic Physicians Licensing Board	3 NDs and 2 public members	24 hours annually, 10 pharmacy
Vermont	Naturopathic Advisory Committee[4]	2 NDs	30 hours annually
Washington	Washington Department of Health Naturopathy Program	3 NDs and 2 public members	20 hours annually

[1] Within the California Department of Consumer Affairs
[2] Advises the Washington DC Board of Medicine on guidelines for the licensing of naturopathic physicians and the regulation of naturopathic medicine
[3] Two subcommittees of the Kansas State Board of Healing Arts include the ***Naturopathic Advisory Council*** to advise the Board and the ***Naturopathic Formulary Advisory Committee*** to develop a list of drugs and substances included in a naturopathic formulary
[4] Under Vermont's Secretary of State

ALASKA NATUROPATHIC COUNCIL:

1) The Alaska Naturopathic Council (hereinafter referred to as the Council) shall investigate what is taught in approved naturopathic medical programs and the formularies of other states that have prescription writing authority for naturopathic doctors.
2) Make recommendations for an appropriate formulary of approved prescription medications and medical devises.
3) Advise the Department of Corporations, Business and Professional Licensing (hereinafter referred to as the Division) on criteria for licensees that seek prescription writing endorsement and continuing education requirements to maintain that endorsement.
4) The Council shall meet at the request of the Division to review allegations of misconduct involving naturopathic doctors or persons claiming the title of naturopathic doctor.
5) Appointments to the Council shall be made by the Division and shall consist of two naturopaths, one pharmacist and two public members, one of whom may be a medical doctor or osteopath.

Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix I: Accrediting Agencies

School	National Accrediting Body	Regional Accrediting Body
Bastyr University	Council for Naturopathic Medical Education	Northwest Association of Schools and Colleges
National College of Naturopathic Medicine	Council for Naturopathic Medical Education	Northwest Association of Schools and Colleges
Southwest College of Naturopathic Medicine	Council for Naturopathic Medical Education	North Central Association of Schools and Colleges
University of Bridgeport College of Naturopathic Medicine	Council for Naturopathic Medical Education Candidate	New England Association of Schools and Colleges

Source: Hough, Dower & O'Neil, *Portrait of a Profession: Naturopathic Practice,* Center for the Health Professions, UCSF, 9/2001, page 46.

The Council of Naturopathic Medical Education (CNME)

The Council of Naturopathic Medical Education (CNME) is the agency recognized the US Department of Education to serve as the accrediting agency for naturopathic medical programs. The USDE also reviews the Liaison Committee on Medical Education that accredits medical education programs within the United States that grant degrees to medical doctors. The accrediting process serves to assist medical programs in maintaining and improving the quality of education and to provide the public, other education institutions and government agencies the assurance that approved programs and their graduates are meeting reasonable and appropriate national standards for primary care medical education. The CNME is an autonomous, freestanding public agency, not subordinate to either the naturopathic profession or its colleges.

Post-secondary Education Commission

In addition to accreditation by the CNME, naturopathic medical colleges must have accreditation from the Post-Secondary Education Commission in the state in which the college is located and from the individual state naturopathic licensing agency.

The Commission on Accreditation is responsible for administering the evaluation process and making accreditation decisions. The Commission uses institutional self-studies, followed by on-site campus visits to evaluate the quality of the education provided. Site visit teams are specially trained and have broad experience in education, accreditation and naturopathic medicine. The Commission renders its decision based on reports of the visits, along with materials provided by the institution. Evaluations of programs may be conducted jointly with a regional accrediting agency, although decisions are made separately.

The Commission on Accreditation, consisting of the Council members but not the institutional members, is responsible for administering the evaluation process and making accreditation decisions. (Peterson's Guide to Graduate Programs in Business, Education, Health, and Law, 1992).

General Introductory Material

for Pharmacy Continuing Education

What you need to know BEFORE you enroll in 60 hours of CME

Introduction
Necessary for all 4 parts of the CME pharmacy course
includes pharmacokinetics, pharmacodynamics, receptor systems and mechanisms.

Part I
Ancillary material for CME course Part I
Neuropharmacology and Controlled Substances
Mechanisms of action
includes neurotransmitter agonists and antagonists, medications affecting neurotransmitter levels, autonomics, serotonin, opiates, GABA, PDE

Part II
Ancillary material for CME course Part II
Cardiovascular Pharmacology
Mechanisms of action
includes renin-angiotensin system, medications affecting the kidney (diuretics), clotting cascade, platelet aggregation

Part III
Ancillary material for CME course Part III
Infectious Diseases and Antibiotics
Mechanisms of action
includes bacterial/viral synthesis, retroviral action and therapeutic interventions

Part IV
Ancillary material for CME course Part IV
Endocrine Pharmacology and Women's Medicine
Mechanisms of action
includes hormone agonists and antagonists and medications affecting hormone response and hormone level.

For additional information, see

- Katzung's Basic and Clinical Pharmacology, 2001, 8th edition, McGraw-Hill.
- Goodman and Gilman's the Pharmacological Basis of Therapeutics, 2001, 10th edition, McGraw-Hill

Alaska Association of Naturopathic Physicians, Inc.

Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix K: Comparison of Allopathic and Naturopathic Disciplinary Reports

Medical boards receive complaints and after investigation met out disciplinary actions. Information on complaints and disciplinary actions is not available for several states. Of 13 states that license Naturopathic physicians, information on disciplinary actions could only be found for six states including Alaska, Arizona, Hawaii, Oregon, New Hampshire and Washington. These results are listed below (Table 1) for the years 2000-2003.

Table 1: Naturopathic Disciplinary Actions

		Dates	Alaska	Arizona	Hawaii	Oregon	New Hampshire	Washington
# Naturopaths			40	369	78	550	32	644
Avg. # complaints/yr				not available	0.2	22.75	not available	10.75
Disciplinary actions		2000-2003						
	Reprimand/Corrective action	"	0	1	0	0	0	1
	Probation	"	0	4	0	6	0	0
	Suspension	"	0	1	0	0	0	0
	Revocation/Surrender	"	0	1	0	2	0	0
	Total		0	7	0	8	0	1

The total number of naturopathic licensed naturopathic doctors in the states was 1,681.
The average number of disciplinary actions per year was 4 for 2000-2003
The yearly rate of disciplinary actions per 100 doctors per year is 0.24.

Arizona and Oregon are two of the three states with the largest population of naturopathic doctors and a long history of licensure. Disciplinary actions are compared between naturopathic and allopathic doctors for each state (see tables 2 and 3).

Alaska Association of Naturopathic Physicians, Inc.

Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix K: Comparison of Allopathic and Naturopathic Disciplinary Reports

Table 2: Comparison of Naturopathic and Allopathic Disciplinary Actions in Arizona

Naturopathic Doctors	***Year***	***Letters of Concern****	***Reprimand***	***Probation***	***Suspension***	***Revocation***	***Surrender***	***Total Disciplinary***
# 369	2000	1	1	1				2
	2001	1				1		1
	2002	2		3	1			4
	2003	2						0
Total		8	1	4	1	1		7
Medical Doctors								
#10,652	2003	unknown	38	35	8	11	9	101

*Letters of concern are not considered disciplinary actions

The total number of naturopathic doctors in Arizona during 2000-2003 was 369. The total number of disciplinary actions during this time period was 7. The yearly rate of disciplinary actions per 100 doctors is 0.47.

The total number of medical doctors in Arizona during 2003 was 10,652. The total number of disciplinary actions during this time was 101. The yearly rate of disciplinary actions per 100 doctors is 0.95.

Alaska Association of Naturopathic Physicians, Inc.

Assuring Safe Naturopathic Medical Practices for Alaskans

Appendix K: Comparison of Allopathic and Naturopathic Disciplinary Reports

Table 3: Comparison of Naturopathic and Allopathic Disciplinary Actions in Oregon

Naturopathic Doctors	Year	Complaints	Reprimand/corrective action	Probation/restriction	Suspension	Revocation	Surrender	Total Disciplinary
# 550	2000	23	none reported	1	0	0	0	1
	2001	30	"	2	0	1	0	3
	2002	23	"	2	0	0	0	2
	2003	15	"	1	0	1	0	2
Total		91	"	6	0	2	0	8
Medical Doctors								
#11,583	2003	unknown	14	20	2	2	5	43

The total number of licensed naturopathic doctors in Oregon during 2000-2003 was 550. The total number of disciplinary actions during this time period was 8. The yearly rate of disciplinary actions per 100 doctors is 0.36
The total number of medical doctors in Oregon during 2003 was 11,583. The total number of disciplinary actions during this time was 43. The yearly rate of disciplinary actions per 100 doctors is 0.37.

Sources:

Arizona Board of Naturopathic Examiners: www.npbomex.az.gov
Arizona Board of Medical Examiners: http://www.azmdboard.org/Agency_Reports/md_stats.pdf
Hawaii Board of Naturopathic Examiners: naturopathy@dcca.hawaii.gov
Oregon Board of Naturopathic Examiners: www.obnme.state.or.us
Oregon Board of Medical Examiners: www.bme.state.or.us
New Hampshire Dept. HHS, Board of Naturopathic Examiners: (603)271-5127 License Clerk, Janet
New Hampshire Board of Medicine: http://www.nh.gov/medicine/cidisciplinary.html
Washington Health Professions Quality Assurance, Naturopathy Program: Holly.Rawnsley@doh.wa.gov

Crater Lake Hwy.
e City, OR 97503

CASCADE CLINIC
Be Well & Well Informed

tel: 541-826-9173
fax: 541-826-8366

February 17, 2004

Representative Jim Holm
Alaska State Capital Building
Juneau, Alaska 99801-1182

Attn: Representative Holm

I am writing to support legislative bills HB434 and SB 306, both titled "An act relating to the practice of naturopathic medicine."

As a pharmacist and naturopathic physician, I taught pharmacology at the Southwest College of Naturopathic Medicine in Tempe Arizona and wrote pharmacology test questions for the naturopathic board exam. I also created the original formulary used in Arizona and later used in Oregon, which included drugs derived from natural sources. As an instructor, I taught students to thoroughly research the warnings and precautions of each drug they prescribed, so they were aware of the possible harm they might cause to their patients. The test questions I wrote required knowledge of pharmacology necessary to protect the public safety. The formulary system, which I have had to practice under, is antiquated and actually has a negative effect on public safety. The formulary forces naturopathic physicians to choose less than optimal drugs over more effective newer medications.

As a provider, I know that naturopathic physicians, like MDs, regularly prescribe a handful of drugs with which they are quite familiar. Unlike medical doctors, naturopathic physicians prescribe medications as a last resort, treat fewer patients each day, and are less likely to place individuals on multiple drug regimens, which lead to interactions and complications. As general practice physicians seeing fewer patients on a daily basis, naturopathic doctors have much more time to research the consequences of drug therapy than do their MD or DO colleagues.

In Oregon, where I practice, medical care has been shifted to nurse practitioners with less education than naturopathic physicians. It is irrational for trained primary care physicians to be limited to non-drug therapies at a time when access to quality health care is becoming scarce. Consequently, I support legislation that allows naturopathic physicians to practice commensurate with their education and to the full scope of their training. Please support this Bill.

Sincerely,

Rick Chester, ND, RPh. LAc

cascadepharmacy.com

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 13, 2009

Honorable Bettye Davis
Chair, Senate Health and Social Services Committee
Alaska State Senate
State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB70 – Naturopath, Scope of Practice Expansion

Dear Senator Davis:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

As stated in my letter to you dated February 24, 2009 (copy attached) ASMA opposes SB 70 and any expansion of a naturopath's scope of practice beyond that which is currently found in AS 08.45. This is a quality of care and patient safety issue.

Attached, also please find a copy of the American Medical Association's ,"Scope of Practice Data Series", that presents data about naturopaths.

Unfortunately, ASMA has been advised by legal counsel that we are unable to sit down outside the legislative process to discuss or agree on the content of SB 70.

A series of U.S. Supreme Court cases (collectively known as the Noerr-Pennington Doctrine) provides protection from claims of violation of restraint of trade laws for an association like ASMA only as long as its activities pertain to a government action, like a bill introduced by the Legislature. Noerr-Pennington, indeed, does not generally extend to ASMA activities outside the public arena with other groups of medical care providers to discuss or agree upon the contents of a bill. The concern is another group or person, not a party to such discussions, claiming that those groups that did meet, met in order to restrain trade by agreeing to something to their detriment. This is why task forces constituted by the Legislature have been formed to address this and other issues related to specific legislation.

ASMA questions that the naturopaths' education and training have the comparable depth and breadth as that of an MD or DO. The ability to prescribe drugs and perform "minor surgery" needs to be left with MD's and DO's. A parallel recently in the news was the pilot who safely landed his aircraft in the Hudson River – when a goose hits the turbine jet engine is it better to have a Captain Sullenberger at the controls or a VFR rated recreational pilot.

ASMA urges you and the Health and Social Services Committee to oppose SB 70.

Sincerely

By: Thomas Vasileff, MD, President
For: The Alaska State Medical Association

cc: Senate Health and Social Services Committee members: Senator Paskvan
Senator Ellis
Senator Thomas
Senator Dyson

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 24, 2009

Honorable Bettye Davis
Chair, Senate Health Education and Social Services Committee
Alaska State Senate
State Capitol, Room 30
Juneau, AK 99801-1182

Re: SB70 – Naturopath, Scope of Practice Expansion

Dear Senator Davis:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

ASMA opposes SB70 and any expansion of a naturopath's scope of practice beyond that which is currently found in AS 08.45.

Naturopaths wish to have the same scope of practice as Primary Care Physicians (MD's and DO's). It is a difficult if not impossible task to determine if a naturopath's education and training is comparable to that of an MD or DO. ASMA questions that the naturopaths' education and training have the comparable depth and breadth as that of an MD or DO.

ASMA will oppose bills such as SB70 that expand the scope of practice beyond what is currently allowed in AS 08.45 until:

1. The U.S. and Canadian schools of naturopathy that grant doctoral degrees are accredited by the same accrediting bodies for the U.S. and Canadian medical schools – the Liason Committee on Medical Education (LCME) or the American Osteopath Association (AOA), Commission on Osteopathic College Accreditation (COCA);

2. All candidates for admission to U.S. and Canadian schools of naturopathy are required to take the Medical College Admission Test (MCAT);

3. All graduates of U.S. and Canadian schools of naturopathy pass all three steps/levels of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Examination (COMLEX – USA), using the same passing criteria as the MD's or DO's respectively;

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4. All naturopaths seeking licensure must successfully complete at least a three year residency program that is accredited by the same accrediting body, Accreditation Council for Graduate Medical Education, for MD's and AOA approved residency programs for DO's; and

5. All naturopaths are subject to the same standard of care criteria as MD's and DO's for licensing sanction actions and in litigation including allegations of malpractice.

ASMA feels such requirements are appropriate to protect the public.

The Alaska State Medical Board (SMB) is a member of a federation of all states' licensing and disciplinary boards, the Federation of State Medical Boards (FSMB). FSMB's journal, "The Journal of Medical License and Discipline," contained, in its most recent edition (Volume 94, Number 3, 2008), an interesting article by David Alan Johnson, M.A., Vice President for Assessment Services – FSMB. The title of the article is "Prospects for a National Clearinghouse on International Medical Schools." It contains an interesting proposal that identifies a way to establish a clearinghouse that contains quality indicators for international medical schools.

There are about 1,800 international medical schools and currently international medical graduates (IMG's) comprise 25% of the U.S. physician workforce. According to Mr. Johnson the contribution of the U.S. licensed IMG's is considerable and data exists that they are more likely to practice in medically underserved areas than U.S. graduates. The FSMB has been dealing with trying to assess qualifications of the international medical schools for many years reported in articles in its journals dating back to 1916, according to Johnson. He states the challenge remains the same, "...how to assess the qualifications of physicians graduated from non-U.S. medical schools despite possessing limited information (at best) as to the educational curriculum of these schools...". However, he also stated that only 10 of these international schools contributed 60% of the IMG's in the U.S. between 1998 and 2002.

The approach for the clearinghouse includes data and information that parallel those quality and patent safety indicators innumerated above for naturopaths. Those indicators as put forth by Mr. Johnson are as follows:

- "admission requirements, including mandatory tests such as the MCAT;
- the number of years the medical school program has been in operation
- school policies related to providing advance standing for students entering from related health professions;
- the degree to which distance learning is utilized in the curriculum; the number of weeks of instruction – both classroom and clinical – culminating in a medical degree;
- the status of the school as it appears in other review processes involving licensure (e.g., the Medical Board of California review process), clinical clerkships (New York state's clerkship approval list) and eligibility for federal student loans (National Commission on Foreign Medical Education and Accreditation);
- aggregate USMLE performance data for students and/or graduates of the school;
- student progression rates toward successful completion of degree requirements;
- the school's success rate in placing students in ACGME or AOA-approved residency programs; and
- information on clinical clerkships, such as whether these are performed outside the host country where the school is located or if an affiliation agreement exists with the hospital(s) where clerkships are being conducted."

This approach is one of developing a "proxy" methodology short of an in depth, ongoing review of each of the 10 international medical schools which is not feasible as it obviously would not be for 1,800 such schools. This is a methodology that could be termed "The proof of the pudding is in the tasting".

ASMA does not believe that the Legislature has the objective information now, and is unlikely to have in the future, that would enable it to make the major patient safety, policy decision it is being asked to make in SB70.

Prescribing drugs and performing "minor surgery" (which could entail the excision of cancerous lesions) by a naturopath require that the naturopath have the equivalent training and education of an MD or DO. The most reasonable way to provide patient safety and public protections is to adopt a policy as suggested by ASMA.

ASMA urges you to oppose SB70 and any other measures to expand the naturopaths' scope of practice beyond that which currently exists in state law.

Sincerely,

Thomas Vasileff, MD
President

March 5th 2009

To Senator Bettye Davis

Please consider this our testimony on Senate Bill 70

My name is Tim Pampusch and I am the current president of the Alaska Academy of Physician Assistants. Our Academy here in Alaska represents nearly 200 practicing Physician Assistants around the state. Physician Assistants attend medical school, often sharing faculty and rotations alongside medical students with focused courses on anatomy and physiology, pharmacology, and applied training on authorization and dispensation of pharmaceuticals. We work in a collaborative fashion with our physician colleagues to help provide health care in every facet of the medical field.

I wish to speak to Senate bill 70, which would authorize prescriptive and minor surgical authority to naturopathic practitioners in Alaska. I have been pondering this issue for several years as it keeps arising during our legislative sessions.

I have several concerns with the current bill. As a Physician Assistant, I have nothing to gain personally from objecting to this bill. My concern is public safety for Alaskan citizens. My understanding of the naturopathic concept, both from my readings and friends who are practitioners, focus on the idea of illness being a disturbance in a person's "vital force". This is a concept removed from science in that it uses unmeasurable and untestable theories to try to approach problematic health concerns. Scientific studies are examining many aspects of naturopathic practice at this time, with unimpressive results so far. Indeed, one of the nationally recognized naturopathic web sites states that the national organization is working to reverse our current model of health care.

The real issue of concern is public safety. Practitioners who currently prescribe controlled medications have years of training and experience to enable understanding of the myriad drug interactions and adverse medical effects of those medications. In my mind, prescriptive authority must be based on training and supervision by those competent and knowledgeable in pharmaceutical effects using scientifically based criteria. This supervision with training, and continuing medical education appears to be an adequate safeguard for the public. In these days of major concerns and expenses dealing with health care reform and funding, we need outcome-based criteria rooted in science for our decision making.

Naturopathic practitioners come from many varied educational backgrounds. There are a few accredited schools with serious training, and there are many nonaccredited correspondence schools. One school offered a Ph.D. in naturopathy for $250, using life experience with no coursework.

Pharmaceutical distribution and surgery are science based activities. Giving permission to dispense drugs to those who reject the scientific methodology developed over the past 400 years would be a mistake. I know several naturopaths, and they are good and caring people, but a basic belief in "vital force" is a handicap to a clear understanding and focus on the scientific method. Giving surgical authority to a practitioner whose training includes this sort of nonvalid concept would be a lamentable risk to the people of Alaska, who, to a greater or lesser degree, understand that the scientific basis of medicine has proven efficacy.

Many naturopaths have been hiring Nurse Practitioners to write pharmaceutical prescriptions. This at least guarantees that the prescriber has completed the training required for safe dispensing. Some naturopaths may be well-suited for prescriptive authority, but there are no national criteria for training programs to provide this. The quality of the educational programs varies to an incredible degree. The Alaska Association of Naturopathic Physicians admits that there are "numerous diploma mill "NDs" throughout the country who certainly do not receive the rigorous training" that the authors obtained.

More to the point of this Senate bill, I ask the question: how could the training programs document equivalence to the training that MDs, Osteopaths, Physician Assistants and Nurse Practitioners receive, that being the basis of accepted criteria for prescriptive authority. Concern over authority for surgical procedures dwarfs the concern over prescriptive authority. Training would need to be documented with objective scientific outcome criteria, unobtainable from the diverse programs.

Because of the above concerns, we will stand along with our collaborative physicians in opposing Senate bill 70. I believe that this bill would allow an unacceptable risk to the residents of the State of Alaska at this time.

Tim Pampusch PA-C
President, Alaska Academy of Physician Assistants

Senator Davis, I appreciate the work you've done in health care. I would hope that our opposition to this bill will not impede our working together in the future for the well being of all Alaskans. As president of the PA Academy, I will continue to reach out to our Nurse Practitioner and Nurse colleagues to try to improve care on a state and national level. Please, let me know if I can be of assistance in any other health care issues.

Emily A. Kane, ND LAc

Naturopathic Doctor
Alaska License № 22
Licensed Acupuncturist
Alaska License № 18

March 3, 2009

Dr. Thomas Vasileff
President, ASMA
4107 Laurel Street
Anchorage, AK 99508

Dear Dr. Vasileff,

Senator Bettye Davis has provided me with the letter from ASMA opposing SB 70, dated February 24, 2009. I have been charged to attempt to redirect your concerns about the naturopathic profession to my group, the Alaska Association of Naturopathic Physicians.

The Senator is the sponsor of this bill, as you know, and it therefore follows that since she and her chief of staff, Mr. Thomas Obermeyer, wrote this bill, they view the bill as part of the solution to Alaska's healthcare crisis. Public protection - the purpose of regulation - should indeed have top priority in scope of practice decisions. This encompasses the belief that the public should have access to providers who practice safely and competently.

Naturopathic doctors are not trying to be MDs or DOs. We practice a different kind of medicine. We are experts in diet, nutrition, exercise physiology, and traditional healing methods such as botanical medicine, physical manipulation, hydrotherapy techniques, and lifestyle counseling, all modalities that are in high demand for today's most common medical conditions. We are excellent diagnosticians. We use a wide range of tools to diagnose, including thorough physical exam, in-depth patient interview and whatever laboratory or imaging methods necessary to understand the patient's pathology. To give you a glimpse of my training, just as examples, I entered ND school as an Ivy league grad, took two years of cadaver anatomy at Bastyr University in Seattle, had five quarters of radiology, sliced and sewed countless pigs' feet, had 7 quarters of pharmacology and spent nearly 2500 hours in supervised clinical training at various clinics and hospitals before applying for licensure.

And now I have been in practice for 15 years without a hint of creating harm. I have over 2000 charts and serve as primary care provider for nearly 200 families in Juneau and SE Alaska. It is unlikely that I would still be in business if, as you suggest, my training lacked depth and breadth.

Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service. The current regulations for naturopathic doctors in Alaska are outdated: they do not reflect the depth and breadth of our training. Naturopathic doctors have been dispensing drugs and offering minor surgery services (as part of a broader scope, obviously) in many Western states, in some cases for decades. NDs have been licensable as fully empowered mid-level providers in Oregon state since the early 1950s. Please consult with the primary malpractice insurer for the naturopathic profession to evaluate rates of harm (virtually zero): www.ncmic.com No group is better at assessing risk than the insurance companies. My malpractice insurance is $1600/year.

418 Harris Street, Suite 329 Juneau, AK 99801
Phone: 907-586-3655 FAX: 907-586-4326 email: DoctorEm@aol.com

2/ letter to Dr. Vasileff

There is no evidence of harm to a patient in Alaska at the hands of a legitimately trained naturopathic doctor. I also hold a license in Oregon (#1662) and if I were to move south I would instantly be able to perform biopsies, remove splinters and sutures, dispense well-indicated antibiotics or antihypertensives, as examples. I am the same doctor here in Alaska. Does the state of Oregon care less about public safety? I pursue rigorous annual CME, nearly half in pharmacology updates, as do all my fellow NDs in the state

Graduation from an approved school and a passing score on the Naturopathic Physicians Licensing Examination (NPLEX) demonstrates that a naturopathic physician has achieved competency to practice as taught in naturopathic medical school (www.nabne.org/nabne_page_23.php). Further, SB 70 stipulates that all NDs who wish to prescribe pharmaceuticals be required to obtain a federal DEA number.

I do not find much parallel between the FSMB's attempt to vet IMGs and the situation here. NDs are not aliens. Our training involves no distance learning. Our educational programs are all federally accredited and all offer access to federal student loans. Entry requirements to our programs include a bachelor's degree and current basic science competency. There are no advanced standing admission criteria other than licensed MDs, DOs and DCs applying for a dual ND degree.

The one parallel that I see between the IMGs and the NDs is that they often practice in medically underserved areas. Surely that is not a problem.

You state that you do not believe the Legislature "has the objective information... that would enable it to make the major patient safety, policy decision it is being asked to make is SB 70." With all due respect, it IS actually the legislators who create law. They read, and you may also read, about the academic curriculae of the accredited naturopathic medical schools in the United States and study the scope of our training in the links provided below.

All six of the North American schools granting the ND degree are accredited by the Council on Naturopathic Medical Education (www.cnme.org) The Council on Naturopathic Medical Education's mission is quality assurance: serving the public by accrediting naturopathic medical education programs that voluntarily seek recognition that they meet or exceed CNME's standards. Founded in 1978, CNME is accepted as the programmatic accrediting agency for naturopathic medical education by the four-year naturopathic colleges and programs in the United States and Canada. CNME advocates for high standards in naturopathic education, and its grant of accreditation to a program indicates prospective students and the public may have confidence in the educational quality of the program. The U.S. Secretary of Education recognizes CNME as the national accrediting agency for programs leading to the Doctor of Naturopathic Medicine (ND or NMD) or Doctor of Naturopathy (ND) degree.

3/ letter to Dr. Vasileff

Let's return to the situation in Alaska, where Medicaid providers are desperately needed, where "access to healthcare services" was rated 49th out of 50 states by the AARP last month, where chronic diseases of obesity, diabetes, alcoholism, tobacco abuse, cardiovascular disease are rampant. Part of our healthcare crisis is the erroneous concept that MDs and DOs can optimally and affordably handle all this demand. The majority of these chronic diseases can be capably managed by NDs, NPs and PAs as well, if not better, than MD specialists. Distributing patients to providers most inclined to serve their needs is going to be critical to the solution to this health care crisis.

NDs have considerably more training than nurse practitioners, yet this competent group of mid-level providers have all the practice scope that NDs seek. Expansion of scope for NPs, dental hygienists and
optometrists have only benefitted Alaskans. No doctor, dentist or opthalmologist has gone out of business due to improved access to mid-level providers, and the safety of Alaskans has not been compromised.

NDs have a well established history of practicing medicine safely. This is our bailiwick. We primarily use gentle, effective, low-tech therapies. It is not up to ASMA to police our profession. Our patients will continue to choose our care because it works for them. We don't need to have drugs and minor surgery, but we are capably trained in these arenas and would be of greater service to the constituents of Alaska were we legally empowered to choose those methods, when best indicated.

My colleagues and I enjoy pleasant and productive relationships with your colleagues. We share patients with many ASMA members, and on a doctor to doctor level, we cooperate well. I invite you to extend this cooperation more broadly for exactly the reason you cite as your chief concern: patient safety.

In health,

Dr. Emily A. Kane
Vice President, Alaska Association of Naturopathic Physicians (www.akanp.org)

naturopathic medical training institutions in the U.S.:
www.NCNM.edu/adademics
www.SCNM.edu/admissions/curriculum.php
www.Bridgeport.edu/pages/2562.asp
www.Bastyr.edu/education/naturopath/degree/training.asp

CC Senator Davis

Lynda Zaugg

From: Thomas Obermeyer
Sent: Thursday, February 19, 2009 2:58 PM
To: Lynda Zaugg
Subject: FW: response to Alaska Academy of Family Physicians opposition to SB 70

Lynda, Please include this e-mail in SB 70 hearing package, which unfortunately did not come through as an attachment.

From: DoctorEm@aol.com [mailto:DoctorEm@aol.com]
Sent: Wednesday, February 18, 2009 11:33 PM
To: akafp@gci.net; Thomas Obermeyer; Sen. Bettye Davis; Rep. Wes Keller; Rep. Bob Herron
Cc: gary.f@gci.net; mminor@alaska.net; drluper@acsalaska.net; DrJasonHarmon@gmail.com; drkristinnd@gmail.com; docdave@acsalaska.net; amycnd@gci.net
Subject: response to Alaska Academy of Family Physicians opposition to SB 70

Feb 18, 2009

Mary Ann Foland, MD
President, Alaska Academy of Family Physicians
35555 Spur Highway, Suite 200
Soldotna AK 99009

Dear Dr. Foland,

Senator Bettye Davis gave me a copy of your letter opposing SB 70, scheduled to be heard in Senate HSS on March 13, at 1:30 PM. She has asked that I respond to you in order to encourage "discussion, and a modicum of accomodation" before the committee hearing.

You make a good point that naturopathic doctors (called physicians in all other states where licensed) practice natural medicine and that our training includes deep investigation of nutritional therapies, the medicinal properties of plant medicine, exercise physiology, and a variety of other non-invasive modalities. However, our training is not limited, as you suggest, to "natural herbs and nutraceuticals not regulated by the FDA." There exists some understandable confusion about my profession because of numerous diploma mill "NDs" throughout the country who certainly do not receive the rigorous training that I and my professional colleagues underwent. It is not difficult to discern the "real" NDs. Only properly trained naturopathic physicians are eligible for membership in our national organization, will be affiliated with their local hospitals and community health establishments, and maintain proof of yearly CME.

Alaska ND licensure is dependent, in part, on ongoing affiliation with our national professional organization, the American Association of Naturopathic Physicians (www.naturopathic.org) which provides yearly continuing medical education (CME) opportunities, and requires both graduation from an accredited school and holding a state license in good standing. One of the objectives of SB 70 would be to mandate CME for NDs in Alaska, lack of which mandate is example of a gap in the current, inadequate, licensure regulations.

The principle objective of SB 70 is to bring the statutes governing naturopathic physicians in Alaska

into the 21st century.

I enclose for your perusal a "white paper" explaining the rationale of the Alaska Association of Naturopathic Physicians for updating our statutes. The white paper includes a curriculum comparison with a conventional medical school. I believe you might not be aware of the scope of our classroom training, nor the requirements for supervised clinical education before graduation.

My own medical education is fairly typical of NDs practicing in Alaska. I graduated from a 4-year college in 1978. Later, I went back to school for 2 years to become eligible to enroll in one of the 6 accredited schools of Naturopathic medicine in North America (Bastyr University, Seattle WA). I spent 6 years at Bastyr University which included just over 2500 hours of supervised clinical training beyond didactic courses. I passed national licensing exams (NPLEX) in 5 basic science topics and 14 clinical science topics. I spent 4 months in intensive hospital rotations after graduation. I spent another year in a clinical residency with a senior ND before opening my own practice.

I think it is not unreasonable to ask new naturopathic licensees to pass the USMLE exams. Are you aware of any precedent for mid-level providers taking these exams? I recently passed my Oregon Board of Naturopathic Licensing exams, which, as you might not know, qualifies me to apply for a DEA number and to perform minor surgery in Oregon. I'm not planning on moving to Oregon at this time! I simply wanted to make the point that I would be just as capable of safely dispensing low schedule drugs and engaging in minor surgery involving the epidermis in Alaska as I would be in Oregon. In the states where NDs have had prescriptive and minor surgeries privileges (in some states, for many decades) there is a stellar public safety record. This is because NDs tend to use prescription medicine as a last resort. However, it is costly and inefficient to not use a simple legend medicine when it is the best therapeutic choice.

Naturopathic physicians have significantly more training than nurse practitioners, but the NPs in Alaska have prescribing rights whereas NDs do not. That is simply because there are more of them, and they can afford a PAC and to hire a lobbyist. I currently have under my tutelage a young nurse practitioner who is studying topics of interest not available to her during her training. She is 20 years younger than me and has been in practice for 2 years, compared to my 15. Yet, when a patient of mine needs an antibiotic or a temporary antihypertensive, my student has to sign off on the prescription. That is just silly!

Last week I had a patient with culture-confirmed strep throat. I had known this patient for years and knew she was sensitive to penecillins. So, she needed a cephalosporin. If I had not been able to prevail upon my nurse practitioner student, my patient would have had to wait 2 weeks and spend another $200 to get into to see another doctor in town for 5 minutes to get the Keflex prescription. This would have wasted time, and wasted money, and caused my patient unnecessary suffering.

SB 70 addresses this waste by allowing NDs to create a board which would in turn determine the basic toolkit of prescription medication we need to work effectively as primary healthcare providers. The idea of this board is fully supported by the Department of Occupational Licensing, which currently governs NDs. Jenny Strickler, head of our DOL division, has told me she thinks it's high time NDs had a board. She has expressed to me personally, and would testify to, how inappropriate it is for a "lay person, such as myself, to be governing a healthcare professional." This board would consist of 3 naturopathic physicians, 1 pharmacist and one member of the public which could be an MD. **We would very much like a member of the AKAFP to express interest in working with us on this new board.**

In addition, SB 70 would update regulations governing naturopathic physicians to allow us to become Medicaid providers. The governor has expressed her support for expanding Medicaid. That's terrific! However, the state doesn't just need more federal dollars. It also needs providers. There is not one family doctor in Juneau right now who is accepting new Medicaid patients. SB 70 would instantly provide Alaskans with 40 seasoned, mature, established family doctors with a long track record of providing not only safe effective therapies for chronic illness, but doctors who focus on wellness and prevention. NDs have been Medicaid providers in Washington and Oregon, as examples, for several decades; NDs are deeply embedded in the public health systems of these forward-looking states. We will always use drugs as a last resort, and mostly we will make referrals for drug therapy. However, it is extremely inefficient to not be able to nip a simple problem in the bud, with access to all the tools which we are trained to use, and maintain.

Thank you for your attention to this letter. I do hope it has provided some assurances against your concerns for public safety in the hands of naturopathic physicians practicing as trained. The primary mission of my profession is adherence to our oath to "Do No Harm." We succeed well in this arena. We are also passionate about helping to reform the culture of "disease management" to one of wellness promotion, disease prevention and low-tech medicine whenever possible. There is increasing public demand for these services, and ultimately, it is the discerning public who will continue to bear out our safety record.

In my opinion, it would be best for healthcare reform in general, and for our shared patients specifically, if our professions could cooperate in our mutual mission to improve community health. However, the need and demand for naturopathic services will continue regardless.

While I do appreciate your concerns for public safety, in this case I think they are unfounded. I invite you to look fairly at public harm at the hands of MDs versus public harm due to NDs, especially in states such as Oregon, Washington and Arizona where NDs are allowed to practice as trained. Please let me know if I can provide any more materials about the training and work of naturopathic physicians.

Best wishes, in health,

Dr. Emily A. Kane
Vice President, Alaska Association of Naturopathic Physicians

www.DrEmilyKane.com

You can't always choose whom you love, but you can choose how to find them. **Start with AOL Personals.**

2/24/09 Gmail

Emily, the Sen. will be taking testimony on SB 70 at the hearing on the 13rh. You should plan to testify. This will be your opportunity to speak on behalf of the bill. This would also be a good time for anyone with an opinion/thought/concern to come forward to testify. The Sen. will try to give folks wishing to testify as much time as they need within limits. If we have a large number of folks to testify she will have to limit speaking time but she will make that decision at the time of the hearing. Hope that answers your question. Lynda

dremily Kane@gmail.com

cc Tom Obermeyer

Emily A. Kane, ND LAc

Naturopathic Doctor
Alaska License № 22
Licensed Acupuncturist
Alaska License № 18

Feb 17, 2009

Dear Senator Paskvan,

I am writing in support of SB 70.

I am one of 40 naturopathic doctors (ND) licensed in the state of Alaska. I have practiced medicine in Juneau for 15 years, with hospital privileges and full insurance reimbursement from all the major medical insurers. I enjoy excellent collegiate rapport with the MDs and other health professionals in town, almost without exception. I have over 2000 patient charts and serve as family doctor to several hundred Juneau families. I believe you recently met my Fairbanks colleague Dr. Mary Minor, who has provided healthcare services in Alaska for nearly 25 years.

I would like to point out the salient features of SB 70 and attempt to dispel some of the mischaracterizations of my profession recently provided in a letter from the Alaska State Medical Association. Many members of ASMA are part of my referral base. I had a long talk yesterday with the immediate past president of ASMA -- we share several patients and I send my more complicated diabetic patients to him in Anchorage. Dr. Ross Tanner explained to me that "docs" involved in groups such as ASMA are not only physicians, but also have political aspirations. I asked him how it could be that when I discuss patients with my fellow healthcare professionals, we have productive interactions and work together for the benefit of the patient, but I cannot for the life of me get an MD to support the updating of laws governing naturopathic physicians. Ross explained that such support would be "political suicide" for an MD, despite their almost universal recognition of the diagnostic capabilities of NDs, and our safe, effective therapeutics which they have witnessed for years in patients we share.

Several ASMA members locally have spent time with me "brainstorming" on how to overcome this problem. Dr. John Raster, a local otolarygologist and current speaker of the house for ASMA, suggested I focus on the fact that naturopathic physicians have significantly more training than nurse practitioners, but the NPs have way more prescribing rights. That is simply because there are more of them, and they can afford a PAC and to hire a lobbyist. I currently have under my tutelage a young nurse practitioner who is studying herbal medicine and some traditional healing methods. She is 20 years younger than me and has been in practice for 2 years, compared to my 15. Yet, when my patient needs an antibiotic or a temporary antihypertensive, she has to sign off on the prescription. That is just silly!

SB 70, a zero-note bill, would update regulations governing naturopathic physicians to allow us to become Medicaid providers. The governor has expressed her support for expanding Medicaid. That's terrific! However, the state doesn't just need more federal dollars. It also needs providers. There is not a one family doctor in Juneau right now who is accepting new Medicaid patients. SB 70 would instantly provide your constituents with 40 seasoned, mature, established family doctors with a long track record of providing not only safe effective therapies for chronic illness, but doctors who focus on wellness and prevention. NDs have been Medicaid providers in Washington and Oregon, as examples, for several decades; NDs are deeply embedded in the public health systems of these forward-looking states. The safety record of NDs in states where they have prescriptive and minor surgery authority is stellar. We will always use drugs as a last resort, and mostly we will make referrals for drug therapy. However, it is extremely inefficient to not be able to nip a simple problem in the bud. Last week I had a patient with culture-confirmed strep throat. I had known this patient for years and knew she was sensitive to penecillins. So, she needed a cephalosporin. If I had not been able to prevail upon my nurse practitioner student, my patient would have had to wait 2 weeks and spend another $200 to get into to see another doctor in town for 5 minutes to get the Keflex prescription. Wasted time, wasted money.

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SB 70 addresses this waste by allowing NDs to create a board which would in turn determine the basic toolkit of prescription medication we need to work effectively as primary healthcare providers. The idea of this board is supported by the Department of Occupational Licensing, which currently governs NDs. Jenny Strickler, the capable head of our DOL division, has told me she thinks it's time NDs had a board. She has expressed to me personally, and I hope would testify to, her thoughts that it is inappropriate for a "lay person, such as myself, to be governing healthcare professionals." Ms. Strickler spent about an hour with me last month discussing the mechanism of how our board would interact with her department. This board would consist of 3 naturopathic physicians, 1 pharmacist and one member of the public which could be an MD.

SB 70 also calls for naturopathic doctors (NDs) who want to prescribe legend drugs to register with the federal Drug Enforcement Agency. Precedent exists for NDs having DEA registration in multiple states. Jenny Strickler has also endorsed this provision because it is her opinion that DEA registration requirement for NDs wanting prescriptive rights provides the state legislators with another layer of "security" for Alaskan residents. I agree.

We are not in competition with the MDs. We provide a different and unique service. Our patients will continue to come to us out of choice. It's a matter of freedom of choice in healthcare. Some patients prefer a "drug as the last resort" approach to their health and health problems. The issue of blocking the updating of our legislation is akin to dentists protesting dental hygienists, MDs blocking the nurse practitioners, opthalmologists blocking the optometrists. All the mid-level providers listed here except NDs have prevailed – and Alaskans are better served because of it. No dentist or MD has gone out of business because the mid-level providers have garnered legislation that allows a scope of practice commensurate with their training.

Like my fellow licensed Alaskan NDs, I have completed a vigorous medical education. I graduated from an Ivy League college in 1978. Later, I went back to school for 2 years to become eligible to enroll in one of the 6 accredited schools of Naturopathic medicine in north America (Bastyr University, Seattle WA). I spent 6 years at Bastyr University which included just over 2500 hours of supervised clinical training. I passed national licensing exams (NPLEX) in 5 basic science topics and 14 clinical science topics. I spent 4 months in intensive hospital rotations after graduation. I spent another year in a clinical residency with a senior ND before opening my own practice. My Alaska licensure is dependent, in part, on ongoing affiliation with my national professional organization, the American Association of Naturopathic Physicians which requires yearly continuing medical education (CME), graduation from an accredited school and a state license in good standing. SB 70 would also mandate CME, lack of which mandate is another example of a gap in the current, inadequate, licensure regulations. To summarize: The statutes governing naturopathic physicians in Alaska need to be brought into the 21st century.

If you have read through this letter, I thank you and appreciate your perseverance. The letter will copied to the current ASMA president, Dr. Thomas Vasileff, as well as directed to the bill's sponsor, Senator Bettye Davis.

I would enjoy an opportunity to discuss your concerns about the benefit of this bill to Alaskans. My clinic is 2 blocks away from the Capitol building and I hope you will call if you have further questions about the naturopathic medical profession, which has provided safe, effective, licensed healthcare services to Alaskan families since 1986.

Sincerely,

Dr. Emily A. Kane

The American Association of Naturopathic Physicians
www.naturopathic.org

Naturopathic Medicine, founded upon a holistic philosophy, combines safe and effective traditional therapies with the most current advances in modern medicine. Naturopathic medicine is appropriate for the management of a broad range of health conditions affecting all people of all ages.

Naturopathic physicians (NDs) are trained in the basic medical sciences and conventional diagnostics. Naturopathic education also includes therapeutic nutrition, botanical medicine, homeopathy, natural childbirth, classical Chinese medicine, hydrotherapy, naturopathic manipulative therapy, pharmacology and minor surgery. NDs are positioned to practice preventive health care – not only engaging patients in health promotion but also treating those with chronic disease to manage the entirety of their health. NDs will always turn to safe, natural, low-tech therapeutics first. However, they are thoroughly trained as primary healthcare providers with skills in physical exam, diagnostic lab and imaging analysis, and pharmacology, and these tools are employed as necessary to provide the best outcome for the patient.

Education and Training requirements for all licensed naturopathic physicians requires successful completion at one of our four year, graduate-level naturopathic medical schools, whose missions are educational excellence in the prevention, diagnosis, and treatment of disease and promotion of optimal health. Like conventional medical schools, the first two years of ND training concentrate on the basic biomedical sciences: anatomy, physiology, histology, embryology, pathology, and biochemistry. The second two years integrate the basic biomedical sciences with clinical sciences, focusing on a broad range of therapeutic interventions: clinical nutrition and diet, botanical medicine, homeopathy, naturopathic physical medicine and hydrotherapy, counseling and health psychology. Students are also trained in pharmacology and in minor office procedures, such as removal of superficial lesions and suturing of minor lacerations. All licensable NDs receive approximately 1400 hours of supervised clinical training, in clinics or hospitals, before graduation. Many NDs complete internships or preceptorships (similar to residencies) for 1 or more years following graduation.

After graduation from our accredited schools, naturopathic physicians have a debt level equal to that of allopathic medical school graduates, and a default rate of almost zero. They actively seek opportunities to work in rural and underserved areas as primary care providers, where they feel they can contribute the most. The need for primary health care services in urban and rural areas, especially for at-risk and underserved populations, is well documented. Naturopathic physicians are thoroughly, vigorously and uniquely trained in health and wellness promotion and can safely and effectively fill the void in health care that is jeopardizing our children, our families and our future.

Editorial

The Collapsing Health Care System

This editorial is being written just after the Dow Jones Industrial Average fell 778 points because of the failure to pass the $700 billion bailout bill. Another headline that appeared in the news today was that Medicaid costs will soon be spiraling out of control, primarily because of the increasing need for long-term care for the elderly and disabled. The presidential candidates have essentially stopped talking about their health care plans, because it is becoming clear that there will be little or no money for new programs and perhaps not enough money to continue some of the old programs. And we, the folks, worry that illness will mean bankruptcy.

A few weeks ago, the Associated Press reported that only two percent of graduating medical students plans to work in primary care internal medicine. Factors cited for the increasing preference for non-primary care specialties include high medical school debt, low insurance payments for office visits (when compared with various simple procedures), difficulty caring for the chronically ill and elderly with complex diseases (especially with the need to see so many patients per hour), and excessive amounts of paperwork. Because of the ongoing loss of front-line physicians, the American College of Physicians warned that the nation's primary care system is "at grave risk of collapse."

A study published September 2008 in the *New England Journal of Medicine* concluded that arthroscopic surgery for osteoarthritis of the knee (a procedure performed by highly paid specialists, some of whom decided not to go into primary care for the reasons cited above) doesn't do any good. Actually, we already knew that, because a 2002 study published in the same *New England Journal of Medicine* came to the same conclusion. But orthopedic surgeons continued performing the procedure about 250,000 times per year at a total cost of about $1.75 billion per year.

It was also reported recently that the use of insulin-sensitizing thiazolidinedione drugs, such as rosiglitazone (Avandia), which are used to treat diabetes, is associated with a two- to threefold increase in the risk of suffering an osteoporotic hip fracture. So, patients taking Avandia may eventually need to take alendronate (Fosamax) to keep their bones strong. Unfortunately, new research shows that the use of Fosamax is associated with a doubling of the risk of developing atrial fibrillation. So, the patient goes into atrial fibrillation, which is treated with amiodarone, which leads to severe pulmonary and hepatic toxicity, and now the patient is in real trouble and on the hook for serious medical bills. Brown rice, beans, chromium, and exercise would have been a lot cheaper and a much safer treatment for diabetes than Avandia.

It also turns out that some upstart drug company got the idea that it owns God's molecule, pyridoxal 5'-phosphate (PLP; the biologically active form of vitamin B6). Apparently, this company has spent money on research demonstrating that PLP is an effective treatment for cardiovascular disease. So, they have petitioned the Food and Drug Administration to have this vitamin declared a drug, so that only they will be allowed to sell it (no doubt at monopoly prices).

All of these stories are symptomatic of a system that has developed very large cracks and is on the verge of breaking.

In my 25 years of writing for the *Townsend Letter*, I have made many suggestions on how we could improve the public health and the health care system, while substantially reducing costs: Emphasize natural medicine. Tax unhealthful food and give a tax credit for healthful food, exercise equipment, and other health-promoting behaviors. Eliminate expensive defensive medicine and expensive malpractice insurance by reforming the tort system. Reconsider the wisdom of spending tens of thousands of dollars on intensive care for people in the last days of their lives. Stop performing expensive procedures that do not work. Emphasize home birth and other low-cost home remedies. Integrate mid-level practitioners (such as nurse practitioners and physician assistants) more fully into the system. Remind doctors that inexpensive older medicines often work just as well as newer, expensive ones.

When I made these suggestions, I did not believe they would be implemented, and most of them have not been. Our society was, and still is, too bound by the desire for money to hear the call of service and altruism. The medical student does not want to do primary care; the orthopedist does not want to stop doing lucrative but worthless operations; the drug companies do not want to stop pushing lucrative but dangerous drugs; and the upstarts want to usurp God's patents. As Paul said to Timothy, "the love of money is the root of all evil." But now, as the money threatens to dry up (the "liquidity crisis") or perhaps to sink the ship (necessitating a "bailout"), even the greedy will be forced to look elsewhere to find new roots.

Why does it take an earthquake, a hurricane, or a tsunami before we come to people's aid? If and when the next Great Depression hits, will we rediscover the joy of service?

Oh, people, look among you; it's there your hope must lie.[1]

Alan R. Gaby, MD

1. From "Rock Me on the Water," by Jackson Browne.

AARP AK

Alaska News www.aarp.org/ak Winter 2008

Calendar

State Legislature Meets
Jan. 15 – April 13. To listen or watch real-time video and audio of "Gavel to Gavel Alaska," go to www.ktoo.org/gavel/stream.cfm.

2008 Iditarod Trail Sled Dog Race
Starts March 1, 10:00 a.m., 4th Avenue & D Street, Anchorage.

Alaska Permanent Fund Dividend
Application deadline is March 31. Go to www.pfd.state.ak.us/.

WGBH's "Caring for Your Parents"
This 90-minute documentary airs April 2 on your local PBS station.

Volunteer

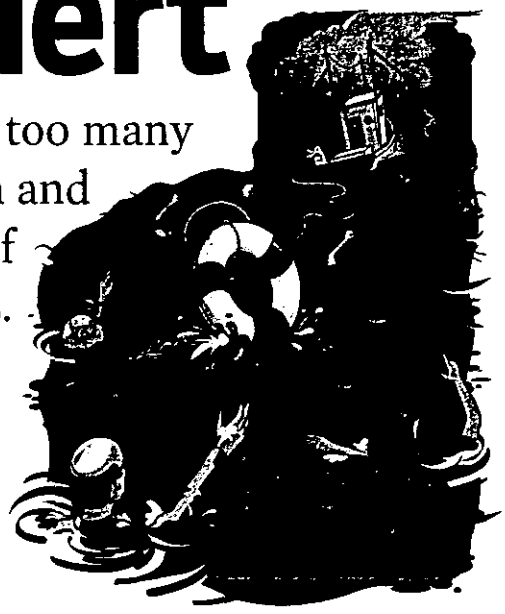
Work in Alaska State Parks.
Volunteers receive valuable training and experience. Apply by April 1. Go to www.dnr.state.ak.us/parks/vip, or call Lynn Wibbenmeyer at 907-269-8708.

Become a child advocate.
Alaska's CASA program serves children in Anchorage, Fairbanks, Juneau and Mat-Su. Go to www.alaskacasa.org, or call LeeAnn Reicks at 907-269-3513.

Speak up for change.
Make sure health care and financial security are top issues in the 2008 elections. Visit www.aarp.org/ak for information on candidate forums across the state.

Rescue Alert

Health care is out of reach for too many Alaskans, especially fishermen and other seasonal workers, most of whom don't get health benefits.



LACK OF HEALTH INSURANCE is a big reason why Alaska leads the U.S. in state spending on health care per person—about $8,000. Then there's the doctor shortage. Alaska needs 200 more physicians, ASAP.

But the state also needs a new approach to making health care affordable. Our costs of care and insurance already exceed the U.S. average and are growing by 9 percent a year.

Everything would change if more Alaskans had health insurance, but 17 percent do not. Most seasonal and part-time employees never will, and they represent 35 percent of the workforce. Not surprisingly, Alaskans pay 13.6 percent more for premiums than if everyone had health coverage.

This is why state Sen. Hollis French (D-Dist. M) and Rep. Gabrielle LeDoux (R-Dist. 26) recently introduced bills that would provide vouchers enabling all Alaska residents to buy health insurance. "No longer can we wait for the federal government to take action on this important issue," they said.

Finding a solution to the health care dilemma is at the top of AARP's national agenda. Through its Divided We Fail initiative, AARP encourages elected officials and community and business leaders nationwide to develop bipartisan solutions to the pressing problems of health and financial security. Details are at www.dividedwefail.org.

Stay informed by visiting www.legis.state.ak.us/index.php. For the full report on which this story is based, read "Employer-Based Health Insurance" online at http://labor.state.ak.us/trends.

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Anchorage, AK 99503

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Long Beach, CA

DR EMILY A KANE
418 HARRIS ST STE 329
JUNEAU AK 99801-1083

Alaska's minimum wage is $7.15 an hour, placing it in the top tier among states and 22 percent above the federal minimum.

Jobseekers can power up their search via the state Labor Department's online database at http://alexsys.labor.state.ak.us.

E[illegible]ly A. Kane, ND LAc

Naturopathic Doctor
Alaska License № 22
Licensed Acupuncturist
Alaska License № 18

January 23, 2009

REF: HSS committee sponsorship of House bill parallel to SB 70

Dear Representative Herron,

I had the pleasure of meeting your assistant Marianna yesterday and she received a "white paper" supporting the expansion of health care services in rural and urban Alaska.

There is a crisis in the shortage of family doctors in the U.S. Alaska, especially rural Alaska, as you well know, is not exempt from this problem. I believe one of your main interests is to promote the availability of both basic and specialty healthcare services for your region.

May I introduce you to a group of healthcare professionals who are primary care physicians specializing in prevention and treatment of chronic disease. These doctors routinely counsel patients in nutrition and healthy lifestyle changes, and treat using natural as well as conventional therapies. Their patients are typically able to largely reduce their health care costs as well as promoting optimal wellness.

I am one of these naturopathic doctors (ND) with training very similar to an MD, except that our therapeutic focus is not pharmaceutical medicine, but intervention with diet, exercise, herbal therapies and other effective, low-tech, low-cost, safe therapies.

We are, however, fully trained as family doctors. Please see a curriculum comparison in the "white paper." In all the western states, except for Alaska, the scope of practice for a naturopathic physician includes minor surgery, legend drugs (not controlled substances such as narcotics), vaccinations, Medicaid reimbursement, and school physicals. This is what we are asking for in our current Senate bill.

Although we are doctors who use expensive drugs and procedures as a last resort, I can assure you we are not shy to make referrals when indicated. I have practiced medicine in Juneau for 15 years, and have been professionally affiliated with our local hospital for nearly as long. I have good working relationships with my MD colleagues here in Juneau, without exception. Nevertheless the Alaska State Medical Association remains the primary obstacle to our bill, which has frustrated Senator Davis and my colleagues. This resistance is softening however, in part because so few MD candidates are chosing to go into family medicine. Increasingly, the mid-level providers such as nurse practitioners, physician assistant and naturopathic doctors are the ones working "in the trenches" in community health.

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As you know, despite necessary budget cuts, the Governor has stated her commitment to expanding DeNali KidCare. This can only happen with both more funding, and more doctors. One of the supporting documents I enclose today reveals the findings of a recent poll of ASMA (Alaska State Medical Society) medical doctors who overwhelming are "burnt out" by family medicine, wish they could retire, and no longer recommend medicine as a career.

Our bill (SB 70) sailed through the Senate during the past several sessions, but we have not had the sponsorship on the House side needed to move our bill into law. Naturopathic doctors desire the ability to fully serve our fellow Alaskans as trained. The documentation I gave Marianna will show you how our training compares to MD training (very comparable but we have many more hours in nutritional intervention, in other words, disease prevention). You will also be able to see our safety record (excellent) in states which have granted naturopathic doctors a full scope of practice, in some cases for many decades, such as in Washington and Oregon.

Our bill is designed to bring the scope of practice of a growing category of mid-level, fully trained, healthcare providers into the 21st century. In Alaska, we have significantly more training than an advanced nurse practitioner, but not nearly the scope of practice. I believe our bill marries well with your purpose of getting more broadly trained healthcare professionals into rural Alaska.

Tom Obermeyer (in Senator Davis' office) knows most about this bill: 465-3762. Senator Davis is very motivated to get this bill all the way through this year, and she would, naturally, welcome an enthusiastic partner on the house side.

Please contact me with any questions or requests for further supportive documentation. Thank you in advance for your consideration of supporting this bill. I look forward to meeting you.

Best wishes,

Dr. Emily A. Kane
Vice president, AKANP
Alaska Association of Naturopathic Physicians

Copy: Rep Cathy Munoz
Rep Wes Keller
Rep Sharon Cissna
Senator Bettye Davis
Thomas Obermeyer
Linda Zaugg

WELLSPRING

Integrative Medical Center

RECEIVED
JAN 23 2009

January 21, 2009

Dear Alaskan Legislators:

I write in support of establishment of a Naturopathic Medical Board consisting of three (3) Naturopathic Doctors (ND), one (1) pharmacist and one (1) member of the public. This board is needed to assure the Alaskan public of safe naturopathic care complying with the regulations of ND practice in Alaska.

Wellspring, an Integrative Medical Center, located in Juneau, Alaska, has employed a naturopathic doctor for nine years. Patients constantly acknowledge their gratefulness for this option. However, he has been unable to fully practice his profession in Alaska because there in no ND Board overseeing the totality of his practice for which he was educated for four years, post-baccalaureate degree.

Please support this ND bill to improve wellness and health care for Alaskans, to increase access to ND care and to provide cost-effective options for our communities.

Please contact me if you have further questions.

Sincerely,

C. Trollan, ANP
Advanced Nurse Practitioner
Owner

2231 Jordan Avenue • Juneau, Alaska 99801 • Phone (907)789-1812 • Facsimile (907)789-7168

Alaska Center for
Natural Medicine
104 Kutter Road • Fairbanks, Alaska 99701 • (907) 452-3600

2/4/09

The Honorable Senator Bettye Davis
State Capitol Bldg, Room 11
Juneau, AK 99801

re: SB 70

Dear Sen. Davis,

Thank you for supporting SB 70, a bill that would update naturopathic licensing and create a licensing board for my profession. This bill would make access to appropriate health care for my patience much easier. Although most of my patients do quite well with interventions including diet, lifestyle modification and natural therapies, some require medical management. When I have to refer that patient to another doctor, it can create a barrier to appropriate care that is unnecessary. The naturopathic licensing board would make a formulary of legend drugs that have been used safely by naturopathic doctors in states such as Washington, Oregon and Arizona.

SB 70 would also protect the public safety by requiring naturopathic doctors to keep their skills up with continuing education. This is common in almost every profession and should be the rule in Alaska as well. Also by increasing the ranks of well-trained doctors who can service Medicare patients, they should relieve some of the burden for conventional providers throughout the state.

Thank you once again for your dedication to the welfare of all Alaskans.

Yours in health,

Mary A. Minor, ND
CC: Senators Ellis, Thomas, Dyson and Paskavan.

Identifying the Similarities and Differences:

An analysis of two medical training programs -- Bastyr University's Naturopathic Doctorate (ND) compared to the University of Washington's Medical Doctorate (MD) program

Admissions Criteria

Similarities – Overall, a high degree of similarity exists between the programs.

- Both programs:
  - Expect applicants to have completed, but do not require completion of, a baccalaureate degree.
  - Encourage a strong background in the humanities and liberal arts.
  - Require a strong background in the sciences, including chemistry, biology, and physics.
    - While not required for admission, biochemistry is very strongly recommended.
  - Allow for waiving a limited number of academic requirements under exceptional circumstances.

Differences

- Medical College Admissions Test (MCAT):
  - Required for University of Washington (UW) medical school, taken no later than fall in the year prior to possible matriculation.
    - Under *exceptional* circumstances, GRE scores may be considered for admission, but MCAT must be taken prior to matriculation.
  - Not required for Bastyr University (BU) naturopathic medical school
- Required courses:
  - UW specifies science requirements by number of credit hours* for each:
    - Chemistry (18*), biology (12*), and physics (4*), plus additional "open" science credits (8*).
  - BU specifies science requirements by number of courses for each:
    - Chemistry (4, for science majors), physics (1, college level), algebra or pre-calculus (1, college level), and psychology (1, introductory course recommended).
    - Additionally, BU requires a minimum of 3 quarter credits in general biology for science majors, with a lab.
- Additional Notes:
  - UW provides mean statistics for the entering class 2004 – GPA 3.71, MCAT scores (Verbal 10.3; Physical Sciences 10.8; Biological Sciences 11.1 and mode of "Q" in writing) -- BU does not.
  - UW states:
    - "All candidates must demonstrate substantial academic ability in their major field as well as in the required science courses."
    - "Candidates should be proficient in the use of the English language and of basic mathematics, and are expected to have a basic understanding of personal computing and information technologies."
  - BU requires admissions committee review for all chemistry and biology courses not completed within 7 years of matriculation, and may require additional courses if deemed appropriate.
  - BU allows submission of test scores for prerequisite consideration as noted below:
    - AP, IB, CLEP, or GRE for math, psychology, or physics.
    - AP or IB for biology or chemistry.

*All credit hours stated for quarter calendar system, unless otherwise noted

Clinical Training

Similarities

- Both programs emphasize training in the clinical setting, where the student receives practical, hands-on training from licensed practicing physicians.

Differences

- BU naturopathic students complete a total of 25 shifts, all in the outpatient setting. The only specialized shifts completed are in physical medicine (4 shifts). Three shifts are completed as preceptorships, with independently practicing physicians.
- UW medical students complete 10 rotations of varying lengths in numerous areas of specialized as well as general medicine. Some of these are in the outpatient setting, others in an inpatient setting. In total, they complete a total of 58 weeks of these rotations, with the greatest emphasis on general medicine (12 weeks).
- All inpatient setting rotations such as surgery and trauma/emergency medicine are required by UW, but unavailable to BU naturopathic students (or with very limited availability as preceptoships).
- UW students are required to complete a rotation in obstetrics and gynecology; BU students complete rotations in childbirth only if enrolled in the separate midwifery program.
- UW students may complete elective rotations in rural/underserved community medicine; BU students may volunteer in these programs away from school (although preceptorship credits may be available).

Licensure Examinations

- Both MD and ND licensure require successful completion of a two-step examination process, one covering basic or pre-clinical sciences, and a second covering clinical sciences.
  - MD students complete the United States Medical Licensure Examination (USMLE) Part I at some point prior to their last year, and the USMLE Part II during their final year of enrollment at UW.
  - ND students complete the Naturopathic Physician Licensure Examination (NPLEX) Basic Sciences exams after their second academic year, and the Clinical Sciences exams post-graduation.

Sources

- http://eduserv.hscer.washington.edu/uwsom/ Accessed 5 April 2005
- http://www.washington.edu/students/crscat/humbio.html Accessed 5 April 2005
- http://www.bastyr.edu/academic/naturopath/curriculum.asp?track=4 Accessed 6 April 2005
- http://biomed.uaa.alaska.edu/A_Z/Curriculum.htm Accessed 7 April 2005

*All credit hours stated for quarter calendar system, unless otherwise noted

Emily A. Kane, ND LAc

Naturopathic Doctor
Alaska License № 22
Licensed Acupuncturist
Alaska License № 18

RECEIVED
DEC 16 2008

December 15, 2008

Alaska State Medical Association
4107 Laurel St
Anchorage AK 99508

Dear Officers of the Association,

This letter is in regard to legislative changes that will again be sought by Naturopathic Doctors in Alaska during the upcoming session. Our aim will be, as in previous years, to modify some of our statues governing the naturopathic medical profession which are no longer serving Alaskan citizens.

We are a well-trained group of mostly mature primary healthcare providers. Most of the naturopathic doctors in Alaska have been practicing medicine for over 10 years. I have been in practice in Juneau, with outpatient hospital privileges, for 15 years. Despite training in all aspects of primary healthcare, naturopathic doctors (ND) cannot perform minor surgery, nor prescribe any legend drugs. This means our patients may require costly, non-expedient referrals to other providers for basic services in which we are well versed, but currently restricted from providing.

The shortage of primary care, family doctors has become critical, as you know. Alaska in not exempt from this problem. In states where naturopathic doctors have expanded their scope of practice to include legend drugs and minor surgery per their training, there has been no evidence of public harm. I have documentation of these statistics, some of which date back to the 1950s, as well as charts comparing our training with medical doctors if you would like further information.

Our medical training exceeds that of nurse practitioners, yet they have prescription authority in Alaska while naturopathic doctors do not. I, and all my colleagues licensed in Alaska, have passed national licensing boards which include segments on pharmacology and minor surgery/laceration repair technique.

Drugs and surgery will never be our first lines of therapy. We are naturopathic doctors, mostly using diet, exercise and herbal therapies to help our patients achieve or maintain wellness. However, we have exceptionally thorough training and are certainly capable of providing the full scope of services in which we were trained. The principle reason our legislation has not yet passed is resistance from the medical community. Individual medical doctors in this community are, almost without exception, courteous, collegiate, supportive, and interested in mutual referrals. However, there seems to be a need to "resist" at a group level. I invite you to please consider what you could "live with" and not feel compelled to try to block, in the upcoming session. For example, could you be supportive of, or at least not resistant to, Naturopathic Doctors being able to provide vaccinations, school physicals, have a limited formulary and be permitted to perform superficial wound care?

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Phone: 907-586-3655 FAX: 907-586-4326 email: DoctorEm@aol.com

My aim is to work towards legislation that would create a Board for the naturopathic medical profession. The Board would consist of 5 members: 3 Naturopathic Doctors, 1 pharmacist and one member of the public who may be a medical doctor. In this way we invite your members to participate in advising Naturopathic Board subcommittees such as a formulary council.

We would welcome an opportunity to discuss with your Association what degree of expansion of scope of practice for naturopathic doctors your group would accept. I would very much appreciate working towards legislation that won't be met by resistance from ASMA. Legislators have generally been very interested in bringing mature primary healthcare providers, already installed in the state, to bear on the shortage of physicians in Alaska

I hope to hear from you before the beginning of session, January 20, 2009

Respectfully,

Dr. Emily A Kane
Vice President, Alaska Association of Naturopathic Physicians (AKANP)

cc Senator Bettye Davis ✓
Representative Sharon Cissna
Representative Cathy Munoz
Nancy Davis, executive Director Alaska Pharmacists Association

Lynda Zaugg

From: DoctorEm@aol.com

Sent: Friday, March 13, 2009 10:52 PM

To: Sen. Bettye Davis; Lynda Zaugg; Rep. Bob Herron

Cc: NearyPT@aol.com; eagledoc@mtaonline.net; gary.f@gci.net; drluper@acsalaska.net; mminor@alaska.net; gillespiend@prodigy.net; drkristinnd@gmail.com; amycnd@gci.net; mellenburg@acsalaska.net; lerickson@ndnet.ccnm.edu; pythea@yahoo.com; DrJasonHarmon@gmail.com; daturadoc@yahoo.com; HMC@alaska.com; birgit_lengernd@yahoo.com; lushjennifer@gmail.com; drmaddynd@yahoo.com; docdave@acsalaska.net; kimsweazy@hotmail.com; dramyw@hotmail.com; czarndt@hotmail.com; rickhope82@yahoo.com; drharmonnd@yahoo.com; cwjasper@gci.net; rabbott@sinbad.net; roverini@juno.com; torrey.smith@acsalaska.net

Subject: Fwd: SB 70 -- endorsement, with qualifications, from AK Pharmacy association

---

From: akphrmcy@alaska.net
To: doctorem@aol.com
CC: sher.zinn@alaska.gov, susprof@mtaonline.net, iamsamiam1@hotmail.com, island.pharm@juno.com, dirkrph@ptialaska.net
Sent: 3/13/2009 11:35:23 A.M. Alaskan Daylight Time
Subj: RE: SB 70

Dear Emily Kane,

The Alaska Pharmacists Association (AkPhA) would support the establishment of an Alaska Naturopathic Board with the purpose of regulation of the practice of the Naturopathic Doctors in the State of Alaska. We appreciate your inclusion of pharmacists in the development of the Naturopathic Board.

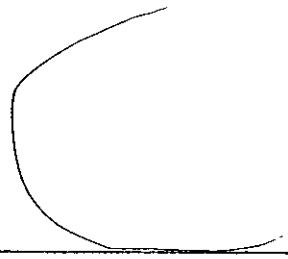
AkPhA appreciates the rigorous education and training many Naturopath Doctors have completed. We also understand that all Naturopath Doctors do not complete the same level or quality of training. Our hopes are that the development of a Naturopathic Board would develop standards for Naturopathic practitioners within the State of Alaska, including post graduate residency training and mandatory continuing education. AkPhA does not view naturopaths as an alternative to allopathic health care providers, but an addition to traditional practice. Naturopathic medicine is not meant as a replacement in areas where health care providers are of short supply or where there are not physicians accepting Medicare patients.

Finally, prescription endorsement regulations need to be developed in extensive detail beyond what is described in SB 70. AkPhA, with the assistance of the Board of Pharmacy, is willing to open a dialog concerning prescriptive authority guidelines for Naturopathic Doctors.

Respectfully,

Amber L Briggs, Pharm.D., BC-ADM

President, Alaska Pharmacists Association



Worried about job security? Check out the 5 safest jobs in a recession.

ALASKA ACADEMY OF FAMILY PHYSICIANS

35555 Spur Highway #266, Soldotna, AK 99669 akafp@gci.net www.alaskaafp.org 907 258-2255 office 530 326-5612 fax

February 1, 2009

Dear Sen. Bettye Davis:

The Alaska Academy of Family Physicians represents over 360 primary care physicians practicing throughout Alaska. We have serious concerns about Senate Bill 70, which grants further medical and surgical privileges to naturopaths. By definition naturopaths practice holistic medicinal treatments limited to natural herbs and nutraceuticals not regulated by the FDA. That is their training, their experience, and their stated mission. Surgical procedures are considered invasive and not "natural." Prescription medicines are pharmaceutical agents and not under their scope of practice.

Naturopaths state that their education encompasses some course work in pharmacology. However naturopathic training programs clearly do not provide anywhere near the breadth and depth of education when compared to medical and osteopathic medical schools. In addition, they do not require carefully supervised postgraduate residency training for patient care, adverse medical effects, drug interactions, and patient's safety prior to health care providers being licensed to practice independently. The same argument goes for surgical interventions where focused supervised procedural training is the accepted norm. This is essential for assuring patient safety and competent providers. Continuing medical education and recertification are the norm in the medical profession. We know of no such requirements for naturopaths and this current senate bill is inadequate to assure patient safety and quality of care.

This is clearly an issue of public safety. With the small number of naturopaths in this state and limited number of primary care providers this is not a "turf" issue. It is however, a Pandora's box for our state considering these important scope of practice issues. In these times, the daily headlines are focusing on enhanced patient safety. It makes little practical or legal sense to license providers with minimal if any professional training in the complexities of drug prescribing and surgical interventions to perform these services for our fellow Alaskans.

To document the equivalence of such different training programs seems to be impossible. The only way I can imagine is to require naturopaths to take the Medical College Admission Test (MCAT) and have the same scores that would allow admission to M.D. or D.O. training programs. It would also be necessary to pass the same National Certification Tests (USMLE, COMLEX, PANCE, etc.) to document a minimum of training and education. The same credentialing, continuing medical education requirements and overview provided by the State Medical Board would also add to the reassurance that public safety is being protected.

I am certain this is also your goal and request you to reconsider this bill. Because of these concerns we must oppose Senate Bill 70.

Sincerely,

Mary Ann Foland, M.D.
President, Alaska Academy of Family Physicians

MAF/ILHS/cqc.BGX

March 30, 2009 RE: SB 70

To: Chairman & Members, HHS Committee

SB70 is as much a **consumer issue** as it is another step in the struggle by ND's and naturopathic medicine for just recognition and regulation.

I am nearly 60 years of age, have resided in Homer since 1977, and consider myself active and very much responsible for my health. I look to the State to do it's part in making the best choices for healthcare available to me, particularly those that help me help myself.

Since my first encounter with an ND in 1993 (Hawaii, a low back injury), I have progressively entrusted more and more of my healthcare decisions to the guidance of ND's and the naturopathic approach, which has led to more study, involvement, and responsibility on my part. I now consciously spend nearly 100 percent of my healthcare dollars, whether reimbursable or not, on a naturopathic approach and my primary care is clearly coming from my local ND. If this bill (SB70) had been enacted earlier, I could have obtained more of my needs (including pharmacy and minor surgery) from my primary care physician.

In recent years, I've observed steady growth in the "newcomers" at the doctor's office, where interestingly the patients tend to interact much more than at the "traditional doctor's office". Many of these older patients are having to pay out of pocket to get the care they want and this is clearly not sitting well with them. Although I am currently lucky enough to have insurance that covers me (for the doctor's time only), I will soon be of an age where Medicare coverage is a big consideration in my healthcare choices. The citizens of Alaska shouldn't have to decide whether to dig into their savings, or perhaps go to Arizona or Hawaii where the laws are more progressive, or settle for a lesser choice, simply because of a lack of enabling legislation.

If Alaska truly wants to encourage it's citizens to take responsibility for their own health (which is a positive for the financial health of the State), then the passing of SB70 is one good step in that direction.

Lastly, be prepared for the last minute scare tactics that will likely come from the ASMA, as I've seen on previous bills. They are clearly concerned about their members economic interests as opposed to my health and my finances. If anyone among the medical community understands and lives the tenet "First, do no harm", it is the ND's and their associates. That's exactly why we subscribers to naturopathic care are a growing number in spite of the laws and economic forces that make it a challenge.

Sincerely,

Wayne Aderhold
350 Grubstake Ave.
Homer, AK 99603
907. 235. 6540
aderhold@xyz.net

VII. State licensure and regulation

States that license naturopaths

Naturopaths must meet licensing requirements in all states that recognize naturopathy through licensure. Presently, 14 states and the District of Columbia regulate naturopaths through licensure: Alaska, Arizona, California, Connecticut, Hawaii, Idaho, Kansas, Maine, Montana, New Hampshire, Oregon, Utah, Vermont and Washington. Puerto Rico and the U.S. Virgin Islands similarly license naturopaths.

The rest of the country does not recognize the profession through licensure, with South Carolina and Tennessee both expressly prohibiting the practice of naturopathy.[144] Wyoming states the following in its case law:

> Our statute is clear, that the practice of naturopathy cannot be regarded as a separate and distinct profession like that of dentistry for instance, nor can any good reason be given why the legislature may not for the benefit of society require that those who practice the healing art should know and keep up with the improvements and advanced learning in that art.[145]

Florida abolished its naturopath licensing laws in 1959, and in 2004 a legislative committee concluded that an expanded scope might be harmful, and that naturopathic licensing is not cost-effective.[146] Several other states, including Texas and Virginia, have abolished previous naturopathy licensure provisions.[147]

It is critical to note that in most states and provinces where naturopathic medicine is not regulated, individuals may practice similar therapeutic approaches and/or call themselves naturopaths (whether or not they have been trained at a school for naturopathic medicine), because the terms "naturopath" and "naturopathic medicine" are not restricted terms.[148] Traditional naturopathy is not a medical practice and, therefore, is not regulated through statutes or regulations in the states.

One of the major initiatives of the AANP is to obtain licensure for naturopaths in all 50 states.[149] (See Figure 1 for more information on requirements for state licensure.)

State scope of practice regulations for naturopaths

Naturopaths' scope of practice varies by state. Naturopaths seek privileges to prescribe drugs, not only those considered "natural" (hormones, purified botanicals, etc.), but also legend drugs, up to and including schedule III and IV controlled substances. Specific information on naturopath scope of practice can be found in Figure 2.

State boards of naturopathy

Information on the authority, procedures of operation, composition and appointment procedures of state boards of naturopathy can be found in Figure 3. Additionally, a roster of state boards of naturopathy can also be found in the Appendix (page 35).

144. Web. North American Board of Naturopathic Examiners. Licensing and registration. Retrieved July 30, 2006. *www.nabne.org/licensereg.php* and verified through Lexis searches September 2, 2006.

145. *Hahn v. State*, 78 Wyo. 258, 322 P.2d 896 (1958).

146. Florida state sunrise report (2004). See page 16 for more information.

147. Lexis-Nexis statutory searches. September 8, 2006.

148. Boon H. Practice patterns of naturopathic physicians: results from a random survey of licensed practitioners in two US States. BMC *Complement Altern Med.* October 20, 2004. *www.pubmedcentral.nih.gov/articlerender.fcgi?artid=529271&tools=bot*.

149. Web. AANP. Issues and legislation. *http://capwiz.com/naturopathic/issues/*. Retrieved September 6, 2006.

AMA Scope of Practice Data Series

demographics

education and training

licensure and regulation

professional organization

current literature

A resource compendium for state medical associations and national medical specialty societies

Naturopaths

American Medical Association
June 2008

Disclaimer: This module is intended for informational purposes only, may not be used in credentialing decisions of individual practitioners, and it does not constitute a limitation or expansion of the lawful scope of practice applicable to practitioners in any state. The only content that the AMA endorses within this module is its policies. All information gathered from outside sources does not reflect the official policy of the AMA.

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AMA Scope of Practice Data Series module distribution policy

The modules are advocacy tools used to educate legislators, regulatory bodies and other governmental decision-makers on the education and training of physician and nonphysician health care providers. As such, the AMA will distribute the modules to the following parties:

(1) State medical associations
(2) State medical boards
(3) National medical specialty societies
(4) National medical organizations

In line with the express purpose of the modules being governmentally directed advocacy, it will not be the policy of the AMA to provide the modules to individual physicians. Organizations supplied with the module shall mirror the intent, purpose and standards of the AMA distribution guidelines.

Acknowledgments

Many people have contributed to the compilation of information contained within this module. The American Medical Association (AMA) gratefully acknowledges the contributions of the Alaska State Medical Association, the Maine Medical Association, the Missouri State Medical Association and the American Osteopathic Association.

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I. Overview

The American Medical Association (AMA) Advocacy Resource Center has created this information module on naturopaths to serve as a resource for state medical associations, national medical specialty societies and policymakers. This guide is one of 10 separate modules collectively comprising the AMA Scope of Practice Data Series, each covering a specific nonphysician health care profession.

Without a doubt, limited licensure providers play an integral role in the delivery of health care in this country. Efficient delivery of care requires a team-based approach that cannot exist without inter-professional collaboration between physicians, nurses and other limited licensure health care providers. With the appropriate education, training and licensing, such providers can and do provide safe and essential health care to patients. The health and safety of patients are threatened, however, when limited licensure providers are permitted to perform services that are not commensurate with their education or training.

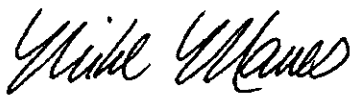
Each year in nearly every state and at times on the federal level, limited licensure health care providers lobby legislatures and regulatory boards to expand their scope(s) of practice. While some scope expansions may be appropriate, others definitely are not. It is important, therefore, to be able to explain to legislators and regulators the limitations in the education and/or training of limited licensure health care providers that can result in substandard or potentially harmful care of patients. Those limitations are brought clearly into focus when compared with the comprehensiveness and depth of the medical education and training of physicians.

Issues of access to qualified physicians in rural or underserved areas give limited licensure providers what, at first glance, seems to be a legitimate rationale for lobbying for expanded scope of practice. However, solutions to actual or perceived work force shortages simply cannot justify practice expansions that expose patients to unnecessary health risks.

In November 2005 the AMA House of Delegates approved Resolution 814, which called for the study of the qualifications, education, academic requirements, licensure, certification, independent governance, ethical standards, disciplinary processes and peer review of limited licensure health care providers. By surveying the type and frequency of bills introduced in state legislatures, and in consultation with state medical associations and national medical specialty societies, the AMA identified 10 distinct limited licensure professions that are currently seeking scope of practice expansions that may be potentially harmful to the public.

Each module in the AMA Scope of Practice Data Series is intended to assist in educating policymakers on the qualifications of a particular limited licensure health care profession, as well as on the qualifications physicians possess that prepare them to accept the responsibility for full, unrestricted licensure to practice medicine in all its branches. It is within the framework of education and training that health care professionals are best prepared to deliver safe, quality care under legislatively authorized state scopes of practice.

It is the AMA's intention that these Scope of Practice Data Series modules provide background information for state- and federal-based advocacy campaigns where the health and safety of patients may be threatened as a result of unwarranted scope-of-practice expansions sought by limited licensure providers.



Michael D. Maves, MD, MBA
Executive Vice President, Chief Executive Officer
American Medical Association

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II. Introduction

The American Medical Association (AMA) is pleased to offer this informative module to assist physicians in countering the advocacy efforts of naturopaths seeking licensure and/or expansion of their current scope of practice to include privileges or procedures unwarranted by their education and training.

This module examines the background, education and training of those practitioners who have earned a doctor of naturopathy or doctor of medical naturopathy degree, and who refer to themselves as "naturopathic physicians" or "naturopathic doctors." Through their state chapters and their national professional organization, the American Association of Naturopathic Physicians, these practitioners seek to establish licensure in the 50 states, as well as liberal prescribing authority, "primary care physician" status and, in many cases, mandated insurance coverage for services. This stands in contrast to the beliefs of "traditional" naturopaths—providers of natural health care who do not seek state recognition or regulation through licensure.

Naturopaths frequently argue that licensure allows patients the freedom to choose them as primary health care providers. At the same time they are looking to distinguish themselves from and assert privileges over their colleagues, the traditional naturopaths. A wide schism separates these two factions, which have a long, documented history of philosophical differences culminating in the divergence of the "naturopathic physician" (and the corresponding quest for state licensure) from the non-medical practice of traditional naturopathy.

Currently, 14 states and the District of Columbia license naturopaths. However, naturopaths may practice without a license in states where naturopathy is not expressly prohibited. In a few such states, this has provoked concern over whether naturopathic practitioners treating patients should be subject to some sort of state regulation (in the form of limited licensure, certification or registration) as a mean to protect the public. Official legislative reports from several states have unearthed specific shortcomings in the education, training and competency testing of naturopaths, and several of these recommend against licensure for naturopaths.

Naturopathy involves the application of natural (non-pharmaceutical and non-surgical) treatment modalities to encourage and facilitate the body's healing of itself. The practice of naturopathy involves the application of a number of healing systems or physical, nutritional or natural agent regimens. Common naturopathic care includes treatments of botanical medicine/herbology, conventional nutritional counseling, homeopathy, acupuncture and/or traditional Chinese medicine, massage and manipulative bodywork, mind/body treatments, hydrotherapy, as well as physical treatments such as ozone therapy, air and light therapy, and ultraviolet, ultrasound and electro-stimulation therapies.

Such treatment modalities are collectively known as complementary and alternative medicine (CAM), and their usage has significantly increased in popularity within the last decade. In 1998 the federal government created the National Center for Complementary and Alternative Medicine (NCCAM), an arm of the National Institutes of Health (NIH), to study the efficacy of CAM in the treatment of chronic and acute diseases. Its mission is to apply accepted scientific principles to CAM by providing funding and grants to support CAM clinical trials and research, in order to objectively assess the efficacy of CAM treatments as compared to conventional medical treatments and placebo.

Consumers use CAM as either a complete treatment or as an adjunct to conventional medical care. Typically categorized as therapies not widely taught in U.S. medical schools, proponents of CAM broadly extend its definition to include common patient self-help strategies such as low-fat, low-sodium diets, stretching and exercise, daily vitamins and minerals, and prayer. In 2004 the NCCAM reported the results of a survey indicating that 36 percent of U.S. adults use some form of CAM. According to this survey, when megavitamin therapy and prayer specifically for health reasons are included in the definition of CAM, that number rose to 62 percent.[1] With such a broad definition, it is little wonder CAM usage statistics are so high.

For medical professionals and policymakers alike, the naturopathic profession's reluctance and/or inability to apply evidence-based principles and scientific study its

1. Web. National Center for Complementary and Alternative Medicine. The use of CAM in the United States. *http://nccam.nih.gov/news/camsurvey_fs1.htm#use*. Retrieved December 5, 2007.

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treatment modalities is of great concern. For example, naturopaths' longstanding opposition to childhood vaccination has been demonstrated as recently as 1999, well after the remarkable decreases in childhood disease as a result of widespread vaccination had been documented (see page 17 for more information).

The mechanism of action and the efficacy of many naturopathic treatment modalities are not scientifically supported; yet practitioners of naturopathy continue to offer patients such treatments. Such behavior would not be tolerated in the practice of medicine. Care that is not premised on scientific evidence, and for which the patient is not informed of its experimental nature, would be considered unethical by the standards of the medical profession. Specifically, AMA Ethical Opinion E-3.01 states:

> It is unethical to engage in or to aid and abet in treatment which has no scientific basis and is dangerous, is calculated to deceive the patient by giving false hope, or which may cause the patient to delay in seeking proper care ... .[2]

Some naturopathic treatments are blatantly unsafe and place the health of the patient at great risk for additional health complications. The *Textbook of Natural Medicine*,[3] the foremost textbook used in schools of naturopathy, discusses naturopathic treatments that defy medical knowledge or, incredulously, omit discourse on the therapeutic benefits of pharmaceutical or surgical interventions. For example, the second edition of the book called for St. John's wort in the treatment of HIV-positive individuals. Results of an NIH-funded study published in February 2000—just months after the September 1999 release of the textbook—found that St. John's wort interacts with protease inhibitors commonly used in treating patients with HIV and significantly decreases their concentration in the blood.

Compared to medical school and residency training, a naturopathic education consists of relatively few contact hours of study on pharmacological treatment of disease, and provides virtually no clinical reinforcement of pharmaceutical intervention on patients during clinical rotations or optional post-graduate training. Most drugs are considered toxic by naturopaths, so alternative treatments are instead prescribed. One important component to consider in the debate over naturopath licensure is whether a practitioner with such limited exposure to pharmaceuticals can appropriately treat patients who take prescription medicines regularly or who would likely benefit from pharmacological intervention.

When faced with the claims of naturopaths that the rigors of their education and licensing exams parallel those of physicians, legislators should recognize that graduates of campus-based, four-year naturopathic programs who have passed a standardized examination may demonstrate *consistency* from one naturopathic practitioner to the next. But that says nothing about the *validity* of their practice, which can be determined only by reference to the laws of science or nature, and by rigorous testing of biologically plausible claims.[4] By failing to rigorously study all the treatments they provide, naturopaths may place patients' safety at risk.

According to a 2003 article in *MedScape General Medicine*, "without licensing standards, individuals with little or no formal education may proclaim themselves naturopathic physicians without medical school education or board testing. ... [T]he clear message is that such licensing implies competence. There is, however, no evidence that 'educated' naturopaths—i.e., the NDs or naturopathic 'physicians'—are more competent than others. If anything, 'traditional naturopaths' (i.e., those who did not attend the 'approved' schools) may be less of a threat to public health because they do not pretend to be primary care physicians."[5]

We hope the information contained in this module provides the tools necessary to help physicians present relevant facts in response to naturopaths' efforts to enact state licensure laws or expand their current scopes of practice. The AMA stands ready to assist state and specialty societies in their efforts to protect and preserve the health and safety of patients.

Advocacy Resource Center
American Medical Association

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2. Web. American Medical Association. Ethical Opinion E-3.01 Nonscientific Practitioners. *www.ama-assn.org*. Retrieved December 5, 2007.

3. Web. Pizzorno JE, Murray MT, eds. *Textbook of Natural Medicine*. Pub. Churchill Livingstone, 1999. p. 803, 1292. As quoted on Quackwatch. *www.quackwatch.org*. Retrieved December 5, 2007.

4. Web. Atwood KC. Naturopathy: A critical appraisal. *Medscape General Medicine*. December 30, 2003. *www.medscape.com/viewarticle/465994*. Retrieved November 19, 2007. As attributed to Ernst E. The role of complementary and alternative medicine. *BMJ*. 2000;321:1133-1135.

5. Web. Atwood KC. Naturopathy: A critical appraisal. *Medscape General Medicine*. December 30, 2003. *www.medscape.com/viewarticle/465994*. Retrieved November 19, 2007.

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III. Naturopathy as a profession

Definition(s) of naturopathy

Webster's dictionary defines naturopathy as a system of treatment of disease that avoids drugs and surgery, and emphasizes the use of natural agents (such as air, water and herbs) and physical means (such as tissue manipulation and electrotherapy).[6] The National Center for Complementary and Alternative Medicine, a bureau of the National Institutes of Health, notes that naturopathy is a system of healing originating from Europe that views disease as a manifestation of alterations in the processes by which the body naturally heals itself. It emphasizes health restoration as well as disease treatment. The term naturopathy literally translates as "nature disease."[7]

Although the most visible professional organizations of naturopaths do not provide a formal definition of a naturopath, the American Association of Naturopathic Physicians (AANP) notes:

> [A] licensed naturopathic physician [ND] attends a four-year graduate level naturopathic medical school and is educated in all of the same basic sciences as an [MD] but also studies holistic and non-toxic approaches to therapy with a strong emphasis on disease prevention and optimizing wellness. In addition to a standard medical curriculum, the naturopathic physician is required to complete four years of training in clinical nutrition, acupuncture, homeopathic medicine, botanical medicine, psychology, and counseling (to encourage people to make lifestyle changes in support of their personal health). A naturopathic physician takes rigorous professional board exams so that he or she may be licensed by a state or jurisdiction as a primary care general practice physician.[8]

This module will focus mostly upon the education, training and qualifications of naturopathic "physicians," practitioners who attend four-year graduate schools of naturopathy and earn advanced degrees, as opposed to traditional naturopaths, who receive either apprenticeship-style training or attend unaccredited naturopathy schools.

Principles of naturopathy

Classical naturopathy training is guided by the following six principles. Students in naturopathy schools worldwide are taught to abide by these principles.

- **First do no harm** *(Primum no nocere)*
  Illness is a purposeful process of the organism. The process of healing includes the generation of symptoms that are, in fact, an expression of the life force attempting to heal itself. Therapeutic actions should be complementary to and synergistic with this healing process. The naturopathic physician's actions can support or antagonize the actions of the *vis mediatrix naturae*, the healing power of nature. Therefore, methods designed to suppress symptoms without removing the underlying causes are considered harmful and are to be avoided or minimized.

- **The healing power of nature** *(Vis mediatrix naturae)*
  The body has an inherent ability to establish, maintain and restore health. The healing process is ordered and intelligent; nature heals through the response of the life force. The naturopathic physician's role is to facilitate this process, to identify and remove obstacles to health and recovery, and to establish or restore a healthy internal and external environment.

- **Identify and treat the cause** *(Tolle causam)*
  Illness does not occur without cause. Underlying causes of disease must be discovered and removed or treated before a person can recover completely from illness. Symptoms express the body's attempt to heal, but are not the cause of disease and, therefore, should not be suppressed by treatment. Causes may occur on many levels including the physical, mental, emotional and spiritual. The naturopathic physician must evaluate fundamental underlying causes on all levels, directing treatment at root causes rather than at symptomatic expression.

- **Heal the whole person** *(Tolle totum)*
  Health and disease are conditions of the whole organism, a whole involving the complex interaction of many factors. The naturopathic physician must treat

6. Web. Merriam-Webster online dictionary. *www.merriam-webster.com*. Retrieved November 7, 2007.
7. Web. National Center for Complementary and Alternative Medicine. *www.nccam.nih.gov/health/backgrounds/wholemed.htm*. Retrieved November 2, 2007.
8. Web. American Association of Naturopathic Physicians. *www.naturopathic.org*. Retrieved November 7, 2007.

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the whole person by taking these factors into account. The harmonious functioning of physical, mental, emotional and spiritual aspects is essential to the recovery from and the prevention of disease. This requires a comprehensive approach to diagnosis and treatment.

- **The physician as teacher** *(Docere)*
  A cooperative doctor-patient relationship has inherent therapeutic value. The naturopathic physician's major role is to educate and encourage the patient to take responsibility for their own health. The naturopathic physician is a catalyst for healthful change, empowering and motivating the patient to assume responsibility. It is the patient, not the doctor, who ultimately creates/accomplishes healing. Teaching with hope, knowledge and understanding, the physician acts to enable patients to heal.

- **Prevention** *(Praevenire)*
  The ultimate goal of any health care system should be prevention of disease. This is accomplished through education and the promotion of life habits that create good health. Naturopathic physicians learn to assess risk factors and to sharpen their deductive reasoning, and to understand the patient's circumstances. Appropriate interventions are then sought to avoid further harm or risk to the patient. Building health works better and more surely than fighting disease.[9]

General duties

Naturopaths assess and diagnose patient conditions, devise treatment plans using natural, complementary and alternative medicine (CAM), or conventional remedies, and provide counseling to patients. They typically focus on prevention and promoting the understanding that healing comes from within.[10,11,12]

Naturopathic practice may include the following diagnostic and treatment modalities: clinical and laboratory diagnostic testing, including diagnostic radiology and other imaging techniques; hair, skin and nail analysis; iridology; nutritional counseling, dietetics and therapeutic fasting; medicines of vitamin, mineral, animal and botanical/herbal origin; hormones and biosynthetic agents; hygiene and public health measures; homeopathy; acupuncture; traditional Chinese medicine; psychotherapy and counseling; minor surgery and naturopathic obstetrics (natural childbirth); naturopathic physical medicine including manipulation and massage; the use of hydrotherapies, heat, cold, ultrasound, ultraviolet light, magnetic and electrical fields; energy-based treatments, including reiki, biofeedback and therapeutic touch; and therapeutic exercise.[13,14]

Brief history of the profession

The modern form of naturopathy can be traced to 18th- and 19th-century healing systems in Germany and Austria. While naturopathy was being used in Europe during those time periods, it was not until the turn of the 20th century that the term surfaced in America. In 1902 Benedict Lust, a German immigrant, introduced naturopathy to the United States when he founded the American School of Naturopathy, which was later reorganized as the American Naturopathic Association in 1919.[15]

Once naturopathy was introduced in the United States, naturopathic schools were established and large numbers of naturopaths were trained for practice. However, the advent of scientific medicine in the 20th century greatly decreased the demand for naturopathic treatment. In the 1970s, when a "natural" counterculture movement espousing health foods and natural remedies began, many consumers sought out alternative treatments and CAM modalities enjoyed a surge in popularity.

9. Web. Naturodoc. *www.naturodoc.com/cardinal/naturopathy/nat_principles.htm*. Retrieved November 15, 2007.
10. Web. Natural Healers. Common Q&A. Retrieved July 28, 2006. *www.naturalhealers.com/qa/naturopathy.html#q1*.
11. Web. Homeo Info. Non-classical topics—naturopathy. Retrieved July 28, 2006. *http://homeoinfo.com/08_non-classical_topics/wide/naturopathy.php*.
12. Web. American Naturopathic Certification Board (ANCB). ANCB Policies. Retrieved July 28, 2006. *www.ancb.net/policies.html*.
13. Web. American Osteopathic Association document. Non-physician monograph series: Naturopaths. September 2005, as referencing the American Association of Naturopathic Physicians. Positions and Practice, accessed on October 7, 2005. *www.naturopathic.org/naturopathic_medicine/positions_and_practice.aspx*.
14. Web. National Center for Complementary and Alternative Medicine. *www.nccam.nih.gov*. Retrieved December 2, 2007.
15. Web. American Osteopathic Association document. Non-physician monograph series: Naturopaths. September 2005, as referencing *Natural Health*, The European Healers, available at: *www.naturalhealth.org/tradnaturo/history2.html#erop*, accessed October 7, 2005; and *Natural Health*, Natural Healers and Education, available at *www.naturalhealth.org/tradnaturo/history3.html#edu*, accessed October 7, 2005.

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Additionally, in the late 20th century consumers began to utilize complementary and alternative approaches to healing as either adjunct or separate, distinct treatment modalities to traditional allopathic/osteopathic medical treatments. During this time, the number of complementary and alternative practitioners, including naturopaths, acupuncturists, homeopaths, energy healers, herbalists and bodywork technicians, grew and licensure efforts for these non-traditional practitioners expanded.

As discussed earlier, a naturopath (or naturopathic "physician") has graduated from a four-year graduate school of naturopathy with a doctor of naturopathy (ND) or doctor of medical naturopathy (NMD) degree, and is educated in both the basic sciences and complementary and alternative treatment modalities. In some of the 14 states where naturopaths maintain licensure, statutory language may allow them to be called naturopathic physicians.

Notably, doctoral-level graduate naturopathic education is not the norm in the rest of the world. In England and Germany, for example, four-year degrees are adequate to train naturopathic practitioners.[16] Nor are there two competing factions of naturopathic practitioners in most of the world. The norm is to practice traditional naturopathy. Moreover, in no other country are naturopathic practitioners referred to as naturopathic physicians.

The AANP, the organization that represents "naturopathic physicians," declares their members to be (*emphasis added*) "... educated in *all of the same basic sciences as an M.D.* but also [studied in] holistic and nontoxic approaches to therapy with a strong emphasis on disease prevention and optimizing wellness. *In addition to a standard medical curriculum*, the naturopathic physician is required to complete four years of training in clinical nutrition, acupuncture, homeopathic medicine, botanical medicine, psychology, and counseling (to encourage people to make lifestyle changes in support of their personal health). A naturopathic physician takes rigorous professional board exams so that he or she may be licensed by a state or jurisdiction as a *primary care general practice physician*."[17]

A traditional naturopath is a practitioner who has obtained his or her education through some combination of a mentorship program with another practitioner or an alternative clinic, or a distance learning program, and/or classroom schooling on natural health or otherwise holistic studies. These practitioners do not have naturopathy degrees from schools recognized as accredited by the U.S. Department of Education, but they may earn degrees from other schools or obtain certification from professional naturopathic organizations.[18] Traditional naturopaths' education and training is neither standardized nor accredited, and therefore their skill set and training varies widely.[19] No state currently permits the licensure of traditional naturopaths, therefore no minimum requirements for practice are mandated.[20]

The philosophical divide that separates traditional naturopaths from naturopathic "physicians" could not be wider. Traditional naturopaths, collectively represented by the American Naturopathic Medical Association (ANMA), actively oppose the licensure of naturopathy in any form, preferring to practice natural health care unlicensed.[21] Traditional naturopaths believe that licensure takes away their right to practice natural health care.[22] In fact, testimony from the ANMA or individual traditional naturopaths opposing the licensure of naturopaths can often be found in the legislative dockets of many states.

Accordingly, the ANMA offers this sample letter for their members to write their elected representatives on the licensing issue[23]:

16. Web. Natureline. Training to be a naturopath. *http://mypage.direct.ca/a/agaul/index.htm*. Retrieved December 10, 2007.

17. Web. AANP. Education. *www.naturopathic.org/viewbulletin.php?id=29*. Retrieved December 5, 2007.

18. Web. The Cure Research Foundation. Naturopaths. Retrieved June 3, 2008. *www.cancure.org/naturopaths.htm*.

19. *Id.*

20. AOA Document. Non-physician monograph series: Naturopaths. September 2005. Verified by Lexis search, September 5, 2006.

21. Web. American Naturopathic Medical Association (ANMA). Writing your representative. Retrieved December 18, 2007. *www.anma.com/writing yourrepresentative.html*.

22. *Id.*

23. *Id.*

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Dear (Representative):

My name is (Name) and I live in (Dist #) in the State of (Name). I am writing to urge you to vote No on H.R./S Bill (#).

My practice involves education of my clients, using natural therapies, including but not limited to fresh air, clean water, good diet, and exercise to attain a healthier body. I do not diagnose or treat disease and I represent the majority of practicing naturopaths. Naturopaths, Naturopathic Doctors, or Naturopathic Physicians have no business diagnosing, dispensing drugs, or performing surgeries as set out in the legislation in question. Naturopaths, Naturopathic Doctors, or Naturopathic Physicians simply don't have the experience or education required. When diagnosing, dispensing drugs, or performing surgeries is needed, clients should see those licensed and trained to do so. You owe it to the public to protect them from the group seeking this scope of practice for naturopaths. You should require those people to attend traditional medical school. I took an oath to "First do no harm" and I intend to do just that. Please do not take my right to practice away because of a few untrained who want to be "doctors" and have the right to practice as equals to DO's and MD's.

Thank you for considering a "NO" vote on (Bill #).

In a recent proposal by naturopaths for expansion of scope of practice in Washington state, the ANMA notes: "The naturopaths are asking for drugs, surgery and IV therapy which would cover chelation. These naturopaths are not just asking for any drug, they want narcotics under the Controlled Substances III & IV categories. It is obvious that these naturopaths want to be MDs without earning the education and doing an internship in hospitals. We urge you [ANMA members] to read this carefully, understand it, then write, call or e-mail a Washington State legislator whose name, address and phone number will appear on this page. We do not oppose properly trained doctors doing these practices. However, a naturopath pretending to have the knowledge to practice in this manner is definitely a 'danger to the public.'"[24]

Primer on complementary and alternative medicine

Greatly concerned with growing consumer use of CAM, in 1998 Congress established a new bureau of the National Institutes of Health, the National Center for Complementary and Alternative Medicine (NCCAM). Not a formal recognition of CAM, but rather a federal agency funded to apply rigorous scientific inquiry to the outcomes and safety of various CAM modalities, the stated mission of the NCCAM is to:

- Explore complementary and alternative healing practices in the context of rigorous science
- Train complementary and alternative medicine researchers
- Disseminate authoritative information to the public and professionals[25]

The NCCAM defines CAM as "a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine. Conventional medicine is medicine as practiced by holders of M.D. (medical doctor) or D.O. (doctor of osteopathy) degrees and by their allied health professionals, such as physical therapists, psychologists, and registered nurses." The National Cancer Institute defines CAM as "forms of treatment that are used in addition to (complementary) or instead of (alternative) standard treatments. These practices generally are not considered standard medical approaches. Standard treatments go through a long and careful research process to prove they are safe and effective, but less is known about most types of CAM. CAM may include dietary supplements, megadose vitamins, herbal preparations, special teas, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation."

However, the common popular characterization of CAM is any treatment that does not involve pharmaceuticals or surgery. To that end, many conventional treatments are considered CAM by certain CAM practitioners and advocates. For example, nutritional counseling, vitamins, physical activity, the application of ice packs or heat compresses—all conventional treatments—have been adopted as CAM, and are typically counted in surveys and/or polls to indicate the surge of CAM in America. Other research includes prayer, meditation or other spiritual/contemplative thought into the broad definition of CAM as well.

24. *Id.*

25. Web. NCCAM. *http://nccam.nih.gov/about/ataglance/*. Retrieved October 2, 2006.

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The NCCAM categorizes CAM treatments into five distinct groupings. Below is a brief primer on the modalities in each NCCAM grouping,[26] many of which are commonly used by naturopaths.

Whole medical systems

Whole medical systems are built upon complete systems of theory and practice. Often, these systems have evolved earlier than and apart from the conventional medical approach used in the United States.

- Homeopathy—a whole medical system that originated in Europe. Homeopathy seeks to stimulate the body's ability to heal itself by giving very small doses of highly diluted substances that in larger doses would produce illness or symptoms (an approach called "like cures like").
- Traditional Chinese medicine (TCM)—a whole medical system that originated in China. TCM is based on the concept that disease results from disruption in the flow of qi and imbalance in the forces of yin and yang. Practices such as herbal therapy, meditation, massage and acupuncture seek to aid healing by restoring the yin-yang balance and the flow of qi.
- Ayurveda—a whole medical system that originated in India. Ayurveda aims to integrate the body, mind and spirit to prevent and treat disease. Therapies used include herbs, massage and yoga.
- Naturopathy—a whole medical system that originated in Europe. Naturopathy aims to support the body's ability to heal itself through the use of dietary and lifestyle changes together with CAM therapies such as herbs, massage and joint manipulation.

Mind-body medicine

Mind-body medicine uses a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms. Some techniques that were considered CAM in the past have become mainstream, for example patient support groups and cognitive-behavioral therapy.

- Meditation—a conscious mental process using certain techniques, such as focusing attention or maintaining a specific posture, to suspend the stream of thoughts and relax the body and mind.
- Other—prayer, mental healing and therapies that use creative outlets such as art, music or dance.

Biologically based practices

Biologically based practices in CAM use substances found in nature, such as herbs, foods and vitamins. Some examples include dietary supplements, herbal products and the use of other so-called natural, but as yet scientifically unproven therapies (for example, using shark cartilage to treat cancer). The CAM domain of biologically based practices includes, but is not limited to, botanicals, animal-derived extracts, vitamins, minerals, fatty acids, amino acids, proteins, prebiotics and probiotics (which are live bacteria and sometimes yeasts found in foods such as yogurt or in dietary supplements), whole diets and functional foods.

Manipulative and body-based practices

Manipulative and body-based practices in CAM are based on manipulation, the application of controlled force to a joint, moving it beyond the normal range of motion in an effort to aid in restoring health. Manipulation may be performed as a part of other therapies or whole medical systems. Under the umbrella of manipulative and body-based practices is a heterogeneous group of CAM interventions and therapies including Tui Ná, rolfing, Bowen technique, Trager bodywork, Alexander technique, Feldenkrais method and a host of others.

- Chiropractic—a form of spinal manipulation whereby subluxations, or misalignments of the spine, interrupt or interfere with "nerve flow." The manipulation serves to "adjust" the vertebrae with the goal of correcting subluxations.[27]
- Massage—pressing, rubbing and moving muscles and other soft tissues of the body, primarily by using the hands and fingers. The aim is to increase the flow of blood and oxygen to the massaged area.

26. Web. This entire primer (with the exception of the separately footnoted definition of "chiropractic," below) is taken from the NCCAM Web site. What is CAM? *http://nccam.nih.gov/health/whatiscam/#4*. Retrieved December 10, 2007.

27. The NCCAM does not provide a formal definition of "chiropractic." This brief definition is condensed from information found on the NCCAM Web page: About chiropractic and its use in treating low back pain. *http://nccam.nih.gov/health/chiropractic/#1a*. Retrieved December 14, 2007.

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- Reflexology—a practice in which pressure is applied to points on the foot and sometimes the hand with the intent to promote relaxation or healing in other parts of the body.

Energy medicine

Energy therapies involve the use of energy fields. They are of two types.

1. **Biofield therapies** are intended to affect energy fields that purportedly surround and penetrate the human body. The existence of such fields has not yet been scientifically proven. Some forms of energy therapy manipulate biofields by applying pressure and/or manipulating the body by placing the hands in or through these fields. Biofields have defied measurement to date by reproducible methods.

Therapies involving these putative energy fields are based on the concept that human beings are infused with a subtle form of energy. This vital energy or life force is known by different names in different cultures, such as qi (pronounced "chi"). In traditional Chinese medicine, the vital energy or life force is supposed to regulate a person's spiritual, emotional, mental and physical health, and to be influenced by the opposing forces of yin and yang. Vital energy is believed to flow throughout the human body, but it has not been measured by means of conventional instrumentation. Nonetheless, therapists claim that they can work with this subtle energy, see it with their own eyes, and use it to effect changes in the physical body and influence health.

Examples of biofield therapy include:

- Qi gong—a component of traditional Chinese medicine that combines movement, meditation and controlled breathing. The intent is to improve blood flow and the flow of qi.
- Reiki—a therapy in which practitioners seek to transmit a universal energy to a person, either from a distance or by placing their hands on or near that person. The intent is to heal the spirit and thus the body.
- Therapeutic touch—a therapy in which practitioners pass their hands over another person's body with the intent to use their own perceived healing energy to identify energy imbalances and promote health.

2. **Bioelectromagnetic-based therapies** involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating-current or direct-current fields. The veritable energies employ mechanical vibrations (such as sound) and electromagnetic forces, including visible light, magnetism, monochromatic radiation (such as laser beams) and rays from other parts of the electromagnetic spectrum. They involve the use of specific, measurable wavelengths and frequencies to treat patients.

Assessing the evidentiary basis for naturopathy

Naturopaths claim that their natural treatments have been in use for hundreds of years. In many cases, neither the mechanism of action nor the efficacy of the naturopathic treatment as prescribed have been documented or established. The lack of randomized controlled trials and other forms of rigorous scientific inquiry into naturopathic treatments has not gone unnoticed by the medical and scientific communities.[28,29]

Reinforcing the self-image of naturopathy as a distinct type of health care, according to one article, the AANP states that "naturopathic medicine has its own unique body of knowledge, evolved and refined for centuries" and is "effective in treating all health problems, whether acute or chronic."[30] This collective professional isolationist identity of naturopaths lays the groundwork for substandard patient care. Not only does naturopaths' insistence on practicing on the fringe of modern medicine produce providers of questionable medical competence through an educational system fraught with scientific inaccuracies and omissions of even the most basic established medical principles, it also propagates the unfortunate result of patient care that is devoid of current, evidence-based medically accepted concepts.

28. Web. Atwood KC. Naturopathy, pseudoscience, and medicine: Myths and fallacies vs. truths. March 25, 2004. *Med Scape Today*. *www.medscape.com/viewarticle/471156*. Retrieved December 26, 2007.

29. Web. Skolnick A. Live Science. Voice of reason: Licensing naturopaths may be hazardous to your health. *www.livescience.com/health/naturopathy_license_041118.html*. Retrieved December 26, 2007.

30. Web. American Association of Naturopathic Physicians. *www.aanp.org*. Retrieved December 16, 2007.

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A lack of scientific proof for many of their treatment modalities does not deter naturopaths, however. One article in the April 2006 issue of the *Journal of Alternative and Complementary Medicine* proposes that naturopaths disdain the application of evidence-based medicine (EBM) to their practice:

> This paper presents the voices of tradition-sensitive naturopathic practitioners in response to what they perceive as an ideologic assault by EBM advocates on the validity and integrity of natural medicine practice. Those natural medicine practices, which have tradition-based paradigms articulating vitalistic and holistic principles, may have significant problems in relating to the idea of EBM as developed in biomedical contexts. The paper questions the appropriateness of imposing a methodology that appears to minimize or bypass the philosophic and methodological foundations of natural medicine, and that itself seems primarily driven by political considerations.[31]

Is this "unique body of knowledge" not then subject to the same scientific, peer-reviewed scrutiny as are medical concepts? At least one mainstream medical journal article has acknowledged the inherent difficulty in using traditional, randomized, controlled clinical trials for CAM modalities. At the same time, it called for medicine to demand CAM "develop and defend a rational and coherent method for assessing causality and efficacy, though not necessarily one based on the results of controlled clinical trials."[32] To date, proponents of CAM and/or naturopathy have not proposed any alternative epistemology calculated to assess the efficacy of CAM treatments.

Nonetheless, naturopaths and other CAM providers have begun conducting limited research and contributing their results to the scientific body of literature. In many instances, such as the NCCAM-funded clinical trials discussed below, the efficacy of naturopathic treatments is not supported by clinical evidence. The NCCAM "Research Results" Web page lists the following examples[33]:

- "Pilot Study Provides New Insight on Effect of Ginkgo Extract on Dementia in the Elderly." Overall, in this study of the elderly, researchers did not find a reduction in progression to dementia in those using ginkgo versus those using placebo. (February 2008)
- "Drinking Black Tea Shows No Impact on Cardiovascular Risk Factors." It is commonly believed that polyphenol antioxidants, found in tea, have a variety of health benefits, including cardiovascular benefits. However, randomized trials to date have yielded mixed results on the effects of tea on cardiovascular risk factors. (October 2007)

Some naturopathic treatments have been subjected to the gold standard research design: the randomized controlled trial. However, many of the studies considered by the profession to be "naturopathic" in nature involve treatments that are not unique to naturopathy. For example, Bastyr University, Seattle, considered by many to be the top naturopathic school in the United States, lists current and past research projects on its Web site. Two of its current research projects include the nutritional studies, "Will a naturopathic diet improve glycemic management?" and "Effectiveness of two levels of pulse [beans/legumes] consumption on caloric restriction adherence and chronic disease risk."[34] Dietary modifications are hardly the sole province of naturopaths. However, results from these studies will add to the general scientific body of knowledge and should be encouraged.

Bastyr also posts that 40 research projects have been completed or are underway.[35] A cursory review of its "Current Research Studies" Web page reveals 11 current research projects.[36] Four are non-clinical research projects, seven are clinical research projects. Of these, one is an animal research project and six are human research projects, only one of which is identified as a randomized controlled trial.[37] Furthermore, of the 11 research projects listed, only two investigators listed are also named as faculty on Bastyr's Web site. In just one study is the *primary* investigator also a faculty member.[38]

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31. Jagtenberg T et al. *J Altern Complement Med.* Evidence based medicine and naturopathy. 2006 Apr;12(3):323-8. *Note:* the authors are Australian.
32. Tonelli MR et al. *Acad Med.* Why alternative medicine cannot be evidence-based. 2001 Dec;76(12):1213-20.
33. Web. NCCAM. *http://nccam.nih.gov/research/results/.* Retrieved March 11, 2008.
34. Web. Bastyr University. Research Home Web page. *www.bastyr.edu/research/default.asp.* Retrieved March 11, 2008.
35. *Id.*
36. *Id.*
37. *Id. Trametes versicolor* in women with breast cancer. Principal Investigator: L.J. Standish.
38. *Id.* Principal Investigator: L.J. Standish. Dr. Standish is also a co-investigator on a second research project. Co-investigator: W. Weber.

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NCCAM funding for CAM clinical trials has increased every year since its inception in 1999. Congress appropriated $121.4 million to the NCCAM for the fiscal year 2007.[39] However, 2007 press releases on the results of NCCAM-funded botanical/herbal clinical trials note a lack of efficacy for many CAM modalities studied (naturopaths commonly employ herbal/botanical and nutritional counseling in their treatments):

Shark cartilage supplement does not extend the lives of lung cancer patients[40]
Researchers announced the results of an NCCAM and National Cancer Institute co-funded clinical trial showing that a shark cartilage supplement did not improve the overall survival of patients with lung cancer. Colleagues at the University of Texas M.D. Anderson Cancer Center conducted this phase III randomized, double-blind, placebo-controlled clinical trial at cancer centers throughout the U.S. and Canada. All 379 patients in the study received radiation and chemotherapy in addition to a shark cartilage supplement or a placebo pill. The study team found that those who took the supplement did not live any longer than those who took the placebo. A previous NCCAM-funded study also found shark cartilage did not benefit patients with advanced breast or colon cancer.

Echinacea for the prevention and treatment of colds in adults[41]
The research team tested three preparations of the roots of a species of echinacea called *Echinacea angustifolia*, which prior smaller studies had found to benefit adults with the common cold. The three preparations were made by extracting the root of *E. angustifolia* using procedures that represent some of the different ways that echinacea is available and used to treat the common cold. In this study, researchers found that none of the three preparations of *E. angustifolia* at the 900 mg daily dose had significant effects on whether volunteers became infected with the cold virus or on the severity or duration of symptoms among those who developed colds. However, critics of this study believe the dose of *E. angustifolia* used was too low.

St. John's wort and depression[42]
An extract of the herb St. John's wort was no more effective for treating major depression of moderate severity than placebo, according to research published in the *Journal of the American Medical Association*. The randomized, double-blind trial compared the use of a standardized extract of St. John's wort (*Hypericum perforatum*) to a placebo for treating major depression of moderate severity. The multisite trial, involving 340 participants, also compared the FDA-approved antidepressant drug sertraline (Zoloft®) to placebo as a way to measure how sensitive the trial was to detecting antidepressant effects.

Questions remain as to whether naturopaths are integrating such clinical evidence into their treatment protocols and, moreover, to what extent they are attempting to elucidate—for the benefit of their patients, as well as the scientific community—the mechanisms of their traditional treatments such as homeopathy, traditional Chinese medicine, and botanical or herbal preparations. In a 2006 editorial in the *Journal of Alternative and Complementary Medicine*, researchers from the National College of Naturopathic Medicine, Portland, Ore., and the Oregon College of Oriental Medicine, also in Portland, note that aside from the difficulty in applying the randomized controlled trial design to CAM treatments, "an equally important impediment is the paucity of our understanding of the basic mechanisms underlying most CAM therapies. Stated most directly, in the absence of knowing how a treatment 'works,' an appropriate sham control cannot be designed rationally. And, without an appropriate sham control, the efficacy of a treatment cannot be assessed adequately. It has even been suggested that sham controls are more appropriate for studying *why* CAM treatments are effective than *whether* they are effective."[43]

This module does not purport to be an exhaustive literature search on the natural remedies most commonly

39. Web. NCCAM. NCCAM funding: Appropriations history. *http://nccam.nih.gov/about/appropriations/*. Retrieved December 26, 2007.

40. Web. NCCAM. Research results spotlight. *http://nccam.nih.gov/research/results/spotlight/061507.htm*. Retrieved December 26, 2007.

41. *Id.*

42. *Id.*

43. Hammerschlag R and Zwickey H. Evidence based complementary medicine and alternative medicine: Back to basics. *Journal of Alternative and Complementary Medicine*. Vol. 12, No. 4, 2006. pp. 349–350. *Authors' note:* We prefer the term 'sham' rather than placebo, because sham implies better to research on therapies involving devices and physical manipulation, in which—unlike in pharmaceutical research—there is no assumption that the control will be inert.

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used by naturopaths, and should not be held as evidence of the efficacy or lack thereof of the particular naturopathic CAM modalities discussed. However, it should be noted that, without consideration of research design or methodology, through the most basic of PubMed literature searches on the efficacy of CAM modalities, several sources (NCCAM press releases and studies in peer-reviewed medical journals) demonstrated positive outcomes for directed uses of acupuncture. As discussed elsewhere in this module, naturopathic graduate education does not typically prepare naturopaths to practice acupuncture. Most states that license naturopaths require additional training beyond the ND or NMD degree for naturopaths to use acupuncture in practice.

Official state reports on naturopathy

Many states have commissioned investigative reports or special committees to study the issues related to licensure or, in states where naturopaths currently enjoy licensure, issues related to the expansion of scope-of-practice privileges. Most of these state legislative or agency reports exhibit significant research into the history of the naturopathic profession, both nationally and within the state, as well as other states' experiences with naturopath licensure and/or professional regulation. These reports are excellent resources for those states anticipating licensure or scope of practice expansion proposals by naturopaths.

Arizona (2000)

In 2000 the Arizona Office of the Auditor General conducted an audit and sunset review[44] of the Arizona Naturopathic Physicians Board of Medical Examiners pursuant to a June 16, 1999, resolution of the Joint Legislative Audit Committee. This audit noted significant concerns with the operative processes of the Arizona board, potentially attributable to lack of oversight. (*Note:* The Arizona Naturopathic Physicians Board of Medical Examiners was established in 1935 to regulate naturopathic physicians through licensure. Naturopaths were once restricted to using natural, drugless and nonsurgical methods, however, in 1992 the law was changed to allow naturopaths to perform many of the same activities performed by allopathic and osteopathic physicians.)

The audit report also concluded that the Arizona board needed to improve complaint processing to ensure that complaints were resolved in a timely and appropriate manner. At the time of the review, it had developed a backlog of cases. Of 13 unresolved complaints, five had been open for more than 1,000 days.[45]

The audit report also noted that Arizona naturopaths enjoyed the most liberal scope of practice and prescribing formulary in the nation, and suggested the Legislature review the board's statutes in order to ascertain whether "the Legislature intended such an extension of naturopaths' activities." With regard to the Arizona board's proposal to recognize 16 specialties within naturopathic medicine, including family medicine and minor surgery, internal medicine, neurology and psychiatry, and ophthalmology, the report authors concluded, "No other state that regulates naturopaths recognizes such a broad range of specialties."[46]

The audit report authors also suggested the Legislature review the Arizona Naturopathic Physicians Board of Medical Examiners statutes to determine if increased oversight should be provided on what prescriptions naturopaths can write. "The Board's statutes require it to develop a list of 'natural substances' that naturopaths can prescribe, but the statutes do not define what 'natural substances' are. The Board has developed an extensive list, or formulary, that includes not only vitamins and minerals, but also vaccines, antibiotics, oral contraceptives, anabolic steroids, and controlled substances such as morphine and cocaine. The U.S. Drug Enforcement Administration has recently approved Arizona naturopaths to prescribe controlled substances from the formulary because this appears to be in accordance with state law. Although some other states allow naturopaths to prescribe and dispense drugs, none has a list as extensive as what the Board has developed. Most of these states also have separate oversight bodies to develop or review the list, while Arizona does not."[47]

Most importantly, however, the Arizona Auditor General's Office found a disturbing lack of valid competency assessment of candidates for naturopathic licensure in the state (*emphasis added*):

44. Web. State of Arizona Office of the Auditor General. Naturopathic Physicians Board of Medical Examiners (June 2000, Report No. 00-9). Available at: *www.azauditor.gov/Reports/State_Agencies/*.

45. *Id.* Executive summary.

46. *Id.*

47. *Id.*

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> The Board needs to correct numerous problems with its three-part licensing examination, or adopt a national examination, to ensure that the naturopaths it licenses are competent. Since 1997, the Board has been administering a licensing examination it developed specifically for Arizona. Problems with this examination call into question its validity as a tool for measuring an applicant's competence to practice naturopathy. For example, *the Board has not ensured that the examination tests what a naturopath would need to know to practice safely* and has not shown that examination writers possess the necessary expertise and training to develop test questions. *Further, the Board has made extensive adjustments to examination scores.* For example, one licensure applicant received credit for 90 questions that she had answered incorrectly on one part of the February 1999 exam. *As a result of such scoring adjustments, no one has failed the Board's exam since September 1998.*

The shortcomings noted in the Auditor General's report indicate a serious and disconcerting lack of regard for public safety. The failure of the naturopathic profession in the state of Arizona to address professional complaints in a timely manner, to ensure the administration of licensing examinations of sufficient quality so as to protect the public from dangerous practitioners, and to maintain their professional scope of practice within the areas for which naturopaths are educated and trained, should instill a lack of public confidence in the naturopathic profession in Arizona.

Colorado (2005)

The state of Colorado performed a sunrise review of naturopaths in 2005.[48] The Colorado report found that naturopaths in the state presented evidence supporting their proposal request for state licensure and regulation. This report contains a valuable compilation of other states' licensure and scope of practice regulations for naturopaths as of 2005. For instance, the Colorado report illustrates the lack of recognized safeguards prevalent in the licensed practice of naturopathy in the United States:

- Four out of 15 states do not require licensed naturopaths to partake in any continuing medical education whatsoever.
- Only three out of 15 states mandate that licensed naturopaths carry professional liability insurance.

Additionally, the Colorado report provides an excellent psychometric analysis of the Naturopath Physicians Licensing Examination (NPLEX). The Colorado Office of Examination Services performed an analysis of the NPLEX test construction and scoring methods, and made several key observations:[49]

> To date, there is little generalizable evidence that NPLEX Part II clinical licensing examinations actually measure clinical competence.

> The thirteen years of NPLEX examination statistics presented ... indicate that the band within which we can be reasonably sure an examinee's true score lies can be variable and somewhat concerning if we are drawing conclusions about technical knowledge of a candidate based on his/her particular test score.

Unlike the NPLEX, the United States Medical Licensing Examination™ and the Comprehensive Osteopathic Medical Licensing Examination are three-part licensing examinations, each containing a separate Step/Level 3 that specifically assesses whether the examinee can apply medical knowledge and understanding of biomedical and clinical science essential for the unsupervised practice of medicine, with emphasis on patient management in ambulatory settings. Step/Level 3 provides a final assessment of physicians assuming independent responsibility for delivering general medical care.[50]

Florida (2004)

The "2004 Sunrise Report on Proposed Licensure of Naturopathic Physicians" concluded that there is "potential risk from licensing naturopathic physicians to allow them to provide a broad range of primary care services." The state of Florida abolished its licensing provisions for naturopathy in 1959, grandfathering in several practicing naturopaths who had been licensed at that time. The 2004 report was conducted as proponents for naturopathy again sought licensure in the state.

48. Web. Colorado Department of Regulatory Agencies, Office of Policy, Research and Regulatory Reform. 2005 sunrise review of naturopathic physicians. *www.dora.state.co.us/opr/archive/2005Naturopaths.pdf*. Retrieved December 12, 2007.

49. *Id.* pp. 40–50.

50. Web. United States Medical Licensing Examination. *www.usmle.org*. Retrieved December 17, 2007.

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The authors of the report concluded that:

- The proponents of regulation did not provide evidence that there is substantial harm or that the public is endangered from the unregulated practice of the profession.
- The department and other sources indicate there is a risk of harm to the public from licensing naturopathic physicians with an expanded scope of practice.[51]

Massachusetts (2002)

A legislative commission to study naturopathy and the prospect of licensure was established at the request of naturopaths in Massachusetts. In 2002 the Majority and Minority of the Massachusetts Special Commission on Complementary and Alternative Medical Practitioners presented their reports.[52]

Although the majority report recommended licensure for naturopaths be granted, the minority of the special commission was compelled to submit its own report, highlighting significant deficiencies in the majority's fact-finding process and in the information presented within the majority report. The minority report provides extensive examples of the unscientific basis for naturopathic treatment and calls into question the failure of the majority to report on the validity of treatments used by naturopaths in the care of patients. "Those [members of the commission] favoring licensure of naturopaths did not show an interest in investigating the validity of naturopathic practices. We ask the legislature to question why the proponents of naturopathy did not discuss the validity of specific naturopathic practices."

In addition, the minority report contains detailed significant findings related to the education and practice of naturopaths.[53] "Evidence shows that the course content of naturopathy schools is filled with unscientific assertions that strain credulity. ... Evidence was presented showing that both graduates and practicing naturopaths lack experience in recognition of disease and effects of treatment."

The authors of the minority report assert a logical approach in opposing licensure to naturopaths. "Standard naturopathic practice is substandard medical practice. Thus, an independent naturopathic board would legitimize unacceptable practices. ... [T]hus, the establishment of a self-regulating naturopathic board would, paradoxically, endorse practices that would be grounds for discipline if performed by a physician."

Though professional collaboration should be the norm among health professionals, the authors of the minority report state that serious problems would arise with regard to professional collaboration should naturopaths be granted licensure in Massachusetts. First, they argue, naturopaths by their very training are disinclined to refer patients for conventional medical care. Naturopaths consider naturopathy to be a "*distinct* system of complementary health care," not complementary to conventional medical care. In fact, the authors note that every naturopathic treatise or professional literature denigrates modern medicine as "treating only the symptoms, not the cause" of disease, and warns the reader about pharmaceuticals, which are consistently referred to as "toxins."[54] Therefore, it is highly unlikely, the authors conclude, that a naturopath would refer a patient to a physician for medical care.

These statements are corroborated by a 1999 study published in the *Archives of Pediatric and Adolescent Medicine*. Using professional naturopathic associations to identify possible subjects, the author surveyed practicing naturopaths and homeopaths in Massachusetts. Results showed that nearly all respondents reported treating children, but *fewer than half* of the responding practitioners reported any formal pediatric training. Most practitioners reported that they *did not* actively recommend immunizations and *fewer than half* of the nonphysician practitioners reported that they would refer a two-week-old neonate with a fever to a medical doctor or emergency medical facility. The author concluded that many of the patients using homeopathy and naturopathy are children. **"Failure on the part of these providers to recommend immunizations or recognize potentially serious illnesses is cause for concern."**[55]

51. Web. Sunrise report on proposed licensure of naturopathic physicians. January 2004. Found at Naturowatch. *www.naturowatch.org/licensure/flasunrise2004.html*. Retrieved December 17, 2007.

52. Web. Minority report of the Massachusetts Special Commission on Complementary and Alternative Medicine Providers, 2003. Retrieved December 5, 2007. *www.quackwatch.org/01QuackeryRelatedTopics/Naturopathy/minority.pdf*.

53. *Id.*

54. *Id.*

55. Lee AC, Kemper KJ. Homeopathy and naturopathy: practice characteristics and pediatric care. *Arch Pediatr Adolesc Med.* 2000 Jan;154(1):75-80.

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The Massachusetts minority report also notes that the medical code of ethics precludes physicians from collaborating with unscientific practitioners, such as naturopaths. In particular, AMA Ethical Opinion E-3.01 is referenced, which reads:

> It is unethical to engage in or to aid and abet in treatment which has no scientific basis and is dangerous, is calculated to deceive the patient, by giving false hope, or which may cause the patient delay in seeking proper care.

The report of the majority, as mentioned above, does not include any information on the safety, efficacy or scientific validity of naturopathic treatments. Instead, it provides recommendations for an administrative framework to support the implementation of naturopath licensure, as well as training standards for licensure that mirror the requirements of the accrediting body for naturopathic schools. Although presented with textbooks used in naturopathy schools, the majority "was not able to determine the quality or reliability of these books or the standards used in developing them."[56]

There is at least one statement in the majority report that is untrue. Under the section entitled "Criteria that suggest the need for licensure," the majority truthfully states that the accreditor of naturopathy schools, the Council on Naturopathic Medical Education (CNME), is a private accrediting agency not recognized by the federal government. The report then incorrectly states that the accrediting body for conventional medical schools is similarly not recognized by the federal government.[57] Nothing is further from the truth. The Liaison Committee on Medical Education, the accreditor of U.S. medical schools, has been continuously recognized by the U.S. Department of Education since 1952.[58] Instead, it was the CNME that had its recognition from the U.S. Department of Education revoked in 2001 (just prior to the release of the majority and minority Massachusetts reports) for failure to apply its own standards to a naturopathy school in candidate status for accreditation. At the time of the Massachusetts Commission's reports, the CNME was *not* recognized by the Department of Education, while the Liaison Committee on Medical Education previously had been and continues to be recognized by the Department of Education as the sole accreditor of U.S. medical schools awarding the MD degree. Likewise, the American Osteopathic Association's Commission on Osteopathic College Accreditation is recognized by the Department of Education as the sole accreditor of U.S. osteopathic medical colleges awarding the DO degree, and has continuously maintained its recognition since 1952.[59]

Missouri (2006)

A 2006 Report of the Senate Interim Committee on Naturopathic Medicine in Missouri[60] noted significant concerns with the education and standardized testing of naturopaths:

> Questions have been raised as to the extent to which the NPLEX (the Naturopathic Licensing Examination) effectively measures competency. ... Unlike the NPLEX, the USMLE (U.S. Medical Licensing Exam) has a third part (USMLE Part III) designed to test clinical competence and "assess whether medical graduates can apply medical knowledge and understanding of biomedical and clinical science essential for the unsupervised practice of medicine." The Committee views the absence of such an evaluation as a significant flaw in the NPLEX.
>
> The main accrediting organization for naturopathic colleges has been in and out of favor with the U.S. Department of Education. ... As a result, the Committee does not have full faith in the diligence of the CNME as an accrediting body."

Finally, emphasizing the inadequacy of the evidence presented them by proponents for naturopathic licensure, and also echoing public confusion regarding the

56. Web. Majority report of the Massachusetts Special Commission on Complementary and Alternative Medicine Providers, 2003. Retrieved December 5, 2007. Available at *www.quackwatch.org/01QuackeryRelatedTopics/Naturopathy/minority.pdf*.

57. *Id.*

58. Web. U.S. Department of Education. Specialized accrediting agencies. *www.ed.gov/admins/finaid/accred/accreditation_pg8.html#med*. Retrieved December 18, 2007.

59. Web. A brief history of AOA accreditation activities. *www.do-online.org/index.cfm?PageID=edu_main&au=D&SubPageID=acc_main&SubSubPageID=acc_predoc*. Retrieved March 10, 2008.

60. Web. Report of the Senate Interim Committee on Naturopathic Medicine. Prepared by Chris Hogerty, Senate Research Staff. January 20, 2006. Retrieved December 5, 2007. *www.senate.mo.gov/06info/comm/interim/sinm/NaturopathReport.pdf*.

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qualifications of naturopaths, the committee concluded, "it remains unclear to the committee ... who is a naturopath or what makes one a naturopath. This is a fundamental and necessary question that the committee was unable to determine."[61]

Nevada (An administrative history of the Board of Naturopathic Healing)

The Nevada Board of Naturopathic Healing was created in 1981. Nevada statutes required that the board consist of the following members appointed by the Governor: three licensed naturopaths engaged in the practice of naturopathic healing for more than two years in the state, one licensed physician who is a valid Nevada resident and one public member who is neither a licensed health practitioner nor a health administrator. The statute allowed the initial naturopaths on the board to be licensed and engaged in practice in another state, and authorized their appointment to the board to constitute their licensure in Nevada.

The first chairman of the Nevada Board of Naturopathic Healing submitted his resignation in 1982 and the three other members resigned in 1983, leaving the one non-health practitioner, who was unable to take any action for lack of a quorum. Until the governor appointed qualified members, the board remained inactive. Meanwhile, the legislative subcommittee received testimony and correspondence alleging that certain licensed naturopaths in the state were practicing with questionable, if not fraudulent credentials. The subcommittee recommended a modification of the board's membership, and that the skills and knowledge of all Nevada licensed naturopaths be thoroughly examined and verified. There appeared to be little board activity after 1983, and in 1987 the state assembly enacted a bill that rendered the board defunct. Any license issued by the Nevada Board of Naturopathic Healing expired on July 1, 1987.[62]

Demographics of the profession

Number of licensed naturopaths in the U.S. work force

In 2004 it was estimated there were 1,500 naturopaths practicing in the United States.[63] As of late 2005, the AANP reported approximately 4,000 naturopathic doctors were practicing in the United States, but a 2006 tally of naturopaths in the 15 states that permit licensure of naturopaths revealed approximately 3,300 licensed naturopaths. There is no practical estimate of the number of naturopaths practicing in states where licensure is not permitted, nor is there an estimate of the number of traditional naturopaths currently practicing in any or all states. (See Figure 1, page 46, for more information.)

Employment types/locales

Most naturopaths establish private naturopathic practices or teach at schools of naturopathy. Naturopathic practitioners may work with physicians or chiropractors, or in hospitals, nursing homes, clinics, health clubs or resorts.[64]

Salary data

A Seattle newspaper stated in December 2003 that most naturopaths established private practices and earned $35,000 to $100,000 annually.[65] A 2004 survey conducted by the National College of Naturopathic Medicine found that the median take-home pay for individuals working 32 hours or more per week was $45,000, while the average was $54,000. The high annual take-home pay was $250,000.[66]

The Princeton Review online, in its graduate school and careers section, notes that "according to a survey by the AANP, naturopathic doctors generally earn in the low to mid range of family practice doctors. A beginning ND, just starting up his or her practice, working part time or building a staff, may earn between $20,000 to $30,000 per year. However, an ND who runs or partners in a large, busy practice makes an average estimated income of $80,000 to $90,000 per year—and may make upwards of $200,000."[67]

61. *Id.*

62. Web. Nevada State Library and Archives. Board of Naturopathy; Administrative History. *http://dmla.clan.lib.nv.us/DOCS/nsla/archives/archival/lic-rec/naturo.htm*. Retrieved December 10, 2007.

63. Web. eNotes. Alternative medicine—naturopathic medicine. Retrieved July 28, 2006. *http://health.enotes.com/alternative-medicine-encyclopedia/naturopathic-medicine*.

64. Web. UniXL. Retrieved July 28, 2006. Search term "naturopathy jobs." *www.unixl.com/dir/health_sciences/naturopathy/*.

65. Perry N. University carves niche in alternative health care. *The Seattle Times*. December 24, 2003. *www.ntskeptics.org/news/news2003-12-28.htm*.

66. Web. National College of Naturopathic Medicine. Alumni survey summer 2004—income data. Retrieved July 28, 2006. *www.ncnm.edu/alumniandfriends/2004AlumniSurvey.pdf*.

67. Web. The Princeton Review. Retrieved November 20, 2007. *www.princetonreview.com/grad/research/programProfiles/salariescareers.asp?programid=98*.

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IV. Billing for services

Medicare

Medicare does not provide for the reimbursement of naturopathy.[68] In 1968 the U.S. Department of Health, Education, and Welfare (now the U.S. Department of Health and Human Services) reported to Congress, recommending that naturopathic services not be added to Medicare coverage.[69] Naturopaths had requested coverage for the services of naturopathic physicians under Part B of the Supplementary Medical Insurance Program as independent practitioners serving as "points of entry," similar to doctors of medicine and osteopathy, but subject to restrictions in treatment as specified in state licensure laws.[70]

The report contained an enormous amount of research, and Congress ultimately declined the naturopaths' request for coverage, concluding that "naturopathic theory and practice are not based on the body of basic knowledge related to health, disease, and health care which has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of naturopathic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment."[71]

Medicaid

Medicaid will cover acupuncture and/or naturopathic services if the practitioner is licensed in the state where the service is provided and the service is considered a medical necessity.[72] The Medicaid Act does not define "medically necessary"; each state is allowed to develop its own definition for operation of the Medicaid program in the state.[73]

Private payers

More than 90 insurance carriers currently cover naturopathic medicine in the United States and Canada.[74] Increasingly, NDs are covered as specialists and primary care providers under corporate reimbursement plans.[75] Connecticut, Washington, Montana and Alaska have mandated insurance reimbursement for "medically necessary and appropriate naturopathic medical services."[76]

68. Web. AOA Document. Non-physician Monograph series: Naturopaths. September 2005; also NaturoWatch, Sunrise report on proposed licensure of naturopathic physicians (Jan. 2004). *www.naturowatch.org/licensure/flasunrise2004.html*. Verified by CMS Web site search. *www.cms.hhs.gov/default.asp*. Search terms: naturopath and naturopathic (searched September 2, 2006).

69. Web. *Quackwatch.org*. HEW report on naturopathy (1968). Retrieved December 18, 2007. *www.quackwatch.org/01QuackeryRelatedTopics/Naturopathy/hew.html*. Referencing U.S. Department of Health, Education, and Welfare's Report to Congress: Independent practitioners under Medicare: 1968.

70. *Id.*

71. *Id.*

72. Web. AOA Document. Non-physician monograph series: Naturopaths. September 2005; also verified by Lexis search, September 5, 2006.

73. Web. Neighborhood Legal Services Inc. The "Medical Necessity Requirement" in Medicaid. Tim Sindelar, Disability Law Center, Boston, MA. *www.nls.org/conf2002/medicaidandmedicalnecessity.htm*. Retrieved November 19, 2007.

74. Web. Vital Stream Naturopathy. About naturopathy. Retrieved July 29, 2006. *www.vsnaturopathy.com/aboutnd.html*.

75. Dunne N. Naturopathic medicine: What can patients expect. *The Journal of Family Practice* 54,12 (Dec. 2005): 1067-72.

76. Leonard T. Naturopathic medicine focuses on body's natural healing processes. *Santa Cruz Sentinel*. September 25, 2005.

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V. Education and training of naturopaths

Doctoral programs/degrees

As mentioned earlier, naturopathy has been in existence in the United States for more than 100 years, but modern graduate naturopathic education is relatively new. The oldest of the accredited U.S. schools of naturopathy was established in 1956, with the remaining three accredited schools first admitting students in the years 1978, 1992 and 1996, respectively.[77]

The ND and NMD programs lead to a doctoral degree in naturopathy and typically require four years of graduate study. Some schools offer ND degrees as correspondence courses with little or no requirement for supervised clinical practice. Programs accredited by the CNME that offer an ND or NMD degree require clinical internship during the third and fourth years of study.[78]

Accrediting bodies

Founded in 1978, the CNME is presently accepted as the programmatic accrediting agency for naturopathic education by the four-year naturopathic colleges and programs in the United States and Canada, by the American and Canadian national naturopathic professional associations, and by the North American Board of Naturopathic Examiners. The CNME received initial recognition from the U.S. Department of Education in 1987, lost recognition status in 2001 due to its failure to apply its own accreditation standards to a candidate school for accreditation, and ultimately regained recognition status in 2003. *(See next section for more information.)*

The American Naturopathic Medical Accreditation Board (ANMAB) also accredits U.S. schools of naturopathy leading to the ND degree, as well as schools that offer certificates, diplomas or coursework in the naturopathic arts and sciences.

U.S. Department of Education recognition of accrediting bodies

The U.S. Department of Education recognizes the CNME as the national programmatic accrediting agency for programs leading to the NMD or ND degree.[79] Accrediting agencies with the Department of Education's recognition have been found in compliance with the federal regulations that apply to educational accrediting agencies, and are determined to be reliable authorities as to the quality of education or training provided by the institutions of higher education and the higher education programs they accredit.[80] The Department of Education's recognition means the schools or specialized educational programs the accrediting agency accredits are eligible to seek participation in programs sponsored by federal agencies. Students and graduates of U.S. naturopathic medicine programs with CNME accreditation are eligible to apply for such federal programs as the Academic Research Enhancement Awards and the Loan Repayment Program, and receive federal student aid.[81]

Originally recognized by the Department of Education as an accrediting agency in 1987, the CNME was stripped of its recognized status Jan. 16, 2001, as a result of its failure to apply its own standards to a candidate school for accreditation, the Southwest College of Naturopathic Medicine and Health Sciences.[82] Before 1987, U.S. schools of naturopathy were not accredited by any body recognized by the U.S. Department of Education, thus providing no assurance as to the quality of the education received by naturopathic graduates prior to this time.

77. Web. National College of Natural Medicine, *www.ncnm.edu*; Bastyr University, *www.bastyr.edu*; Southwest College of Naturopathic Medicine, *www.scnm.edu*; University of Bridgeport College of Naturopathic Medicine, *www.bridgeport.edu*. Retrieved December 12, 2007.

78. Hough H, Dower C, and O'Neil E. *Profile of a Profession: Naturopathic Practice*. Center for the Health Professions: University of California, San Francisco, 2001.

79. Web. U.S. Department of Education. National institutional and specialized accrediting bodies. *www.ed.gov/admins/finaid/accred/accreditation_pg8.html#nnm*. Retrieved September 6, 2006.

80. Web. U.S. Department of Education. Overview of accreditation. *www.ed.gov*. Retrieved December 12, 2007.

81. Web. CNME. *www.cnme.org/faq.html*. Retrieved September 6, 2006.

82. Web. Memorandum from the U.S. Secretary of Education to the Council on Naturopathic Medical Education. January 16, 2006. Docket No. 00-06-O. *www.ed-oha.org/secretarycases/2000-06-O.pdf*. Retrieved November 26, 2007.

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In order to be recognized by the Department of Education, an "accreditor must have standards for accreditation that assess, among other things, an institution's 'curricula,' 'faculty,' and 'fiscal and administrative facility.'"[83] Further, the accreditor must be one that "consistently applies and enforces standards that ensure that the course or programs ... are of sufficient quality to achieve ... the stated objectives for which the course of programs are offered."[84]

The CNME's standards for accreditation noted several particular situations that would lead the CNME to issue a show-cause letter to withdraw a candidate institution from contention for accreditation. One of these situations included the "inadequate financial support and control of the institution."[85]

The U.S. Department of Education found that during the period of 1996–1999, while Southwest College was a candidate for accreditation, "the entire financial structure [of the college] had become unstable." Because of financial constraints, the school had no president, senior vice president/chief operating officer or dean of students. Moreover, the college had "a large accumulated debt," and the school's tuition could not cover its operating expenses, much less its debt. The November 1997 CNME evaluation team believed the school was operating "under crisis management."[86]

A prior 1996 CNME evaluation visit to Southwest College, as well as the November 1997 visit, produced merely recommendations and scheduled future visits by the CNME. Situations had not improved in April 1998 or in March 1999. Regulations of the Department of Education require that candidate status for accreditation can last no longer than five years. In 1999, as the college's period for candidacy neared its end, its leadership announced a decision to close the school and classes were ultimately cancelled for two weeks.

The Department of Education denied the CNME recognition as an accreditor of naturopathic schools due to its failure to issue a show-cause letter to Southwest College, despite overwhelming evidence of the school's inadequate financial support and control. More succinctly, the "[c]onditions at [Southwest College] continued to deteriorate significantly," yet the CNME did not act (deliver a show-cause letter) until officials attempted to close the school. According to the Department of Education's memorandum, the CNME did not "take prompt adverse action" or "require [Southwest College] to bring itself into compliance" with CNME standards for accreditation.

The CNME was re-recognized by the U.S. Department of Education in 2003.[87] To regain its recognition, the CNME had to "consistently apply and enforce standards that ensure that the course or programs ... are of sufficient quality to achieve ... the stated objective for which the courses or the programs are offered" in the future. The CNME is scheduled for a renewal of recognition review by the Department of Education again in the spring of 2008.[88]

The ANMAB is not currently recognized by the U.S. Department of Education as a programmatic accreditor of post-secondary programs in naturopathy. However, four U.S. schools awarding ND degrees publicize their ANMAB accreditation on their Web sites.[89]

U.S. and Canadian schools granting ND or NMD degrees

Research has identified eight U.S. schools of naturopathy that grant doctoral degrees and two additional schools in Canada. There are four CNME-accredited doctoral programs in the United States, one in Canada, and one school in Canada that is a candidate for accreditation.[90] As of August 2006, among the four U.S.

83. *Id.*
84. *Id.*
85. *Id.*
86. *Id.*
87. *Id*
88. Web. U.S. Department of Education. Accreditation in the United States. *www.ed.gov/admins/finaid/accred/accreditation_pg8.html#nnm.* Retrieved December 14, 2007.
89. Clayton College; Canyon College; Trinity College of Natural Health; The University of Natural Medicine.
90. Web. The Council on Naturopathic Medical Education. CNME accredited and candidate programs. Retrieved July 29, 2006. *www.cnme.org/links.html.*

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CNME-accredited schools, there were approximately 1,290 students enrolled in naturopathy programs.[91,92,93,94] The CNME-accredited schools in the United States are:

- Bastyr University in Kenmore, Wash. (est. 1978)
- National College of Naturopathic Medicine in Portland, Ore. (est. 1956)
- Southwest College of Naturopathic Medicine and Health Sciences in Tempe, Ariz. (est. 1992)
- University of Bridgeport (UB) College of Naturopathic Medicine in Bridgeport, Conn. (est. 1927, ND program est. 1996)

The sole CNME-accredited Canadian school, located in Ontario, is the Canadian College of Naturopathic Medicine. The CNME has granted candidate status to The Boucher Institute of Naturopathic Medicine located in British Columbia.[95] All U.S. and Canadian accredited schools operate their degree programs on campus (as opposed to distance or online learning).

The financial instability of the Southwest College of Naturopathic Medicine has been previously mentioned. The UB similarly faced significant fiscal and administrative problems when, as a result of declining enrollment in the 1980s and reduced state and federal funding for higher education during this period, the school's administration attempted to fire nearly 50 tenured faculty and demand a 30 percent decrease in salary from the rest of the faculty. What resulted was the longest strike of faculty in the history of U.S. higher education.[96]

Interestingly, a group called the Professors World Peace Academy (PWPA) offered financial assistance to the UB with a program of forgivable loans in 1992. The PWPA is a satellite group of the Unification Church of Sun Myung Moon[97] (a group commonly known as the "Moonies"). The amount loaned to the UB over the years nears $110 million.

According to one 1997 article on the Unification Church bailout of the UB:

> Instantly, there was a mass exodus of faculty from the university. Many professors did not want to be associated with a cult. The strikers settled with UB, but had to sign documents to the effect that they would never seek employment at the school again. The Law School, the university's only profitable program, dissolved its association and fled to Quinnipiac College in Hamden.
>
> The PWPA was given the right to name 60% of the UB board.
>
> UB has become a center for alternative and unproven pseudo-medical propaganda. It was the first U.S. university to officially create a College of Chiropractic. In the fall of 1996, the new school of Naturopathy was opened .... [T]hey are trying to gain acceptability through the legitimizing tonic of university affiliation.[98]

Average annual tuition and fees at the four U.S. CNME-accredited schools for the 2007–2008 academic year was $22,315.[99]

The four U.S. schools of naturopathy granting ND degrees that are accredited by the ANMAB include:

- Clayton College of Natural Health in Birmingham, Ala.
- Canyon College in Caldwell, Idaho
- Trinity College of Natural Health in Warsaw, Ind.
- The University of Natural Medicine in Santa Fe, N.M.

91. Pfau, Jason L. Naturopathic program questions. E-mail from school. August 7, 2006.
92. Ackles, Kelly. ND program question. E-mail from school. August 8, 2006.
93. Phone conversation with the National College of Natural Medicine Admissions Department (August 7, 2006).
94. Grandison, Mike. ND degree program question. E-mail from school. August 7, 2006.
95. Web. The Council on Naturopathic Medical Education. CNME accredited and candidate programs. Retrieved September 2, 2006. *www.cnme.org/links.html*.
96. Web. *New York Times*. Judson G. Strike by professors is settled at the University of Bridgeport. August 29, 1992. Retrieved December 18, 2007. *http://query.nytimes.com/gst/fullpage.html?res=9E0CE7D91030F93AA1575BC0A964958260*.
97. Web. *New York Times*. Liotta J. For Bridgeport campus, a new kind of college. October 19, 1997. *http://query.nytimes.com/gst/fullpage.html?res=9E03E1D7143FF93AA25753C1A961958260&sec=&spon=&pagewanted=1*. Retrieved December 14, 2007.
98. Web. Perry DeAngelis. The New England Skeptic Society. The Cultiversity of Bridgeport. January 1, 1997. *www.theness.com/articles.asp?id=60*. Retrieved December 14, 2007.
99. Web. Bastyr University ($23,515), *www.bastyr.edu*; Southwest College of Naturopathic Medicine ($22,820), *www.scnm.edu*; National College of Naturopathic Medicine ($22,928), *www.ncnm.edu*; phone call to University of Bridgeport ($20,000). All retrieved December 19, 2007.

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Graduates per year

Approximately 270 students graduated from CNME-accredited U.S. schools of naturopathy in 2005.[100]

Core competencies required for accreditation

The CNME accredits programs using the *Handbook of Accreditation*.[101] The following are the core accreditation standards for naturopathic programs:

- Program must have a well-defined mission and practical objectives
- Program is well-organized, administered and has a competent faculty
- Program is financially stable and financially well-managed
- Adequate student services
- Core curriculum must meet the following minimum standards:

1. **Academic program** presented over a period of 12 quarters (10–12 weeks per quarter) and has a minimum of 4,100 total clock hours, at least 1,200 of which must be devoted to clinical education
2. **Basic Sciences program** consisting of: anatomy (including gross anatomy, dissection and/or prosection, neuroanatomy, embryology, histology); physiology (lecture and lab); pathology; biochemistry; environmental/public health (also including immunology and infectious diseases); and pharmacology/pharmacognosy
3. **Clinical Sciences program** consisting of: diagnostic courses (physical, clinical, laboratory, diagnostic imaging and differential diagnosis); therapeutic courses (botanical medicine, homeopathy, emergency and legend drugs, nutrition, physical medicine [includes naturopathic, osseous and soft tissue manipulative therapy, physiotherapy, sports medicine, therapeutic exercise and hydrotherapy], psychological counseling, nature care, acupuncture and Oriental medicine, medical procedures/emergencies and minor surgery); and specialty courses (organ systems [includes cardiology, dermatology, endocrinology, EENT, gastroenterology, genitourinary system, gynecology, neurology, orthopedics, pulmonary], natural childbirth/obstetrics, pediatrics, geriatrics, rheumatology, oncology, jurisprudence, marketing principals and practice management)
4. Courses in the history, philosophy and principles of naturopathic medicine must also be offered in the curriculum

- Program must have a clinical education program designed to equip the students with the skills necessary for successful clinical practice
- Program must have adequate library/information resources
- Program must encourage research
- Program has sufficient physical resources, including instructional and research facilities[102]

There is no information available on the ANMAB standards for accreditation other than the following excerpt from their Web site[103]:

> The accreditation procedures adopted have become the standard recognized by the majority of practitioners, and institutions in the naturopathic profession. To become a recognized institution of learning, and to win approval of worthiness by ANMAB, an institution has voluntarily submitted its programs to a thorough investigation by ANMAB. To insure quality in programming, the following entities underwent close scrutiny before accreditation was bestowed:
>
> - Curricula, Faculty
> - Fiscal and administrative capacity
> - Student support services
> - Program length, tuition, and fees in relation to academic objectives and credit received
> - Student achievement (job placement, certification examination, etc.)
> - Student complaints received by, or available to, the accreditor
> - Credible recruiting, admissions practices, calendars, proper student records catalogues, and other publications, grading practices, advertising and publicity

100. Web. Bastyr University *www.bastyr.edu/*. National College of Natural Medicine *www.ncnm.edu/*. Southwest College of Naturopathic Medicine and Health Sciences *www.scnm.edu/*. University of Bridgeport–College of Naturopathic Medicine *www.bridgeport.edu/pages/3240.asp*.

101. Web. Council on Naturopathic Medical Education. *www.cnme.org/index.html*. Retrieved November 15, 2007.

102. Web. The Council on Naturopathic Medical Education. *Handbook of Accreditation*. Retrieved on September 5, 2006. *www.cnme.org/resources/2004_hoa.pdf*.

103. Web. The American Naturopathic Medical Accreditation Board. Retrieved on November 25, 2007. *www.anmab.org*.

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Admission requirements

From surveying the four CNME-accredited U.S. naturopathic doctoral programs, general requirements for admission include a baccalaureate degree (or 90 credit hours of courses) with specific undergraduate course requirements detailed below, essays, letters of recommendation, personal interviews and a grade point average of 2.5–3.0.[104] No entrance examination, such as the Medical College Admissions Test, is required of applicants to schools of naturopathy.

Course	Average prerequisite credit hours
Algebra	0–3
Chemistry (including organic)	12–16
Biology	8–12
Physics	4–6
English	6
Humanities	6
Psychology	3–6

The Association of Accredited Naturopathic Medical Colleges (AANMC) was established in February 2001 "to propel and foster the naturopathic medical profession by actively supporting the academic efforts of accredited and recognized schools of naturopathic medicine."[105] However, unlike the Association of American Medical Colleges or the American Association of Colleges of Osteopathic Medicine, the AANMC does not compile statistics on applicants or matriculants to its member schools. Nor does the AANMC publish a journal or disseminate information to the public regarding educational teaching methods, noticeable trends or statistics in the student body and/or in the achievement of educational goals, or provide information as to advanced study of students' learning processes or faculty development programs. Therefore, a comparison of the average grade point averages, bachelor's degree attainment rates and the demographic makeup of matriculants to naturopathic schools cannot be made to matriculants of U.S. medical schools.

Naturopathy school curriculum requirements

The four CNME-accredited colleges that award ND degrees in the United States follow fairly standard curricula. CNME accreditation standards do not require minimum contact hours in any one discipline. Students typically take basic science courses comprising two years of didactic study, then spend the following two years in their clinical rotations.[106]

Didactic curriculum (years one and two)

Biological sciences[107]:

Course	Credits required for graduation
Anatomy (including neuroanatomy)	13–25.5
Embryology	2–3
Histology	0–4
Biochemistry	4–12
Physiology	9–21
Microbiology/Immunology	6–7
Public health/Epidemiology	0–3
Pathology	4–14
Correlative basic science	0–2

104. Web. Bastyr University *www.bastyr.edu/*. National College of Natural Medicine *www.ncnm.edu/*. Southwest College of Naturopathic Medicine and Health Sciences *www.scnm.edu/*. University of Bridgeport–College of Naturopathic Medicine *www.bridgeport.edu/pages/3240.asp*.

105. Web. Association of Accredited Naturopathic Medical Colleges. *www.aanmc.org*. Retrieved December 18, 2007.

106. Web. Bastyr University *www.bastyr.edu/*. National College of Natural Medicine *www.ncnm.edu/*. Southwest College of Naturopathic Medicine and Health Sciences *www.scnm.edu/*. University of Bridgeport–College of Naturopathic Medicine *www.bridgeport.edu/pages/3240.asp*. Last accessed September 6, 2006.

107. *Id.*

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Naturopathic medicine studies and organ systems[108]:

Course	Credits required for graduation
Living anatomy (including massage, palpation)	1.5–4
Profession history and philosophy	2–4
Nutrition	8–13
Botanical medicine	7–14
Hydrotherapy	1.5–3.5
Oriental medicine	3–18
Homeopathic medicine	8–15
Naturopathic manipulative therapy	0–9
Diagnostic imaging	0–7
Medical genetics	1–2
Gynecology	3–4
Cardiology	2–3
Pediatrics	2–3
Minor surgery	1.5–5
Emergency procedure	2–5
Addictions and disorders	0–2
Obstetrics	2–3
EENT	1.5–2
Endocrinology	1.5–10.5
Neurology	1.5–2
Environmental medicine	1.5–4
Prevention/Therapeutic exercise	0–2
Geriatrics	1–2
Urology/Proctology	1.5–2
Oncology	1.5–2
Dermatology	1.5–2
Orthopedics/Sports medicine	1.5–4
Pharmacology	7–11

Other professional skills[109]:

History taking/Critical thinking	0–1
Counseling skills (class)	3–3.5
Psychological assessment	1.5–2
Practice management	3.5–6
Jurisprudence/Ethics	1.5–4
Diagnostic skills (class)	3–4
Doctor-patient relationship	0–2
Research	2–4

Naturopaths employ any number of CAM modalities in their treatment, claiming mastery of all such modalities, even while practitioners of each individual modality devote years of experience to mastering their craft. Whole-system modalities, such as traditional Chinese medicine and the Ayurvedic healing system from India, which are iconic forms of cultural healing in their respective countries, are covered in naturopathy schools in 33 (three credits) and 22 (two credits) contact hours, respectively.[110]

Additionally, in states where acupuncturists enjoy licensure, typical state requirements for licensure include board certification from the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). Minimum standard requirements for NCCAOM certification include graduation from an accredited program leading to a Master of Acupuncture certificate. This course must be at least three academic years in length and consist of at least 105 credits of specified coursework, with at least 1,905 contact hours, 660 of which must be spent in supervised clinical experiences.[111] Naturopathy students at Bastyr University receive a three-credit (33 hour) didactic course on "the fundamental principles" of traditional Chinese medicine and unknown hours of supervised clinical experience with acupuncture technique.[112] Most schools of naturopathy do, however, offer optional extended study for their students to meet most state licensing requirements for acupuncture.

Greater contact hours are given to the botanical and nutritional curriculum, with Bastyr University requiring 22 credits (271 contact hours).[113] In contrast, the Bachelor of Science in Dietetics degree at Purdue

108. *Id.*

109. *Id.*

110. Bastyr University course catalog, 2004–2005. Graduate programs and curricula—naturopathic medicine. p. 51.

111. Web. Accreditation Commission for Acupuncture and Oriental Medicine. Handbook. *www.acaom.org/index.htm*. Retrieved December 18, 2007.

112. Bastyr University course catalog, 2004–2005. Graduate programs and curricula—naturopathic medicine. p. 51.

113. *Id.*

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University[114] requires 66 credits of specific dietetics- and nutrition-related course work after completion of prerequisites, such as one year of general biology, one year of general chemistry, one year of organic chemistry, and one semester each of microbiology and biochemistry.[115] In addition, 1,100 hours of supervised practica are required before the new graduate can sit for the registered dietitian examination.

Clinical curriculum (years three and four)

From surveying the four accredited naturopathic programs, many of the schools' curriculums have generic course titles for third- and fourth-year clinical courses or rotations (i.e., Clinical Rotation 1, Clinical Education I, Patient Care, etc.), and are not standardized with regard to when they are completed during the program.[116] Generally, all naturopathic students' clinical experience is gained through outpatient clinics. These clinical rotations may include specialization in organ system studies, physical medicine and naturopathic manipulative therapy.[117] It also appears that didactic education continues throughout the third and fourth years of study (i.e., these years are not wholly spent in clinical rotations), although with fewer lecture hours than in the first two years, further decreasing the time spent in clinical settings.

All CNME-accredited naturopathic doctoral programs require candidates for graduation to participate in clinical rotations.[118] The clinical education program begins in the third year of naturopathic education and must be at least 1,200 clock hours, with at least 60 percent of the program's required hours in direct patient care.[119] Therefore, the minimum requirement for direct patient care in a CNME-accredited naturopathic doctoral program is only 720 hours over two years.

The Textbook of Natural Medicine

Popularly hailed as the foremost reference book in naturopathy, the *Textbook of Natural Medicine* was written by Joseph E. Pizzorno, ND, and Michael T. Murray, ND. Pizzorno is the founding president, now emeritus, of Bastyr University, and Murray is a former faculty member at Bastyr. Originally published in 1985, the textbook, now in its third edition, is widely studied in schools of naturopathy.

In 2001 Arnold S. Relman, MD, professor emeritus, Medicine and Social Medicine, Harvard Medical School, and editor-in-chief emeritus of *The New England Journal of Medicine*, reviewed the second edition of the *Textbook of Natural Medicine* (1999) as part of a legislative inquiry into naturopathic medicine in Massachusetts.[120] Dr. Relman's thoughts appear below.

> [T]he licensing of naturopathic medical practitioners as independent providers of primary health care would endanger the health and safety of the public and would not result in health benefits commensurate with its risks. There is abundant evidence in the *Textbook* to support this conclusion, but I summarize below only a few of the most problematic examples of the deficiencies and dangers in naturopathic practices[121]:
>
> The *Textbook* describes the diagnosis and treatment of only 70 "specific health problems," and they are simply listed in alphabetical order, without regard to the nature of the condition or the organ(s) involved. In comparison, standard textbooks of conventional medicine provide a much more rational and systematic presentation that includes hundreds of disease conditions and describes them in much greater depth and detail. The *Textbook* includes in its 70 chapters on specific diseases nothing about cancer, diseases of the blood (including leukemias and anemias), nothing about heart attacks or serious abnormal rhythms

114. The Purdue University program in dietetics was ranked fourth in the nation out of 240 undergraduate dietetics/nutrition programs in 1998, as reported by the Gourman Report.

115. Web. Purdue University. Division of Food and Nutrition, College of Consumer and Family Sciences. *www.cfs.purdue.edu/fn/undergrad/majors_minors_dietetics.shtml*. Retrieved December 5, 2007.

116. Web. Bastyr University *www.bastyr.edu/*. National College of Natural Medicine *www.ncnm.edu/*. Southwest College of Naturopathic Medicine and Health Sciences *www.scnm.edu/*. University of Bridgeport-College of Naturopathic Medicine *www.bridgeport.edu/pages/3240.asp*. Last accessed September 27, 2006.

117. Web. Bastyr University *www.bastyr.edu/*. National College of Natural Medicine *www.ncnm.edu/*. Southwest College of Naturopathic Medicine and Health Sciences *www.scnm.edu/*. University of Bridgeport–College of Naturopathic Medicine *www.bridgeport.edu/pages/3240.asp*. Last accessed September 27, 2006.

118. Hough H, Dower C, and O'Neil E. *Profile of a Profession: Naturopathic Practice*. Center for the Health Professions: University of California, San Francisco, 2001.

119. Web. The Council on Naturopathic Medical Education. *Handbook of Accreditation*. Retrieved on September 5, 2006. *www.cnme.org/resources/2004_hoa.pdf*.

120. Web. Review of the *Textbook of Natural Medicine*. Presented to the Massachusetts Special Commission on Complementary and Alternative Medical Practitioners. Retrieved December 18, 2007 from *www.quackwatch.com/01QuackeryRelatedTopics/Naturopathy/relman1.html*.

121. *Id.*

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of the heart (such as atrial fibrillation), and virtually nothing about kidney diseases, chronic obstructive pulmonary disease, cirrhosis of the liver, or about many common and serious infections such as pulmonary tuberculosis, malaria, syphilis, meningitis, encephalitis or bacterial endocarditis. Lacking adequate education about these diseases, naturopathic practitioners might fail to diagnose them in a timely fashion or delay in referring patients for appropriate medical treatment.[122]

Dr. Relman cited several examples of common, serious diseases that are dangerously mistreated in the textbook[123]:

> The chapter on the treatment of anginal (coronary artery) heart disease does not even mention the use of nitrates, beta-blockers or calcium-channel blockers—all of which are standard, effective, FDA-approved treatment for this condition. Failure to use one or more of these agents in the treatment of severe angina would probably be considered medical malpractice. There is no mention of "statin" drugs to lower cholesterol and prevent further progression of coronary heart disease. The use of angioplasty or bypass surgery for patients unresponsive to pharmacologic therapy is dismissed.
>
> The chapter on high blood pressure says nothing about the diagnostic workup that is often needed to rule out certain curable causes (such as certain diseases of the adrenal gland, or obstruction in the aorta or the renal arteries). It recommends diet lifestyle changes and the use of herbs, but admits that severe cases unresponsive to these "natural" measures may require treatment with pharmaceuticals (presumably under the management of a conventional medical doctor). However, it ends with the dangerous advice that once control of high blood pressure has been achieved with drugs, the naturopathic physician should have the patient "taper off" the medications. For some such patients, a reduction in medication risks sudden resurgence of severe hypertension and the possibility of a stroke or heart attack. Most patients with severe hypertension need to remain on medication indefinitely, or for many years.
>
> The chapter on diabetes says very little about the use of insulin, nothing about oral hypoglycemic drugs, and nothing about the diagnosis, prevention or treatment of diabetic acidosis—except to warn that it is a medical emergency that will require hospitalization.
>
> The chapter on HIV infection and AIDS advocates various types of herbal and "natural" remedies, but gives no information about conventional drug therapy. Although it is admitted that no clinical studies have yet demonstrated the effectiveness of naturopathic medical care in HIV infection when used alone, or even as a supplement to conventional medical treatment, the chapter nevertheless ends with this advice: 'We urge physicians to apply the principles of naturopathic medicine in the care of their HIV positive patients.' As if this neglect of the proven life-prolonging value of anti-viral pharmacotherapy were not shocking enough, the chapter also fails to recommend drug treatment of pregnant women with HIV infections, which is standard practice for the prevention of HIV transmission to the newborn. Neglect of such treatment would surely be considered malpractice in the medical profession.
>
> As already noted, naturopathic teaching (as exemplified in the *Textbook*) claims that "natural" herbal remedies are generally superior to pharmaceuticals in the treatment of most diseases—despite the fact that the FDA forbids the manufacturers of herbal preparations and dietary supplements from making therapeutic claims. The *Textbook* nevertheless devotes a large section to herbs and dietary supplements in which many such claims are made, often with little or no credible supporting evidence in the peer-reviewed scientific literature.[124]

Dr. Relman concludes his review by stating:

> Primary care practitioners whose education does not include the use of prescription drugs simply cannot be expected to provide effective and safe care for many serious conditions they are likely to encounter. While it is true that unnecessary or inappropriate use of drugs is harmful, and that even proper usage of drugs can sometimes cause serious reactions, there can be no doubt that on balance prescription drugs have been enormously beneficial, and that drugs will be even more important in

122. *Id.*
123. *Id.*
124. *Id.*

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the future. The anti-pharmaceutical bias of naturopathic education (as illustrated in the *Textbook*) therefore poses real risks for patients who rely on naturopaths for the management of their illnesses. Without prompt and appropriate drug therapy many patients with serious diseases will die.[125]

Specific examples of other dangerous scientific inaccuracies in the second edition of the textbook include the following naturopathic treatment claims (with corresponding scientific commentary refuting the treatment claim):

St. John's wort for the treatment of HIV-positive patients

In 2000 the U.S. Food and Drug Administration (FDA) posted the following public health advisory* on its Web site: "[R]esults from a study conducted by The National Institutes of Health (NIH) that showed a significant drug interaction between St John's wort (*Hypericum perforatum*), an herbal product sold as a dietary supplement, and indinavir, a protease inhibitor used to treat HIV infection. In this study, concomitant administration of St. John's wort and indinavir substantially decreased indinavir plasma concentrations, potentially due to induction of the cytochrome P450 metabolic pathway. ... [B]ased on these results, it is expected that St John's wort may significantly decrease blood concentrations of all of the currently marketed HIV protease inhibitors (PIs) and possibly other drugs (to varying degrees) that are similarly metabolized, including the nonnucleoside reverse transcriptase inhibitors (NNRTIs). Consequently, concomitant use of St John's wort with PIs or NNRTIs is not recommended because this may result in suboptimal antiretroviral drug concentrations, leading to loss of virologic response and development of resistance or class cross-resistance."[126]

*This FDA public health advisory was released in February 2000. The second edition of the *Textbook of Natural Medicine* was published in September 1999.[127] Information on NIH-funded trials is public information.

Electrochemical silver solutions exhibit antimicrobial effectiveness

In 1999 the FDA stated it was "issuing a final rule [21 CFR Part 310] establishing that all over-the-counter (OTC) drug products containing colloidal silver ingredients or silver salts are not generally recognized as safe and effective, and are misbranded. FDA is issuing this final rule because many OTC drug products containing colloidal silver ingredients or silver salts are being marketed for numerous serious disease conditions and FDA is not aware of any substantial scientific evidence that supports the use of OTC colloidal silver ingredients or silver salts for these disease conditions."[128]

Publisher Churchill Livingstone released a third edition of the *Textbook of Natural Medicine* in November 2005. Critiques or analyses of this current edition are either not known to exist or are unavailable.[129]

Requirements for graduation

An ND or NMD degree generally requires four years of graduate study. Several ND programs allow students to extend study by one or two years. All students are required to complete both the didactic and clinical portions of the education program.[130]

Post-graduate training

Post-graduate training is not required of graduates of naturopathic schools except in the state of Utah, which currently requires one year of post-graduate naturopathic training. Each of the four CNME-accredited naturopathic schools offers a one-year post-doctoral training program. These "residencies" may include placement in naturopathic clinics or private practices, where naturopathic philosophy and treatment are applied to patients in primary care, pediatrics, emergency care, pharmacy compounding, geriatrics, nutritional counseling and obstetrics.[131]

125. *Id.*

126. Web. FDA Center for Drug Evaluation and Research (CDER). Public Health Advisory. February 10, 2000. Subject: Risk of drug interactions with St. John's wort and indinavir and other drugs. *www.fda.gov/cder/drug/advisory/stjwort.htm*. Retrieved December 20, 2007.

127. Web. Amazon.com. *www.amazon.com/Textbook-Natural-Medicine-2-Set/dp/0443059454*. Retrieved March 10, 2008.

128. Web. FDA Talk Paper. FDA issues final rule on OTC products containing colloidal silver. *www.fda.gov/bbs/topics/ANSWERS/ANS00971.html*. Retrieved December 20, 2007.

129. When researching this module, the AMA did not review the second or third editions of the *Textbook of Natural Medicine*.

130. Hough H, Dower C, and O'Neil E. *Profile of a Profession: Naturopathic Practice*. Center for the Health Professions: University of California, San Francisco, 2001.

131. Web. Bastyr University *www.bastyr.edu/*. National College of Natural Medicine *www.ncnm.edu/*. Southwest College of Naturopathic Medicine and Health Sciences *www.scnm.edu/*. University of Bridgeport–College of Naturopathic Medicine *www.bridgeport.edu/pages/3240.asp*. Last accessed September 27, 2006.

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In 2005 the CNME implemented an approval process for naturopathic post-graduate training programs. However, there are no standard requirements for naturopathy curriculum, rotations or experiences. In terms of program content, all that is required by the CNME is that the participant receive 35 hours a year of didactic instruction and participate in "scholarly activities that promote a spirit of inquiry, scholarship and critical thinking, such as discussions, rounds, study clubs, presentations, conferences, and local, regional or national professional associations and scientific societies."[132]

As an example of the limited exposure to patients experienced by naturopathic post-graduates, below is a description of the training offered by the UB.[133] Note in particular the administrative nature of the majority of the duties assigned to the "residents," the low number of hours spent in direct patient care and the absence of descriptions of patient pathology or patient populations expected to be seen by the residents.

> The [University of Bridgeport (UB)] residency program is part of the CNME approved residency program at National College of Naturopathic Medicine (NCNM). The UB residency offers a wide range of clinical experiences at three different settings. The resident will have an opportunity to supervise UB student clinicians at the UB Health Center and its satellite clinics. At the Integrative Medicine Center (IMC), which is affiliated with Yale Preventative Research Center (PRC) at Griffin Hospital, the resident will be working closely with conventional practitioners (MDs or a nurse practitioner) and a supervising Naturopathic physician to come up with appropriate diagnoses and treatment plans for patients. To increase patient exposures and to familiarize with conventional assessments and treatments, the resident will also have clinical rotations in different departments at Griffin Hospital and its affiliated clinics.
>
> **UB Health Center:**
>
> - Supervise UB student clinicians at the UB Health Center and its satellite clinics for five 4-hour shifts or 20 hours per week.
> - Perform administrative duties such as posting daily patient schedules and opening/closing the clinics.
> - Keep track of patient contacts to report to the NCNM residency program.
>
> **Integrative Medicine Center (IMC) at Griffin Hospital:**
>
> - Work at the IMC for three 4-hour shifts per week or 12 hours per week.
> - Discuss diagnoses and treatment plans with conventional practitioners and a supervising ND and present to patients.
> - Perform IVMT (Intravenous Micronutrients Therapy) or Myer's cocktail through IV push for fibromyalgia patients or Glutathione IV push for Parkinson's disease.
> - Conduct dictations for new patients.
> - Make follow-up phone calls to returning patients.
> - Present Fire Chat talks on topics of your choice on a monthly basis to local community at the IMC.
> - Keep track of patient contacts to report to the NCNM residency program.
> - The resident may be required to help with the research at the PRC.
>
> **Clinical Rotations at Griffin Hospital:**
>
> - Initiate and maintain clinical rotations in the departments of choice at Griffin hospital and its affiliated clinics for approximately two 5-hour shifts per week or 10 hours per week.
> - Select an interesting case from the rotations and present a grand round to medical students and residents at Griffin hospital.
> - Take a medical history, perform a physical exam, and present the case to attending physicians (MDs) before initiating diagnostic assessments and treatment plans.

132. Web. Council on Naturopathic Medical Education. *The Handbook on CNME Postdoctoral Naturopathic Medical Education Sponsor Recognition Process And Standards. www.cnme.org/resources/residency_handbook.pdf.* Retrieved November 26, 2007.

133. Web. National College of Natural Medicine. *www.ncnm.edu/academics/UB_Residency 2005.doc.* Retrieved October 5, 2006.

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VI. Naturopath licensure and board certification

Standardized national licensure examination

The North American Board of Naturopathic Examiners (NABNE) developed and administers the Naturopathic Physicians Licensing Exam (NPLEX).[134] The exam consists of two parts, unlike the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA), which each contain three steps/levels.

NPLEX Part I, the "basic science" exam, is generally taken by students upon completion of their second year of naturopathy school. Eligibility requirements for Part I include enrollment in an accredited naturopathy school or an approved in-residence program, and completion of courses in the following subject areas to be tested: anatomy, physiology, biochemistry, microbiology and immunology, and pathology.[135] Each section contains 50 multiple choice questions and students are allotted 60 minutes to complete each section.[136]

Individuals are eligible for NPLEX Part II, the "core clinical science" exam, upon graduation from an approved naturopathic medical education program and after fulfilling the NABNE basic science requirement by either passing NPLEX Part I or by having been granted a waiver by the NABNE.[137] NPLEX Part II consists of eight sections that test the core clinical sciences: physical and clinical diagnosis, lab diagnosis and diagnostic imaging, emergency medicine and public health, pharmacology, botanical medicine, nutrition, physical medicine and counseling, behavioral medicine and health psychology. Each section contains 50 multiple choice questions and students are allotted 60 minutes per section. Additional time is given for the physical and clinical diagnosis (150 items, three hours) and lab diagnosis and diagnostic imaging (75 items, 90 minutes) sections.[138] Part II is offered over a course of three days.

NPLEX Part II also features three elective examinations in homeopathy, minor surgery and acupuncture.[139] Each of these elective examinations contains 50 multiple choice questions and runs 60 minutes. [140]

Notably, the state of Colorado, in its detailed analysis of the NPLEX series, found that NPLEX Part II does not adequately measure clinical competence. This deficiency in the assurance of providing competent health care providers to the public is not at issue in examining physicians for licensure. As noted earlier, the USMLE and COMLEX-USA both contain a separate third component to specifically assess whether the examinee can apply medical knowledge and understanding of biomedical and clinical science essential for the unsupervised practice of medicine, with emphasis on patient management in ambulatory settings. Step 3 of the UMSLE and Level 3 of the COMLEX-USA provide a final assessment of physicians assuming independent responsibility for delivering general medical care.[141]

Additionally, states may require candidates for naturopathic licensure pass a state-written and -administered examination for licensure. As mentioned previously, in 2000 the Arizona Office of the Auditor General reported a concerning lack of diligence by the Arizona Naturopathic Physicians Board of Medical Examiners in their examination of candidates for naturopathic licensure:

> The Board needs to correct numerous problems with its three-part licensing examination, or adopt a national examination, to ensure that the naturopaths it licenses are competent. Since 1997, the Board has been administering a licensing examination it developed specifically for Arizona. Problems with this examination call into question its validity as a tool for measuring an applicant's competence

134. Web. NABNE. Licensing and Registration. Retrieved July 30, 2006. *www.nabne.org/licensereg.php*.

135. *Id.*

136. Web. NABNE. Eligibility. Retrieved September 6, 2006. *www.nabne.org/eligibility.php*.

137. Web. NABNE. Waiver. Retrieved September 6, 2006. *www.nabne.org/consideration.php#PWUSNPCPE*.

138. Web. NABNE. FAQs. Retrieved September 6, 2006. *www.nabne.org/questions.php#aboutexams*.

139. *Id.*

140. *Id.*

141. Web. United States Medical Licensing Examination. *www.usmle.org*. Retrieved December 17, 2007.

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to practice naturopathy. For example, the Board has not ensured that the examination tests what a naturopath would need to know to practice safely and has not shown that examination writers possess the necessary expertise and training to develop test questions. Further, the Board has made extensive adjustments to examination scores. For example, one licensure applicant received credit for 90 questions that she had answered incorrectly on one part of the February 1999 exam. As a result of such scoring adjustments, no one has failed the Board's exam since September 1998.[142]

National board certification

There is no generalist board certification available for the practice of naturopathy. However, a naturopath may achieve specialty certification by any of several organizations. Several states require licensed naturopaths to obtain specialty certification in order to provide certain health care services. For example, it is most common for states to require naturopaths to achieve certification in naturopathic childbirth or acupuncture if they want to provide those services.

Naturopathic childbirth

The American College of Naturopathic Obstetrics (ACNO) is the credentialing arm of the American Association of Naturopathic Midwives. Eligibility to sit for the three-hour ACNO examination requires that (1) the candidate is a student of a CNME-accredited naturopathic school or hold a degree from such a school; (2) the candidate has sat through 100 contact hours of didactic instruction on midwifery at a CNME-accredited school; and (3) the candidate has attended 15 births.

A naturopathic midwife must hold a ND or NMD degree, but in essence receives the same certification as a certified professional midwife, more commonly known as a lay midwife. Many naturopathic colleges offer optional training programs that allow students or graduates to qualify for both the ACNO exam and the certified professional midwife exam offered by the North American Registry of Midwives.

The American Association of Naturopathic Midwives describes naturopathic midwives as:

> [T]he most extensively trained natural childbirth providers available to you and your family. Naturopathic midwives are trained to provide you with safe and effective midwifery care and their background as licensed naturopathic doctors broadens the scope of care you will experience from pregnancy and birth to full family natural health care. From preconception and infertility counseling through newborn and pediatric care, ongoing well woman and menopause concerns, naturopathic midwives are healthcare providers for all seasons of your family's health care needs.[143]

Again, it is significant to note that naturopaths who attend births and deliver newborns are licensed only to the extent of a certified professional midwife (also known as a lay midwife). The doctoral degree does not confer upon the naturopath any birthing privileges greater than those of a lay midwife.

Naturopathic acupuncture

States that permit naturopaths to perform acupuncture typically require specialty certification. Candidates must submit documentation of didactic instruction and supervised clinical experience. In addition, candidates must typically pass an examination, either the NPLEX Part II elective examination in acupuncture or a test offered by the National Certification Commission for Acupuncture and Oriental Medicine. In most cases, students of naturopathy who also want to practice acupuncture will need to extend their doctoral study by at least one year in order to fulfill state and/or examination requirements.

142. Web. State of Arizona Office of the Auditor General. Naturopathic Physicians Board of Medical Examiners (June 2000, Report No. 00-9). Retrieved December 12, 2007. Available at: *www.azauditor.gov/Reports/State_Agencies/*.

143. Web. American Association of Naturopathic Midwives. *www.naturopathicmidwives.org*. Retrieved December 20, 2007.

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VII. State licensure and regulation

States that license naturopaths

Naturopaths must meet licensing requirements in all states that recognize naturopathy through licensure. Presently, 14 states and the District of Columbia regulate naturopaths through licensure: Alaska, Arizona, California, Connecticut, Hawaii, Idaho, Kansas, Maine, Montana, New Hampshire, Oregon, Utah, Vermont and Washington. Puerto Rico and the U.S. Virgin Islands similarly license naturopaths.

The rest of the country does not recognize the profession through licensure, with South Carolina and Tennessee both expressly prohibiting the practice of naturopathy.[144] Wyoming states the following in its case law:

> Our statute is clear, that the practice of naturopathy cannot be regarded as a separate and distinct profession like that of dentistry for instance, nor can any good reason be given why the legislature may not for the benefit of society require that those who practice the healing art should know and keep up with the improvements and advanced learning in that art.[145]

Florida abolished its naturopath licensing laws in 1959, and in 2004 a legislative committee concluded that an expanded scope might be harmful, and that naturopathic licensing is not cost-effective.[146] Several other states, including Texas and Virginia, have abolished previous naturopathy licensure provisions.[147]

It is critical to note that in most states and provinces where naturopathic medicine is not regulated, individuals may practice similar therapeutic approaches and/or call themselves naturopaths (whether or not they have been trained at a school for naturopathic medicine), because the terms "naturopath" and "naturopathic medicine" are not restricted terms.[148] Traditional naturopathy is not a medical practice and, therefore, is not regulated through statutes or regulations in the states.

One of the major initiatives of the AANP is to obtain licensure for naturopaths in all 50 states.[149] (See Figure 1 for more information on requirements for state licensure.)

State scope of practice regulations for naturopaths

Naturopaths' scope of practice varies by state. Naturopaths seek privileges to prescribe drugs, not only those considered "natural" (hormones, purified botanicals, etc.), but also legend drugs, up to and including schedule III and IV controlled substances. Specific information on naturopath scope of practice can be found in Figure 2.

State boards of naturopathy

Information on the authority, procedures of operation, composition and appointment procedures of state boards of naturopathy can be found in Figure 3. Additionally, a roster of state boards of naturopathy can also be found in the Appendix (page 35).

144. Web. North American Board of Naturopathic Examiners. Licensing and registration. Retrieved July 30, 2006. *www.nabne.org/licensereg.php* and verified through Lexis searches September 2, 2006.

145. *Hahn v. State*, 78 Wyo. 258, 322 P.2d 896 (1958).

146. Florida state sunrise report (2004). See page 16 for more information.

147. Lexis-Nexis statutory searches. September 8, 2006.

148. Boon H. Practice patterns of naturopathic physicians: results from a random survey of licensed practitioners in two US States. *BMC Complement Altern Med.* October 20, 2004. *www.pubmedcentral.nih.gov/articlerender.fcgi?artid=529271&tools=bot.*

149. Web. AANP. Issues and legislation. *http://capwiz.com/naturopathic/issues/.* Retrieved September 6, 2006.

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VIII. Professional organizations in naturopathy

The AANP is the professional association for licensed and licensable NDs. The mission of the AANP is to gain licensure for "naturopathic physicians" in all 50 states and to help facilitate the medical paradigm shift from disease management to holistic health care. The AANP offers continuing education and other resources to its members, and referrals to naturopaths for health care consumers.[150]

American Association of Naturopathic Physicians
4435 Wisconsin Ave. N.W., Suite 403
Washington, DC 20016
Toll free: (866) 538-2267[151]

There are approximately 1,000 members of the AANP.[152] To become a "regular" or "graduate" member of the association, one must be a graduate of a college of naturopathy and must either: (1) hold a license as a naturopathic physician in a state or jurisdiction whose license is acceptable to the AANP, or (2) be an active regular member of a state association that is recognized by the AANP, such state association being the one which covers the state, commonwealth or territory in which she resides for the majority of each year.[153]

The AANP does not post its policies on the Web for public viewing. The "Positions and Practices" Web page is not available through "guest user" Web registration.

The American Naturopathic Medical Association (ANMA) is a nonprofit, scientific and educational organization, dedicated to exploring new frontiers of mind, body, medicine and health with approximately 4,000 members worldwide.[154]

The ANMA has a nondiscriminatory policy, with membership open to individuals with (ND) or NMD degrees, as well as those who practice in other health care fields. According to the Web site, some members hold other medical degrees, such as an MD, DO, DDS, OMD, HMD and DC.[155] **The ANMA vigorously opposes the state licensing of naturopathic physicians, which is one of the major initiatives of the American Association of Naturopathic Physicians.**

American Naturopathic Medical Association
P.O. Box 96273
Las Vegas, NV 89193
Phone: (702) 897-7053

A roster of naturopathy association state chapters can be found in the Appendix, page 36.

150. Web. The American Association of Naturopathic Physicians. Retrieved August 7, 2006. *www.naturopathic.org/*.
151. *Id.* Contact us. *www.naturopathic.org/*.
152. Phone conversation with the American Association of Naturopathic Physicians (August 8, 2006).
153. Web. American Association of Naturopathic Physicians. Membership. Retrieved August 8, 2006. *www.naturopathic.org*.
154. Web. American Naturopathic Medical Association. Retrieved August 7, 2006. *www.anma.com*.
155. *Id.*

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Appendix

State naturopathy boards

Alaska Department of Commerce and Economic Development
Division of Occupational Licensing, Naturopathic Section
P.O. Box 110806
Juneau, AK 99811-0806
(907) 465-2695
www.dced.state.ak.us/occ/pnat.htm

Arizona Naturopathic Physicians Board of Medical Examiners
1400 W. Washington, Suite 230
Phoenix, AZ 85007
(602) 542-8242
www.npbomex.az.gov

California Bureau of Naturopathic Medicine
Department of Consumer Affairs
1625 N. Market Blvd., Suite S-209
Sacramento, CA 95834
(916) 574-7991
www.naturopathic.ca.gov

Connecticut Board of Naturopathic Examiners
Department of Public Health
P.O. Box 340308
Hartford, CT 06134-0308
(860) 509-7562
www.dph.state.ct.us

District of Columbia Board of Naturopathy
Department of Health
717 14th St. N.W., Suite 600
Washington, DC 20005
(877) 672-2174; fax: (202) 727-8471
http://dchealth.dc.gov/doh/cwp

Hawaii Board of Examiners in Naturopathy
P.O. Box 3469
Honolulu, HI 96801
(808) 586-2704
www.hawaii.gov/dcca/areas/pvl/boards/naturopathy

Idaho State Board of Naturopathic Medical Examiners
Bureau of Occupational Licenses
1109 Main St., Suite 220
Boise, ID 83702-5642
www.ibol.idaho.gov/nat.htm

Kansas State Board of Healing Arts
235 S. Topeka Blvd.
Topeka, KS 66603
www.ksbha.org

Maine Board of Complementary Health Care Providers
35 State House Station
Augusta, ME 04333
(207) 624-8579
www.state.me.us/pfr/olr/categories/cat12.htm#3

Montana Alternative Health Care Board
301 S. Park
Helena, MT 59620-0573
(406) 841-2394
http://mt.gov/dli/bsd/license/bsd_boards/ahc_board/board_page.asp

State of New Hampshire Department of Health and Human Services
Board of Naturopathic Examiners
129 Pleasant St.
Concord, NH 03301
(603) 271-5127
www.dhhs.state.nh.us

Oregon Board of Naturopathic Examiners
800 N.E. Oregon St., Suite 407
Portland, OR 97232
(503) 224-7744
www.obne.state.or.us

Utah Naturopathic Physicians Licensing Board
P.O. Box 146741
Salt Lake City, UT 84114-6741
(801) 530-6628
www.dopl.utah.gov/licensing/naturopathic.html

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Vermont Office of the Secretary of State
Office of Professional Regulation, Naturopathic Physicians Advisors
26 Terrace St., Drawer 9
Montpelier, VT 05609
(802) 828-2191
http://vtprofessionals.org/opr1/naturopaths/

Washington State Naturopathic Physician Licensing Program
P.O. Box 47870
Olympia, WA 98540-7870
(360) 236-4941
https://fortress.wa.gov/doh/hpqa1/hps7/Naturopathy/default.htm

State naturopathy association chapters

Alabama Association of Naturopathic Physicians
503 State St., Suite 3
Muscle Shoals, AL 35661
(256) 386-9804

Alaska Association of Naturopathic Physicians
10928 Eagle River Road, #254
Anchorage, AK 99577
(907) 451-7100

Arizona Naturopathic Medical Association
2101 E. Broadway Road, Suite 14
Tempe, AZ 85282
(480) 921-3088; fax: (480) 921-0061
www.aznma.com

California Naturopathic Doctors Association
1121 L St., Suite 610
Sacramento, CA 95814
(800) 521-1200 or (916) 427-3105
www.calnd.org

Colorado Association of Naturopathic Physicians
1181 S. Parker Road, Suite 101
Denver, CO 80231
(303) 380-1189

Connecticut Naturopathic Association
2558 Whitney Ave.
Hamden, CT 06518
(203) 230-2200
www.cnpaonline.org

District of Columbia Association of Naturopathic Physicians
900 19th St. N.W., Suite 250
Washington, DC 20006
(202) 457-8282

Florida Naturopathic Physicians Association Inc.
445 North Wymore Road
Winter Park, FL 32789
(888) 660-9030
www.fnpa.org

Georgia Association of Naturopathic Physicians
7505 Waters Ave., Suite B-9
Savannah, GA 31406
(912) 354-2222
www.ganp.org

Hawaii Society of Naturopathic Physicians
P.O. Box 542
Kailua, HI 96734
(808) 227-8400

Idaho Association of Naturopathic Physicians
2023 Sandpoint West Drive
Sandpoint, ID 83864
(208) 265-2213

Illinois Association of Naturopathic Physicians
2520 Elisha Ave.
Zion, IL 60099
(847) 872-6325 or (847) 731-4126

Kansas Association Naturopathic Physicians
4824 Quail Crest Place
Lawrence, KS 66049
(785) 749-2255

Maine Association of Naturopathic Physicians
4 Milk St.
Portland, ME 04101
(207) 772-5227

Maryland Association of Naturopathic Physicians
10806 Reisterstown Road, Suite 1E
Owings Mills, MD 21117
(410) 356-4600

Massachusetts Association of Naturopathic Physicians
8 Naples Road
Salem, MA 01970
(617) 699-0812

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Minnesota Association of Naturopathic Physicians
905 Jefferson Ave., Suite 202
Saint Paul, MN 55102
(651) 222-4111; fax: (651) 222-8758

Michigan Association of Naturopathic Physicians
4488 Jackson Road, Suite 1
Ann Arbor, MI 48103
(734) 389-2386

Missouri Association of Naturopathic Physicians
HC 73 Box 74-A
Drury, MO 65638
(417) 261-2399

Nebraska Association of Naturopathic Physicians
7447 Franam St.
Omaha, NE 68114
(402) 391-6714

New Hampshire Association of Naturopathic Physicians
76 Northeastern Blvd., #36A
Nashua, NH 03062
(603) 579-0956

New Jersey Association of Naturopathic Physicians
34 Bussell Court
Dumont, NJ 07628
(201) 385-7106

New Mexico Association of Naturopathic Physicians
P.O. Box 31552
Santa Fe, NM 87594
(505) 454-9525

New York Association of Naturopathic Physicians
303 Park Ave. South, #1175
New York, NY 10010
(800) 846-6778
www.nyanp.org

North Carolina Association of Naturopathic Physicians
301 West Weaver St.
Carrboro, NC 27510
www.ncanp.com

Ohio Chapter of the American Association of Naturopathic Physicians
2460 Fairmont Blvd., Suite 219
Cleveland Heights, OH 44106
(216) 707-9137; fax: (216) 707-0162
www.ocaanp.org

Oregon Association of Naturopathic Physicians
P.O. Box 5876
Portland, OR 97228
(503) 262-8586 or (877) 500-6277
www.oanp.org

Pennsylvania Association of Naturopathic Physicians
P.O. Box 847
Brownstown, PA 17508-0847
(717) 859-4222
www.panp.org

Rhode Island Association of Naturopathic Physicians
144 Waterman St.
Providence, RI 02906
(401) 455-0546

Utah Association of Naturopathic Physicians
2188 S. Highland Drive, #207
Salt Lake City, UT 84106
(801) 474-3684

Vermont Association of Naturopathic Physicians
P.O. Box 1915
Burlington, VT 05402-1915
(802) 985.8250
www.vanp.org

Virginia Association of Naturopathic Physicians
www.vaanp.org

Washington Association of Naturopathic Physicians
4500 Roosevelt Way N.E., Suite C
Seattle, WA 98115
(206) 547-2130 or (877) 788-8882

Wisconsin Association of Naturopathic Physicians
1621 Plainfield Ave.
Janesville, WI 53546
(608) 531-0079
www.wanp.org

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National association policy concerning naturopathy

American Academy of Family Physicians

Complementary Practice
The American Academy of Family Physicians (AAFP) is an advocate of patient access to quality health care and effective education and counseling of patients and consumers. The AAFP recognizes the availability in the market place of complementary and alternative practice and its approaches to healthcare.

The AAFP advocates the evaluation of these alternative treatments and complementary practice through various means including evidenced-based outcomes research as to their efficacy and effectiveness.

To this end, the AAFP believes that physicians can best serve their patients by recognizing and acknowledging the availability of such alternatives and by educating themselves concerning these non-traditional methods of healing in order to facilitate appropriate education, treatment and counseling of patients and consumers.

All clinical information regarding complementary or alternative practice presented or sponsored by the AAFP should include a discussion of the evidence on which it is based. (1997) (2003).

American Osteopathic Association

Non-Physician Clinicians
Whereas, non-physician clinicians can be categorized into one of the three following groups: midlevel professionals who are meant to work under the supervision of or in collaboration with physicians, non-physician independent traditional professionals who practice independently within specialty areas, and alternative medicine providers who follow and independently practice alternative therapies; and

Whereas, non-physician clinicians are gaining increased licensure and practice privileges in areas that were once only held by physicians including, but not limited to, prescribing drugs and medical or surgical treatments, practicing autonomously, performing surgery, and being reimbursed by all types of third-party payors; and

Whereas, non-physician clinicians are gaining even more expansive privileges that they already possess; and

Whereas, patient safety is the foremost concern when addressing issues of expanding scopes of practice for any healthcare profession; and

Whereas, patient safety and state laws mandate that physicians meet a minimum threshold of education, post-graduate training, examination, and regulation for an unlimited license to practice medicine; and

Whereas, many of these non-physician clinician professions are undertaking tasks that overlap with physician practice without being required to meet the equivalent threshold of education, post-graduate training, examination, and regulation established for physicians by state licensing boards; now, therefore, be it

RESOLVED, that the American Osteopathic Association adopt the attached policy paper as its position on non-physician clinicians including appropriate onsite supervision (2000, revised 2005). *www.osteopathic.org/pdf/aoa_postiong-n.pdf* (pages 98-104).

American Academy of Pediatrics

Scope of Practice Issues in the Delivery of Pediatric Health Care (select sections provided)
In recent years, there has been an increase in the number of nonphysician pediatric clinicians and an expansion in their respective scopes of practice. This raises critical public policy and child health advocacy concerns. The American Academy of Pediatrics (AAP) believes that optimal pediatric health care depends on a team-based approach with coordination by a physician leader, preferably a pediatrician. The pediatrician is uniquely suited to manage, coordinate, and supervise the entire spectrum of pediatric care, from diagnosis through all stages of treatment, in all practice settings. The AAP recognizes the valuable contributions of nonphysician clinicians, including nurse practitioners and physician assistants, in delivering optimal pediatric care. The AAP also believes that nonphysician clinicians who provide health care services in underserved areas should be supported by consulting pediatricians and other physicians using technologies including telemedicine. Pediatricians

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should serve as advocates for optimal pediatric care in state legislatures, public policy forums, and the media and should pursue opportunities to resolve scope of practice conflicts outside state legislatures. The AAP affirms that as nonphysician clinicians seek to expand their scopes of practice as providers of pediatric care, standards of education, training, examination, regulation, and patient care are needed to ensure patient safety and quality health care for all infants, children, adolescents, and young adults.

***

In recent years, the role of [complementary and alternative medicine] CAM has also received increased attention. Controversy exists about the efficacy of many of the modalities incorporated under the heading of CAM. Although many definitions exist, the National Center for Complementary and Alternative Medicine defines CAM as "those treatments and health care practices not taught widely in medical schools, not generally used in hospitals, and not usually reimbursed by medical insurance companies." According to the National Center for Complementary and Alternative Medicine, "some approaches are consistent with physiologic principles of Western medicine, while others constitute healing systems with a different origin. Although some therapies are far outside the realm of accepted Western medical theory and practice, others are becoming established in mainstream medicine."

Although this policy statement will not address the treatments but rather the training of individuals who provide such treatments to children, it is important to note that little scientific evidence exists regarding the safety and efficacy of CAM therapies in children. Indeed, there have been few randomized, controlled, double-blinded clinical trials on the use of CAM therapies in the pediatric population. Table 2 summarizes information on 5 of the most common practitioners of CAM. [Only the portion of Table 2 relevant to naturopaths is included below.]

Children may receive care from CAM practitioners without it being revealed to their pediatrician. A 1997 study reported that the percentage of American adults using CAM increased from 34% in 1990 to 42% in 1997. The estimate for CAM use by the general pediatric population is lower, ranging from approximately 11% in 1994 to 20% in 1999.The rate for children with chronic or serious illness, however, is much higher, varying according to age, background, and access to services from 30% to more than 70%, according to 1998 data. These figures raise serious concerns. The pediatrician

TABLE 2. Summary of 5 Major Providers of CAM *(Editors' note: Only naturopaths are included in this table.)*

	No. of Providers	No. of Programs or Schools	Length of Training	Content of Training	Pediatric-Specific Training
Naturopathy	Approx 1500	4 (3 US, 1 Canada) accredited by the Council on Naturopathic Medical Education. Another US program is a candidate for accreditation	3 years of college + 4 years of naturopathic study	Clinical nutrition, acupuncture, homeopathic medicine, botanical medicine, psychology, and counseling	No

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cannot be responsible for overseeing the actions of CAM providers, but can take a proactive role in asking patients and families about their use of CAM therapies. As advocates for their patients, pediatricians need to advise patients and their parents that the interactions between some CAM therapies and conventional medical treatments can cause complications and even death. Many people are unaware of this danger and view CAM therapies as natural and, therefore, safe, and so often do not report their use of CAM to their physicians. The AAP has recognized the importance of this issue and has published a series of recommendations on how to counsel families about CAM use for children with chronic illness or disability. The pediatric community has questioned the ability of CAM practitioners to identify serious or complex medical conditions that require referral to a physician for medical treatment. In addition, the opposition of some CAM practitioners to immunizations negatively affects the health and safety of children in their care.

No uniform standards exist across the country for scope of pediatric practice of chiropractors, naturopaths, and other CAM practitioners. As summarized in Table 2, pediatric training and experience are not specifically outlined or regulated. Studies documenting improved outcomes and efficacy of treatments in pediatric practice for CAM practitioners do not exist. In view of this lack of national standards for pediatric care by CAM practitioners, the absence of studies documenting that the quality of health care for children provided by these practitioners is comparable with that provided by conventional clinicians, and the more extensive training and education of pediatricians, the AAP has concerns about the provision of health care services to pediatric patients by CAM practitioners.

American Medical Association

E-3.01 Nonscientific Practitioners
It is unethical to engage in or to aid and abet in treatment which has no scientific basis and is dangerous, is calculated to deceive the patient by giving false hope, or which may cause the patient to delay in seeking proper care. Physicians should also be mindful of state laws which prohibit a physician from aiding and abetting an unlicensed person in the practice of medicine, aiding or abetting a person with a limited license in providing services beyond the scope of his or her license, or undertaking the joint medical treatment of patients under the foregoing circumstances. Physicians are otherwise free to accept or decline to serve anyone who seeks their services, regardless of who has recommended that the individual see the physician. (III, VI) Issued prior to April 1977; Updated June 1994 and June 1996.

D-35.991 Licensure of Naturopaths
Our AMA will work through the Scope of Practice Partnership and interested Federation partners to oppose the licensure of naturopaths and report back to the House of Delegates at the 2006 Interim Meeting. (Res. 209, A-06)

H-480.964 Alternative Medicine
Policy of the AMA on alternative medicine is: (1) There is little evidence to confirm the safety or efficacy of most alternative therapies. Much of the information currently known about these therapies makes it clear that many have not been shown to be efficacious. Well-designed, stringently controlled research should be done to evaluate the efficacy of alternative therapies. (2) Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate themselves and their patients about the state of scientific knowledge with regard to alternative therapy that may be used or contemplated. (3) Patients who choose alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment. (CSA Rep. 12, A-97; Reaffirmed: BOT Rep. 36, A-02)

H-480.973 Unconventional Medical Care in the United States
Our AMA: (1) encourages the Office of Alternative Medicine of the National Institutes of Health to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of alternative or unconventional medicine; and (2) utilizes the National Institutes of Health's National Center for Complementary and Alternative Medicine's classification system of alternative medicine, "Major Domains of Complementary and Alternative Medicine," in order to promote future discussion and research about the efficacy, safety, and use of alternative medicine. (BOT Rep. 15-A-94; Reaffirmed and Modified by Sub. Res. 514, I-95; Appended: Res. 505, A-00)

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D-480.981 Increasing Awareness of the Benefits and Risks Associated with Complementary and Alternative Medicine
Our AMA will promote awareness among medical students and physicians of the wide use of complementary and alternative medicine, including its benefits, risks, and evidence of efficacy or lack thereof. (Sub. Res. 306, A-06)

H-35.990 Non-Physician Measurement Of Body Functions
In the public interest, the AMA recommends that non-physicians who perform tests such as blood pressure or blood sugar measurements advise the examinee to communicate these findings to a licensed physician. (Sub. Res. 59, I-80; CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-200.969 Definition of Primary Care
(1) The AMA rejects the definition of primary care as stated in the March 1996 report of the Institute of Medicine as "the provision of integrated accessible health care services by clinicians." The AMA believes that primary care consists of the provision of a broad range of personal medical care (preventive, diagnostic, palliative, therapeutic, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive and coordinated by a licensed MD/DO physician over time. Care may be provided to an age-specific or gender-specific group of patients, as long as the care of the individual patient meets the above criteria. (2) The AMA encourages the efforts to define what constitutes primary care services. Data should be collected on which specialties currently provide these services, and how these services are integrated into the practice of physicians. Such data are essential to determine future physician workforce needs in primary care. (3) The AMA encourages that training programs for physicians who will practice primary care include appropriate educational experiences to introduce physicians to the required knowledge and skills, as well as to the types of services and the modes of practice that characterize primary care. (4) Where case management or coordination might limit access to appropriate medical care, patients should have the freedom to see a physician appropriate for the services they need, regardless of specialty. Above all, the best interests of the patient must be paramount. (BOT Rep. 12-A-94; Reaffirmed CMS Rep. 3, A-96; BOT Rep. 19, A-97; Amended: Res. 317, I-97; Reaffirmed: Res. 220, I-98)

H-285.933 Financial Liability Encountered in Referrals for Alternative Care
The AMA supports legislation that managed care organizations that offer alternative medicine as a covered service not require referral by the primary care physician for that service, and that the primary care physician not be held at risk financially for the costs of those provided alternative medical services. (Res. 702, A-98; Reaffirmed: BOT Rep. 36, A-02)

H-295.902 Alternative Medicine
(1) AMA policy states that courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and practice as well as the potential therapeutic utility, safety, and efficacy of these modalities. (2) Our AMA will work with members of the Federation to convey physicians' and patients' concerns and questions about alternative care to the NIH Office of Alternative Medicine and work with them and other appropriate bodies to address those concerns and questions. (CSA Rep. 12, A-97; Appended by Res. 525, A-98)

H-480.957 Health Plan Liability for Complementary and Alternative Therapy Requests
Our AMA recommends that physicians include indemnification clauses for CAT referrals in all health plan contracts when such plans require referral for CAT. (BOT Rep. 36, A-02)

H-405.969 Definition of a Physician
The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine. (CME Rep. 4-A-94; Reaffirmed by Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

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Literature and resources

Practice patterns of naturopathic physicians: Results from a random survey of licensed practitioners in two US States

Boon HS, Cherkin DC, Erro J, Sherman KJ, Milliman B, Booker J, Cramer EH, Smith MJ, Deyo RA, Eisenberg DM. *BMC Complement Altern Med.* 2004 Oct 20;4:14.

Leslie Dan, faculty of Pharmacy, University of Toronto, Toronto, Ontario, Canada. heather.boon@utoronto.ca

BACKGROUND: Despite the growing use of complementary and alternative medicine (CAM) by consumers in the U.S., little is known about the practice of CAM providers. The objective of this study was to describe and compare the practice patterns of naturopathic physicians in Washington State and Connecticut. METHODS: Telephone interviews were conducted with state-wide random samples of licensed naturopathic physicians and data were collected on consecutive patient visits in 1998 and 1999. The main outcome measures were: Sociodemographic, training and practice characteristics of naturopathic physicians; and demographics, reasons for visit, types of treatments, payment source and visit duration for patients. RESULT: One hundred and seventy practitioners were interviewed and 99 recorded data on a total of 1817 patient visits. Naturopathic physicians in Washington and Connecticut had similar demographic and practice characteristics. Both the practitioners and their patients were primarily White and female. Almost 75% of all naturopathic visits were for chronic complaints, most frequently fatigue, headache, and back symptoms. Complete blood counts, serum chemistries, lipids panels and stool analyses were ordered for 4% to 10% of visits. All other diagnostic tests were ordered less frequently. The most commonly prescribed naturopathic therapeutics were: botanical medicines (51% of visits in Connecticut, 43% in Washington), vitamins (41% and 43%), minerals (35% and 39%), homeopathy (29% and 19%) and allergy treatments (11% and 13%). The mean visit length was about 40 minutes. Approximately half the visits were paid directly by the patient. CONCLUSION: This study provides information that will help other health care providers, patients and policy makers better understand the nature of naturopathic care.

PMID: 15496231 [PubMed - indexed for MEDLINE]

Characteristics of visits to licensed acupuncturists, chiropractors, massage therapists, and naturopathic physicians

Cherkin DC, Deyo RA, Sherman KJ, Hart LG, Street JH, Hrbek A, Davis RB, Cramer E, Milliman B, Booker J, Mootz R, Barassi J, Kahn JR, Kaptchuk TJ, Eisenberg DM. *J Am Board Fam Pract.* 2002 Nov-Dec;15(6):463-72.

Center for Health Studies, Group Health Cooperative, Seattle 98101, USA.

BACKGROUND: Despite growing popularity of complementary and alternative medical (CAM) therapies, little is known about the patients seen by CAM practitioners. Our objective was to describe the patients and problems seen by CAM practitioners. METHODS: We collected data on 20 consecutive visits to randomly sampled licensed acupuncturists, chiropractors, massage therapists, and naturopathic physicians practicing in Arizona, Connecticut, Massachusetts, and Washington. Data were collected on patient demographics, smoking status, referral source, reasons for visit, concurrent medical care, payment source, and visit duration. Comparative data for conventional physicians were drawn from the National Ambulatory Medical Care Survey. RESULTS: In each profession, at least 99 practitioners collected data on more than 1,800 visits. More than 80% of visits to CAM providers were by young and middle-aged adults, and roughly two thirds were by women. Children comprised 10% of visits to naturopathic physicians but only 1% to 4% of all visits to other CAM providers. At least two thirds of visits resulted from self-referrals, and only 4% to 12% of visits were from conventional physician referrals. Chiropractors and massage therapists primarily saw musculoskeletal problems, while acupuncturists and naturopathic physicians saw a broader range of conditions. Visits to acupuncturists and massage therapists lasted about 60 minutes compared with 40 minutes for naturopathic physicians and less than 20 minutes for chiropractors. Most visits to chiropractors and naturopathic physicians, but less than one third of visits to acupuncturists and massage therapists, were covered by insurance. CONCLUSIONS: This information will help inform discussions of the roles CAM practitioners will play in the health care system of the future.

PMID: 12463292 [PubMed - indexed for MEDLINE]

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Naturopathic medicine: what can patients expect?
Dunne N, Benda W, Kim L, Mittman P, Barrett R, Snider P, Pizzorno J. *J Fam Pract.* 2005 Dec;54(12):1067-72.
American Association Naturopathic Physicians, Washington, DC, USA.

No abstract available.
PMID: 16321345 [PubMed - indexed for MEDLINE]

Homeopathy and naturopathy: Practice characteristics and pediatric care
Lee AC, Kemper KJ. *Arch Pediatr Adolesc Med.* 2000 Jan;154(1):75-80.
Center for Holistic Pediatric Education and Research, Children's Hospital, Harvard Medical School, Boston, Mass. 02115, USA.

OBJECTIVE: To describe the practice characteristics and pediatric care of homeopathic practitioners (HPs) and naturopathic doctors (NDs). DESIGN: Cross-sectional, descriptive survey. SETTING: Homeopathic and naturopathic practices in Massachusetts. PARTICIPANTS: Homeopathic practitioners (N = 42) and NDs (N = 23) identified from the yellow pages, regional and national society membership lists, schools, magazine advertisements, and by word-of-mouth. The response rate was 55% (23/42) for HPs and 65% (15/23) for NDs. MAIN OUTCOME MEASURES: Demographics, practice characteristics, fee structure, and amount of pediatric care. Practitioners were asked for their approach to childhood immunizations and to treating a febrile neonate. Data were analyzed using simple descriptive statistics. RESULTS: Almost all respondents were white. Among the HPs, 13 (57%) were licensed medical doctors. Naturopathic doctors and HPs reported having an average of only 25 to 40 patient visits per week, but children and adolescents accounted for up to one third of these visits. Nearly all reported treating children, but fewer than half of the practitioners reported any formal pediatric training. Initial patient visits typically lasted more than 1 hour and cost $140 to $150. Follow-up visits were scheduled every 4 to 6 weeks and lasted more than 30 minutes on average. Insurance covered less than one third of the patient visits, and sliding scale payments were offered by less than half of the respondents. Most practitioners reported that they did not actively recommend immunizations and fewer than half of the nonphysician practitioners reported that they would refer a 2-week-old neonate with a fever to a medical doctor or emergency medical facility. CONCLUSIONS: Many patients using homeopathy and naturopathy are children. Visits to these providers are frequent and fees are primarily paid out-of-pocket. Failure on the part of these providers to recommend immunizations or recognize potentially serious illnesses is cause for concern.
PMID: 10632255 [PubMed - indexed for MEDLINE]

A pilot and feasibility study on the effects of naturopathic botanical and dietary interventions on sex steroid hormone metabolism in premenopausal women
Greenlee H, Atkinson C, Stanczyk FZ, Lampe JW. *Cancer Epidemiol Biomarkers Prev.* 2007 Aug;16(8):1601-9.
Mailman School of Public Health, Columbia University, 7th Floor, 722 West 168th Street, New York, NY 10028, USA. hg2120@columbia.edu

Naturopathic physicians commonly make dietary and/or dietary supplement recommendations for breast cancer prevention. This placebo-controlled, parallel-arm, pilot study tested the effects of two naturopathic interventions over five menstrual cycles on sex steroid hormones and metabolic markers in 40 healthy premenopausal women. The intervention arms were as follows: combination botanical supplement (*Curcuma longa, Cynara scolymus, Rosmarinus officinalis, Schisandra chinensis, Silybum marinum,* and *Taraxacum officinalis*; n = 15), dietary changes (3 servings/d crucifers or dark leafy greens, 30 g/d fiber, 1-2 liters/d water, and limiting caffeine and alcohol consumption to 1 serving each/wk; n = 10), and placebo (n = 15). Early-and late-follicular phase serum samples from cycles 1 and 5 were analyzed for estrogens (estrone, estrone-sulfate, total estradiol, and free estradiol), androgens (dehydroepiandrosterone, dehydroepiandrosterone-sulfate, androstenedione, total testosterone, and free testosterone), sex hormone-binding globulin, and metabolic markers (insulin, insulin-like growth factor-I, insulin-like growth factor binding protein-3, and leptin). Serum samples collected during the mid-luteal phase of cycles 1 and 5 were analyzed for total estradiol, free estradiol, and sex hormone-binding globulin. Urine samples collected during the late follicular phase of cycles 1 and 5 were analyzed for 2-hydroxyestrone and 16alpha-hydroxyestrone. During the early follicular phase, compared with placebo, the

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botanical supplement decreased dehydroepiandrosterone (-13.2%; P = 0.02), dehydroepiandrosterone-sulfate (-14.6%; P = 0.07), androstenedione (-8.6%; P = 0.05), and estrone-sulfate (-12.0%; P = 0.08). No other trends or statistically significant changes were observed. When comparing dietary changes with placebo, no statistically significant differences were observed. Overall, in this pilot study, the naturopathic interventions had no substantial effects on estrogen measures. Early-follicular phase androgens decreased with the botanical supplement.
PMID: 17684134 [PubMed - indexed for MEDLINE]

Deaths resulting from hypocalcemia after administration of edetate disodium: 2003–2005
Brown MJ, Willis T, Omalu B, Leiker R. *Pediatrics.* 2006 Aug;118(2):e534-6.
Lead Poisoning Prevention Branch, Division of Emergency and Environmental Health Services, National Center for Environmental Health, Centers for Disease Control and Prevention, Atlanta, Georgia 30341, USA. mjb5@cdc.gov

From 2003 to 2005, deaths of 3 individuals as a result of cardiac arrest caused by hypocalcemia during chelation therapy were reported to the Centers for Disease Control and Prevention. Two were children, both of whom were treated with edetate disodium. At the time of this writing, the adult case was still under investigation. No previous cases of death resulting from hypocalcemia during chelation have been reported. From our experience and review of the literature, we suggest that health care providers who are unfamiliar with chelation consult an expert before undertaking treatment and that hospital formularies evaluate whether stocking edetate disodium is necessary, given the risk for hypocalcemia and the availability of less toxic alternatives.
PMID: 16882789 [PubMed - indexed for MEDLINE]

Why alternative medicine cannot be evidence-based
Tonelli MR, Callahan TC. *Acad Med.* 2001 Dec;76(12):1213-20.
Department of Medicine, Division of Pulmonary and Critical Care Medicine, University of Washington School of Medicine, Seattle, Washington, USA. tonelli@u.washington.edu

The concept of evidence-based medicine (EBM) has been widely adopted by orthodox Western medicine. Proponents of EBM have argued that complementary and alternative medicine (CAM) modalities ought to be subjected to rigorous, controlled clinical trials in order to assess their efficacy. However, this does not represent a scientific necessity, but rather is a philosophical demand: promoters of EBM seek to establish their particular epistemology as the primary arbiter of all medical knowledge. This claim is problematic. The methods for obtaining knowledge in a healing art must be coherent with that art's underlying understanding and theory of illness. Thus, the method of EBM and the knowledge gained from population-based studies may not be the best way to assess certain CAM practices, which view illness and healing within the context of a particular individual only. In addition, many alternative approaches center on the notion of non-measurable but perceptible aspects of illness and health (e.g., Qi) that preclude study within the current framework of controlled clinical trials. Still, the methods of developing knowledge within CAM currently have limitations and are subject to bias and varied interpretation. CAM must develop and defend a rational and coherent method for assessing causality and efficacy, though not necessarily one based on the results of controlled clinical trials. Orthodox medicine should consider abandoning demands that CAM become evidence-based, at least as "evidence" is currently narrowly defined, but insist instead upon a more complete and coherent description and defense of the alternative epistemic methods and tools of these disciplines.
PMID: 11739043 [PubMed - indexed for MEDLINE]

Complementary and alternative medical treatment of breast cancer: A survey of licensed North American naturopathic physicians
Standish LJ, Greene K, Greenlee H, Kim JG, Grosshans C. *Altern Ther Health Med.* 2002 Jul-Aug;8(4):74-6, 78-81.
Bastyr University Research Institute, Kenmore, Wash, USA.

CONTEXT: Complementary and alternative medicine (CAM) use is on the rise in the United States, especially for breast cancer patients. Many CAM therapies are delivered by licensed naturopathic physicians using individualized treatment plans. OBJECTIVE: To describe naturopathic treatment for women with breast cancer. DESIGN: Cross-sectional mail survey in 2 parts: screening form and 13-page survey. SETTING: Bastyr University Cancer Research Center, Kenmore, Wash. PARTICIPANTS: All licensed naturopathic physicians in the United States and Canada (N=1,356) received screening forms; 642 (47%) completed the form. Of the respondents, 333 (52%) were eligible, and 161 completed the survey (48%). MAIN OUTCOME MEASURES: Demographics of naturopathic physicians, development of treatment plans, CAM therapies used, perceived efficacy of therapeutic interventions.

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RESULTS: Of those respondents screened, 497 (77%) had provided naturopathic care to women with breast cancer, and 402 (63%) had treated women with breast cancer in the previous 12 months. Naturopaths who were women were more likely than men to treat breast cancer (P < or = .004). Of the survey respondents, 104 (65%) practiced in the United States, and 57 (35%) practiced in Canada; 107 (66.5%) were women, and 54 (33.5%) were men. To develop naturopathic treatment plans, naturopathic physicians most often considered the stage of cancer, the patient's emotional constitution, and the conventional therapies used. To monitor patients clinically, 64% of the naturopathic physicians used diagnostic imaging, 57% considered the patient's quality of life, and 51% used physical examinations. The most common general CAM therapies used were dietary counseling (94%), botanical medicines (88%), antioxidants (84%), and supplemental nutrition (84%). The most common specific treatments were vitamin C (39%), coenzyme Q-10 (34%), and Hoxsey formula (29%).
PMID: 12126176 [PubMed - indexed for MEDLINE]

Evidence-based medicine and naturopathy
Jagtenberg T, Evans S, Grant A, Howden I, Lewis M, Singer J. *J Altern Complement Med.* 2006 Apr;12(3):323-8.
School of Natural and Complementary Medicine, Southern Cross University, Lismore, Australia.

Evidence-based medicine (EBM) has been advocated as a new paradigm in orthodox medicine and as a methodology for natural medicines, which are often accused of lacking an adequate scientific basis. This paper presents the voices of tradition-sensitive naturopathic practitioners in response to what they perceive as an ideologic assault by EBM advocates on the validity and integrity of natural medicine practice. Those natural medicine practices, which have tradition-based paradigms articulating vitalistic and holistic principles, may have significant problems in relating to the idea of EBM as developed in biomedical contexts. The paper questions the appropriateness of imposing a methodology that appears to minimize or bypass the philosophic and methodological foundations of natural medicine, and that itself seems primarily driven by political considerations.
PMID: 16646733 [PubMed - indexed for MEDLINE]

Other information on naturopathy

"Findings and Recommendations Regarding the Prescribing and Furnishing Authority of a Naturopathic Doctor." Bureau of Naturopathic Medicine, California Department of Consumer Affairs.
www.naturopathic.ca.gov/formspubs/formulary_report.pdf

Profile of a Profession: Naturopathic Practice. Holly J. Hough, PhD, Catherine Dower, JD, Edward H. O'Neil, PhD. Center for the Health Professions, University of California, San Francisco.
www.futurehealth.ucsf.edu/pdf_files/Naturo2.pdf

Naturopathic Public Awareness Campaign (*www.globalnpac.org/index.htm*). Based out of Southwest College of Naturopathic Medicine in Tempe, AZ, this organization is dedicated to furthering and supporting current and future public awareness efforts for naturopathic medicine in the United States and Canada. Our members are students of accredited four-year, graduate-level, in-residence naturopathic medical programs. In coordination with the AANP and the accredited naturopathic medical schools, NPAC seeks to further provide resources on the national level to support both federal and states' needs to educate the public and legislators about the importance of naturopathic medicine. We strive to expand public awareness of naturopathic medicine as a viable, affordable option for quality healthcare. As a strong naturopathic student organization, NPAC is an extremely effective vehicle for public health education and community outreach.

2003 testimony before the National Committee on Vital and Health Statistics. Konrad Kail, PA, ND.
www.ncvhs.hhs.gov/030129p1.pdf.

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Figure 1. State licensure requirements for naturopaths

State	Work force number	Graduate education required	University accreditation	Clinical experience required	Examination required	Reciprocity for licensure	Continuing education required	Medicaid reimbursement	Specialization
Alabama	Does not license naturopaths.								
Alaska	34* (as of April 2008)	Graduate from a school of naturopathy that required four years of attendance at the school. (Sec. 08.45.030)	Accredited or a candidate for accreditation by the Council on Naturopathic Medical Education or a successor organization recognized by the United States Department of Education. (Sec. 08.45.030)	Not addressed.	Applicant must pass the Naturopathic Physicians Licensing Examination (NPLEX). (12 AAC 42.030, Sec. 08.45.030)	Yes. (12 AAC 42.010)	Not addressed.	Not addressed.	Not addressed.
Arizona	541 (as of April 2008)	Graduate of an approved school of naturopathic medicine. (§ 32-1522)	A school or college determined by the board to have an educational program that meets standards prescribed by the Council on Naturopathic Medical Education, or its successor agency. (§ 32-1501)	Internship, preceptorship or clinical training program required. (§ 32-1522)	NPLEX and state jurisprudence exams, passing score = 75%. (§ 32-1525, R4-18-201)	Yes. (§ 32-1523)	30 credit hours per year. Ten credit hours shall be in pharmacology as it relates to the diagnosis, treatment, or prevention of disease (R4-18-205)	Not addressed.	Must have satisfactorily completed a postdoctoral training program in the specialty. (A.R.S. § 32-1529)
Arkansas	Does not license naturopaths.								
California	237* (as of March 5, 2008)	Degree in naturopathic medicine from an approved naturopathic medical school. (8.2 C.C.A. § 3630)	Accredited by the Council on Naturopathic Medical Education or an equivalent federally recognized accrediting body for the naturopathic medical profession that meets specified criteria. (8.2 C.C.A. § 3623)	To qualify as an approved naturopathic medical school, it must require 1,200 hours of supervised clinical training. (C.C.A. § 3623)	NPLEX or an equivalent approved by the North American Board of Naturopathic Examiners. (C.C.A. § 3631, C.C.R. § 4220)	Yes. (C.C.A. § 3633)	60 credit hours biennially. At least 20 being in pharmacotherapeutics. (C.C.A. § 3635)	Not addressed.	Certification in naturopathic childbirth attendance. (C.C.A. § 3651)
Colorado	Does not license naturopaths.								

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State	Work force number	Graduate education required	University accreditation	Clinical experience required	Examination required	Reciprocity for licensure	Continuing education required	Medicaid reimbursement	Specialization
Connecticut	223 (as of April 2008)	Graduate of a legally chartered, reputable school or college of natureopathy. (§ 20-37)	The secretary of the Board of Natureopathic Examiners files a list with the Department of Public Health every year of Bd.-recognized natureopathic colleges. (C.S.A. § 20-37)	A college or program of natureopathic medicine approved pursuant to section 20-37 may include within its curriculum such didactic and clinical training necessary for such college or program to qualify for accreditation by the Council on Natureopathic Medical Education, including such training that is outside the scope of the practice of natureopathy. (C.S.A. § 20-37a (2)(c))	Passing score on exam prescribed by the Department of Public Health with the advice and consent of the Board of Natureopathic Examiners. (C.S.A. § 20-37)	Yes. (C.A.S. § 20-37b)	Not addressed.	Payment for natureopathic services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services. (Sec. 17b-262-550)	Not addressed.
District of Columbi	6 naturopathic doctors (as of April 2008)	Earned a degree of doctor of naturopathic medicine from an accredited college or university. (D.C.C.A. § 3-1205.04)	College or university accredited by The Council of Naturopathic Medical Education (CNME) or any other accrediting agency recognized by the United States Department of Education. (D.C.C.A. § 3-1205.04)	Not addressed.	Pass NPLEX or other Board or Mayor-approved exam. (D.C.C.A. § 3-1205.04)	Not addressed.	30 credit hours (D.C.M.R. § 17.5206.4)	Not addressed.	Can participate in naturopathic childbirth by passing a specialty examination and meeting other criteria. (D.C.C.A. § 3-1206.21)
Delaware	Does not license naturopaths.								
Florida	Licensed naturopaths until 1986 when provisions were repealed. (21N-1.001, F.A.C.-21N-4.001, F.A.C.) Naturopaths licensed prior to 1986 are governed under then existing provisions.								
Georgia	Does not license naturopaths.								
Hawaii	97 (as of January 2008)	Applicant shall be a graduate of a school, university, or college of naturopathy. (H.R.S.A. § 455-3)	School, university, or college of naturopathy that has received candidacy status with, or has been accredited by, a regional or a national accrediting body recognized by the United States Department of Education. (H.R.S.A. § 455-3)	Not addressed.	Passing score of 75 on all parts of NPLEX examination and examination on homeopathy. (C.H.R. § 16-88-12 - § 16-88-14)	Not addressed.	Not addressed.	Not addressed.	Not addressed.

Figure 1. State licensure requirements for naturopaths

State	Work force number	Graduate education required	University accreditation	Clinical experience required	Examination required	Reciprocity for licensure	Continuing education required	Medicaid reimbursement	Specialization
Idaho	15 (as of April 2008)*	The applicant shall provide proof of completion of a naturopathic medical program approved by the board. (I.S.A. § 54-5112)	Accredited by CNME or an equivalent recognized accrediting body. (I.D.A.P.A. § 24.24.01.400.02)	Not addressed.	NPLEX and Idaho Jurisprudence Exam Passing Score = 75% (I.D.A.P.A. § 24.24.01.200.01-24.24.01.200.04)	Yes. (I.D.A.P.A. § 24.24.01.100.02)	Annually. (I.D.A.P.A § 24.24.01.350.01) *20 credit hours: 5 in pharmacology*	No. (I.D.A.P.A. § 16-03-09-065.01)	Naturopathic childbirth special competency certificate. (I.C.S.A. § 54-5109)
Illinois	Does not license naturopaths.								
Indiana	Does not license naturopaths.								
Iowa	Does not license naturopaths.								
Kansas	19 naturopathic registrants* (as of April 2008)	The applicant shall present evidence satisfactory to the board of having successfully completed an educational program in naturopathy from an approved naturopathic medical college. (K.A.S.§ 65-7204)	Shall meet the accreditation standards for naturopathic medical education published by the Council on Naturopathic Medical Education, and the accreditation criteria of the commission on institutions of higher education of the north central association of colleges and schools. (K.A.R. § 100-72-4)	Not addressed.	Passing score of 75 on NPLEX examinations. (K.A.S § 65-7205, K.A.R. § 100-72-5)	Yes. (K.S.A. § 65-7206)	Annually. (K.A.R. 100-72-7) *25 credit hours.*	Not addressed.	Naturopathic acupuncture specialty certification. (K.S.A. § 65-7213)
Kentucky	Does not license naturopaths.								
Louisiana	Does not license naturopaths.								
Maine	27* (as of April 2008)	College or program granting the degree of doctor of naturopathic medicine. (32 M.R.S. § 12501, § 12525)	Approved by the Board and accredited by an accrediting agency recognized by the Federal Government. (32 M.R.S. § 12501)	Not addressed.	Passing score on NPLEX exam. (C.M.R. § 02 502 004)	Not addressed.	25 credit hours annually; at least 7 being in pharmacology. Additional 15 credit hours for naturopathic acupuncture specialists. (32 M.R.S. § 12526, C.M.R. § 02-502-005)	Not addressed.	In order to practice naturopathic acupuncture, a naturopathic specialty certification must first be obtained. (32 M.R.S. § 12525, C.M.R. § 02-502-004)

Figure 1. State licensure requirements for naturopaths

State	Work force number	Graduate education required	University accreditation	Clinical experience required	Examination required	Reciprocity for licensure	Continuing education required	Medicaid reimbursement	Specialization
Maryland	Does not license naturopaths.								
Massachusetts	Does not license naturopaths.								
Michigan	Does not license naturopaths.								
Minnesota	Naturopathy included in definition of "Complementary and alternative health care practices," which are not licensed in the state. (Minn. Stat. § 146A.01)								
Mississippi	Does not license naturopaths.								
Missouri	Does not license naturopaths.								
Montana	49 (as of April 2008)	A graduate of an approved naturopathic medical college. (M.C.A. § 37-26-402)	Accredited by CNME or another accrediting agency recognized by the United States department of education or has been approved by the board. (M.C.A. § 37-26-103 and A.R.M. § 24.111.501)	1200 clock hours in the clinical practicum program. (A.R.M. § 24.111.501)	NPLEX or any other exam to be prescribed or endorsed by the Board. Passing Score = 75. (A.R.M. § 24.111.502, K.A.R. § 100-72-5)	Yes. (A.R.M. § 24.111.503)	15 credit hours annually; at least 5 being in naturopathic pharmacy. (A.R.M. § 24.111.2102)	Not addressed.	Specialty practice of naturopathic childbirth attendance. (M.C.A. § 37-26-304, A.R.M. § 24.111.510)
Nebraska	Does not license naturopaths.								
Nevada	"Naturopathic Healing" provisions repealed in 1987. (Nev. Rev. Stat. Ann. § 633A.010)								
New Hampshire	59* (as of April 2008)	Graduate of an accredited naturopathic medical college. (N.H.R.S.A. § 328-E:9)	Accredited by the Council of Naturopathic Medical Education. (N.H.R.S.A. § 328-E:2)	Minimum of 1000 clock hours of clinical experience in all aspects of naturopathic practice; and primary care responsibility while supervised by a licensed doctor of naturopathic medicine. (N.H.C.A.R. § 303.05)	NPLEX Examinations ; or its substantial equivalent. (N.H.C.A.R. Nat. § 303.02, N.H.C.A.R. Nat. § 304.02)	Yes. (N.H.R.S.A. § 328-E:9, N.H.C.A.R. § 304.01)	The board shall require each licensee to show proof at least every 3 years that the licensee has completed an approved continuing naturopathic medical education program within the preceding 3 years.(N.H.R.S.A. § 328-E:13) *150 credit hours every 3 years: At least 60 must come from a professionally supervised setting with pharmacology courses totaling 24 of the 60 hours.*	Not addressed.	Naturopathic childbirth or acupuncture specialty certification. (N.H.R.S.A. § 328-E:12, N.H.C.A.R. Nat. 305.01 - 305.02, Nat. 306.02 - 306.06)
New Jersey	Does not license naturopaths.								
New Mexico	Does not license naturopaths.								
New York	Does not license naturopaths.								
North Carolina	Does not license naturopaths.								
North Dakota	Does not license naturopaths.								
Ohio	Does not license naturopaths.								
Oklahoma	Does not license naturopaths.								

Figure 1. State licensure requirements for naturopaths

State	Work force number	Graduate education required	University accreditation	Clinical experience required	Examination required	Reciprocity for licensure	Continuing education required	Medicaid reimbursement	Specialization
Oregon	772 (as of April 2008)	Graduation from an accredited naturopathic school or college. (O.R.S. § 685.060)	Must meet the accreditation standards of the Council on Naturopathic Medical Education. (O.A.R. § 850-020-0000)	Not addressed.	The Board of Naturopathic Examiners shall conduct examination of applicant for licensure that includes a basic science section and a clinical section. (O.R.S. § 685.080)	Yes. (O.R.S. § 685.085, O.A.R. § 850-030-0070)	25 credit hours annually; no more than 15 coming from one subject area. (O.R.S. § 685.102, O.A.R. § 850-040-0210)	If the Department of Human Services is responsible for paying for services that a licensed naturopathic physician may render, the services shall be paid for in the same manner and under the same standards as similar professional services. (O.R.S. § 685.055)	Certificate of special competency in natural childbirth. (O.R.S. § 685.135, O.A.R. § 850-035-0230)
Pennsylvania	Does not license naturopaths.								
Rhode Island	Does not license naturopaths. Naturopathy included in definition of "unlicensed health care practices." (R.I. Gen. Laws § 23-74-1)								
South Carolina	"It shall be unlawful for any person whether heretofore licensed or not under the laws of this or any other State to practice naturopathy in this State." (S.C. Code Ann. § 40-31-10)								
South Dakota	Does not license naturopaths.								
Tennessee	Does not license naturopaths. "It is unlawful for any person to practice naturopathy in this state." (Tenn. Code Ann. § 63-6-205)								
Texas	Does not license naturopaths.								
Utah	29* (as of April 2008)	Successful completion of a program of professional education preparing an individual as a naturopathic physician, as evidenced by having received an earned degree of doctor of naturopathic medicine. (U.C.A. § 58-71-302)	CNME accreditation or a naturopathic medical school or college, which at the time of the applicant's graduation, met current criteria for accreditation by the CNME. (U.C.A. § 58-71-302)	A minimum 12 month program associated with a naturopathic medical school or college accredited by the Council of Naturopathic Medical Education. (U.C.A. § 58-71-302, U.A.C. R156-71-102)	NPLEX Basic Science Series, the State of Washington Basic Science Series or the State of Oregon Basic Science Series; NPLEX Clinical Series; NPLEX Homeopathy; NPLEX Minor Surgery; and the Utah Naturopathic Physician Practice Act Law and Rule Examination. (R156-71-302)	Not addressed.	24 credit hours every two years. (U.A.C. R156-71-304)	Not addressed.	Not addressed.

Figure 1. State licensure requirements for naturopaths

State	Work force number	Graduate education required	University accreditation	Clinical experience required	Examination required	Reciprocity for licensure	Continuing education required	Medicaid reimbursement	Specialization
Vermont	148* (as of April 2008)	Granted a degree of doctor of naturopathic medicine, or a degree determined by the Director of the Office of Professional Regulation to be essentially equivalent to such degree, from an approved naturopathic medical college. (V.S.A. § 4127)	Accredited by CNME or a degree determined by the Director of the Office of Professional Regulation to be essentially equivalent. (V.C.R. R04-030-380-2.2)	Not addressed.	Pass all parts of NPLEX. Passing score determined by NPLEX. (V.S.A. § 4127, V.C.R. R04-030-380-2.2)	Yes. (V.C.R. R04-030-380-2.3)	30 credit hours every two years with no more than 10 hours coming from the same subject area. (V.C.R. R04-030-380-3.2)	Not addressed.	Special Endorsement for Naturopathic Childbirth - includes specialty training and exam. (V.C.R. R04-030-380-3.9)
Virginia	Naturopathy is no longer a licensed profession. Naturopaths licensed prior to June 30, 1980, may continue such practice in accordance with regulations promulgated by the Board								
	[of medicine]. (Va. Code Ann. § 54.1-2901)								
Washington	768 (as of April 2008)	Successful completion of an educational program approved by the Secretary of Health, the minimum standard of which shall be the successful completion of a doctorate degree program in naturopathy. (A.R.C.W. § 18.36A.090)	College of naturopathic medicine approved by Washington State Department of Health. (A.R.C.W. §18.36A.090,§18.36A.100, W.A.C. 246-836-130 thru W.A.C. 246-836-150)	Clinical externship/preceptorship is considered a standard in the curriculum of a college of naturopathic medicine when it is considered for approval by the secretary. (W.A.C. 246-836-180)	Licensure exam consists of: (1) basic science component, (2) clinical science component and (3) law of the state and administrative regulations relating to the practice of naturopathic medicine. Passing Score = 75. (A.R.C.W. § 18.36A.090, WAC 246-836-030)	Yes. (A.R.C.W. § 18.36A.120, W.A.C. 246-836-110)	20 credit hours; only courses in diagnosis and therapeutics are eligible for credit. (W.A.C. 246-836-080)	Not addressed.	Not addressed.
West Virginia	Does not license naturopaths.								
Wisconsin	Does not license naturopaths.								
Wyoming	Does not license naturopaths.								
Work force numbers indicate active, in-state licenses, and were gathered from phone conversations with the board or state unless indicated as:									
*Work force number gathered from board or state Web site.									

Figure 2. State scope of practice for naturopaths

State	Statutory authority	Definition of naturopathy	Rx authority	Use of term "physician"
Alaska	Alaska Statutes Sec. 08.45.050, Alaska Statutes Sec. 08.45.200	The use of hydrotherapy, dietetics, electrotherapy, sanitation, suggestion, mechanical and manual manipulation for the stimulation of physiological and psychological action to establish a normal condition of mind and body; in this paragraph, "dietetics" includes herbal and homeopathic remedies. A person who practices naturopathy may not give, prescribe, or recommend in the practice: a prescription drug; a controlled substance; a poison; engage in surgery; use the word "physician" in the person's title.	No.	No. Use of the term "physician" is expressly prohibited. (45.08.45.050) See also disclosure/transparency requirements at 12 ACC 42.900.
Arizona	A.R.S. § 32-1501	A medical system of diagnosing and treating diseases, injuries, ailments, infirmities and other conditions of the human mind and body including by natural means, drugless methods, drugs, nonsurgical methods, devices, physical, electrical, hygienic and sanitary measures and all forms of physical agents and modalities.	Yes. (A.R.S. § 32-1581) A doctor of naturopathy may dispense a natural substance, drug, or device to a patient. A "natural substance" is a homeopathic, botanical, or nutritional supplement that does not require a prescription by federal law before it is dispensed but is prescribed to treat a medical condition diagnosed by the doctor. **HOWEVER:** A notice from the AZ Naturopathic Physicians Board of Medical Examiners dated August 22, 2002 , and addressed to Pharmacists states that "A licensed naturopathic physician will be able to prescribe any legend drug or controlled substance with the following exceptions: (1) intravenous medications (except vitamins, chelation therapy, and drugs used in emergency resuscitation); (2) controlled substances as listed in Schedule I or II (except morphine will be allowed); (3) cancer chemotherapeutics classified as legend drugs; and (4) antipsychotics. The notice also states that after January 1, 2005 only naturopaths who have completed pharmacotherapeutic training and passed a test in pharmacotherapeutics will continue to be authorized to prescribe legend drugs and controlled sub	Yes. A.R.S. §32-1501.36.
California	C.C.A. § 3640 - § 3643	A naturopathic doctor may order and perform physical and laboratory examinations for diagnostic purposes, including, but not limited to, phlebotomy, clinical laboratory tests, speculum examinations, orificial examinations, and physiological function tests. A naturopathic doctor may order diagnostic imaging studies, including X-ray, ultrasound, mammogram, bone densitometry, and others, consistent with naturopathic training as determined by the bureau, but shall refer the studies to an appropriately licensed health care professional to conduct the study and interpret the results. Hot or cold hydrotherapy; naturopathic physical medicine inclusive of the manual use of massage, stretching, resistance, or joint play examination but exclusive of small amplitude movement at or beyond the end range of normal joint motion; electromagnetic energy; colon hydrotherapy; and therapeutic exercise. Devices, including, but not limited to, therapeutic devices, barrier contraception, and durable medical equipment. Health education and health counseling. Repair and care incidental to superficial lacerations and abrasions, except suturing. Removal of foreign bodies located in the superficial tissues. A naturopathic doctor may utilize routes of administration that include oral, nasal, auricular, ocular, rectal, vaginal, transdermal, intradermal, subcutaneous, intravenous, and intramuscular.	Yes. (Cal. Bus. & Prof. Code § 3627) Licensed California naturopaths may prescribe drugs or products contained in the Naturopathic formulary. As of October 2006, a Formulary advisory committee has been established, and is currently meeting, but has not yet produced a naturopathic formulary. Drugs can be furnished by a naturopathic doctor "in accordance with standardized procedures or protocols developed by the naturopathic doctor and his or her supervising physician and surgeon." The furnishing and ordering of such drugs must occur under physician and surgeon supervision, may include Schedule III through Schedule V controlled substances, and may be further limited to those drugs specified in the standardized procedure between the naturopathic doctor and physician and surgeon.	No. Use of the term "physician" is prohibited. (Cal. Bus. & Prof. Code § 3641) "...shall not use any term or designation that would tend to indicate the practice of medicine, other than naturopathic medicine, unless otherwise licensed as a physician and surgeon, osteopathic doctor, or doctor of chiropractic." This section also contains disclosure requirements.
Connecticut	Conn. Ann. Stat. § 20-34	The practice of naturopathy means the science, art and practice of healing by natural methods as recognized by the Council of Natureopathic Medical Education and approved by the State Board of Natureopathic Examiners, with the consent of the commissioner, and shall include counseling and the practice of the mechanical and material sciences of healing as follows: The mechanical sciences such as mechanotherapy, articular manipulation, corrective and orthopedic gymnastics, physiotherapy, hydrotherapy, electrotherapy and phototherapy; and the material sciences such as nutrition, dietetics, phytotherapy, treatment by natural substances and external applications. .	No. "Natural substances" means substances which are not narcotic substances, do not require the written or oral prescription of a licensed practitioner to be dispensed and are only administered orally.	Unclear. Authority to use the term is neither expressly granted nor prohibited. The term "natureopathic physician" is used in CT code (373 § 20-37b). The term is used in the official posted minutes of the Connecticut Board of Natureopathic Examiners.
District of Columbia	DCCA § 3-1201.02, § 3-1206.21, Code of D.C. Regs. § 17-5003	A system of health care that utilizes education, natural medicines, and natural therapies to support and stimulate a patient's intrinsic self-healing processes to prevent, diagnose, and treat human conditions and injuries. Does not include the practices of physical therapy, physical rehabilitation, acupuncture, or chiropractic. Administer or provide for preventive and therapeutic purposes natural medicines by their appropriate route of administration, natural therapies, topical medicines, counseling, hypnotherapy, dietary therapy, naturopathic physical medicine, therapeutic devices, and barrier devices for contraception. For the purposes of this paragraph, the term "naturopathic physical medicine" means the use of the physical agents of air, water, heat, cold, sound, and light, and the physical modalities of electrotherapy, biofeedback, diathermy, ultraviolet light, ultrasound, hydrotherapy, and exercise, and includes naturopathic manipulation and mobilization therapy; and review and interpret the results of diagnostic procedures commonly used by physicians in general practice, including physical and orificial examinations, electrocardiograms, diagnostic imaging	No. An individual licensed to practice naturopathic medicine shall not prescribe, dispense, or administer any controlled substances, except those natural medicines authorized by this chapter.	No. Practitioners of naturopathy or naturopathic healing may use the title "Doctor of Naturopathy." (DC Municipal Regulations. Title 14, Ch. 50, 5003.1)

Figure 2. State scope of practice for naturopaths

State	Statutory authority	Definition of naturopathy	Rx authority	Use of term "physician"
		techniques, phlebotomy, clinical laboratory tests and examinations, and physiological function tests. An individual licensed to practice naturopathic medicine under this chapter shall not: Perform surgical procedures, except for minor office procedures, as defined by rule; Use for therapeutic purposes, any device regulated by the United States Food and Drug Administration ("FDA") that has not been approved by the FDA.		
Hawaii	H.R.S. § 455-1	The practice of: Natural medicine, natural therapeutics, and natural procedures, for the purpose of removing toxic conditions from the body and improving the quality, quantity, harmony, balance, and flow of the vital fluids, vital tissues, and vital energy; and diagnosing, treating, and caring for patients using a system of practice that bases its treatment of physiological functions and abnormal conditions on natural laws governing the human body; utilizing physiological, psychological, and mechanical methods, such as air, water, light, sunshine, heat and cold, earth, phytotherapy, physiotherapy, mechano-therapy, naturopathic corrections and manipulation, and natural methods or modalities, together with natural or homeopathic medicines, natural foods, and herbs, and nature's remedies of the type taught in education and training at naturopathic medical colleges. The practice of naturopathy excludes surgery and the application of x-rays.	No. The practice of naturopathy excludes prescribing, dispensing, or using prescription drugs except as provided for in the definition of natural medicine.	Yes. HRS §455-1.
Idaho	Idaho Statutes § 54-5104	A naturopathic physician may use physical and laboratory examinations consistent with naturopathic medical education and training for diagnostic purposes. A naturopathic physician may order and perform diagnostic and imaging tests consistent with naturopathic medical education and training. All diagnostic and imaging tests not consistent with naturopathic medical education and training must be referred for performance and interpretation by an appropriately licensed health care professional. Naturopathic physicians are authorized to dispense, administer and prescribe prescription drugs and medical devices determined by the naturopathic medical formulary council, and authorized by the board. A naturopathic physician may perform minor office procedures pursuant to privileges authorized by the board. A naturopathic physician may perform those therapies as trained and educated and authorized by the board.	Yes. (I.C.A. § 54-5110) A formulary council was established in 2005 to adopt a formulary for naturopathic physicians. "The formulary list may not go beyond the scope of prescription medicines and medical devices covered by approved naturopathic medical education and training and existing naturopathic medical formularies, or board-approved continuing education." Nothing herein shall allow a naturopathic physician to dispense, administer, or prescribe any prescription drug as defined in {Section 54-1705(28)}, unless such prescription drug is specifically included in the naturopathic medical formulary.	Yes. Idaho Statutes §54-5102.
Kansas	K.S.A. § 65-7202	A system of health care practiced by naturopathic doctors for the prevention, diagnosis and treatment of human health conditions, injuries and diseases, that uses education, natural medicines and therapies to support and stimulate the individual's intrinsic self-healing processes, and includes prescribing, recommending or administering: (A) Food, food extracts, vitamins, minerals, enzymes, whole gland thyroid, botanicals, homeopathic preparations, nonprescription drugs, plant substances that are not designated as prescription drugs or controlled substances, topical drugs as defined in subsection (a)(9) of this section, and amendments thereto; (B) health care counseling, nutritional counseling and dietary therapy, naturopathic physical applications, barrier contraceptive devices; (C) substances on the naturopathic formulary which are authorized for intramuscular or intravenous administration pursuant to a written protocol entered into with a physician who has entered into a written protocol with a naturopathic doctor registered under this act; (D) noninvasive physical examinations, venipuncture to obtain blood for clinical laboratory tests and orificial examinations, excluding endoscopies; (E) minor office procedures; and (F) naturopathic acupuncture. A naturopathic doctor may not perform surgery, obstetrics, administer ionizing radiation, or prescribe, dispense or administer any controlled substances as defined in K.S.A. 65-4101, and amendments thereto, or any prescription-only drugs except those listed on the naturopathic formulary adopted by the board pursuant to this act.	Yes. (K.A.R. § 100-72-8) Only those medicines approved by the Board on the Naturopathic Formulary and pursuant to a written protocol with a physician. The Naturopathic Formulary is available at K.A.R. § 100-72-8.	No. "Physician" means a person licensed to practice medicine and surgery. K.S.A. §65-7272(10).

Figure 2. State scope of practice for naturopaths

State	Statutory authority	Definition of naturopathy	Rx authority	Use of term "physician"
Maine	M.R.S.A. § 12522, CMR 02 502 006	A naturopathic doctor may use and order for preventative and therapeutic purposes the following natural medicines and therapies: food, food extracts, vitamins, minerals, enzymes, digestive aids, whole gland thyroid and other natural hormones, plant substances, all homeopathic preparations, immunizations, counseling, hypnotherapy, biofeedback, dietary therapy, naturopathic manipulative therapy, naturopathic physical medicine, therapeutic devices, barrier devices for contraception and office procedures. Naturopathic doctors may also prescribe medications, including natural antibiotics and topical medicines, within the limitations set forth in subsection 4. A naturopathic doctor may use physical examinations for diagnostic purposes including phlebotomy, clinical laboratory tests, speculum examinations and physiological function tests, excluding all endoscopies and physiological function tests requiring infusion, injection, inhalation or ingestion of medications to perform tests. A naturopathic doctor may order ultrasound, x-ray and electrocardiogram tests but must refer to an appropriate licensed health care professional for conducting and interpreting the tests. A naturopathic doctor may prescribe therapeutic devices or use noninvasive diagnostic procedures commonly used by allopathic or osteopathic physicians in general practice. Naturopathic doctors have a limited scope of prescriptive authority. A naturopathic doctor may not: Prescribe, dispense or administer any substance or device identified in Schedule I, II, III, IV or V as described in the federal Controlled Substance Act, 21 United States Code, Sections 801 to 971 (1988), or any controlled substances or devices; Perform surgical procedures except those office procedures authorized by this chapter; Practice emergency medicine except when a good Samaritan rendering gratuitous services in the case of emergency and except for the care of minor injuries; or Practice or claim to practice medicine and surgery, osteopathy, dentistry, podiatry, optometry, chiropractic, physical therapy or any other system or method of treatment not authorized in this chapter.	Yes. (M.R.S.A. § 12522) A naturopathic doctor may not prescribe, dispense, or administer any substance or device identified in Schedule I, II, III, IV, or V as described in the federal Controlled Substances Act; may prescribe nonprescription medications without limitation; and may only prescribe noncontrolled legend drugs from the following categories: homeopathic remedies, vitamins and minerals, hormones, local anesthesia, and immunizations that are designated by a subcommittee of the board which shall consist of naturopathic members, a pharmacist member, and an allopathic or osteopathic member. Prior to independently prescribing noncontrolled legend drugs, a naturopathic doctor shall establish and complete a 12-month collaborative relationship with a licensed allopathic or osteopathic physician to review the naturopathic doctor's prescribing practices. (MRS §12522)	No. Use of the title "physician" by naturopathic licensees is prohibited. M.R.S. Title 32, Ch. 113-B, §12521(2).
Montana	M.C.A § 37-26-103, M.C.A. §37-26-301	Naturopathic medicine is a system of primary health care practiced by naturopathic physicians for the prevention, diagnosis, and treatment of human health conditions, injury, and disease. Its purpose is to promote or restore health by the support and stimulation of the individual's inherent self-healing processes. This is accomplished through education of the patient by a naturopathic physician and through the use of natural therapies and therapeutic substances. Naturopathic physical applications include the therapeutic use by naturopathic physicians of the actions or devices of electrical muscle stimulation, galvanic, diathermy, ultrasound, ultraviolet light, constitutional hydrotherapy, and naturopathic manipulative therapy. A naturopathic physician may not: administer ionizing radioactive substances for therapeutic purposes; perform surgical procedures except those minor surgery procedures authorized by this chapter; or claim to practice any licensed health care profession or system of treatment other than naturopathic medicine unless holding a separate license in that profession. Naturopathic physicians may engage in and utilize health care counseling, nutritional counseling and dietary therapy, naturopathic physical applications, therapeutic devices, nonprescription drugs, barrier devices for contraception, naturopathic childbirth attendance, and minor surgery.	Yes. (M.C.A. 37-26-301) A naturopathic physician may not prescribe, dispense, or administer any legend drug [as defined in 50-31-301], except for whole gland thyroid; homeopathic preparations; and natural substances, drugs, and therapies described in subsection (2), which includes food, food extracts, vitamins, minerals, enzymes, whole gland thyroid, botanical medicines, homeopathic preparations, and oxytocin (pitocin).	Yes. M.C.A. §37-26-103(9).
New Hampshire	N.H.R.S.A. § 328-E:2, N.H.R.S.A. § 328-E:4	Naturopathic medicine is a system of primary health care for the prevention, diagnosis, and treatment of human health conditions, injuries, and diseases using education, natural medicines and therapies to support and stimulate the individual's intrinsic self-healing processes. Doctors of naturopathic medicine are authorized to use, for preventive and therapeutic purposes, natural medicines and therapies, counseling, hypnotherapy, biofeedback, dietary therapy, naturopathic physical medicine, therapeutic devices, and barrier devices for contraception. Naturopathic physical medicine is the therapeutic use of the physical agents of air, water, heat, cold, sound, light, and electromagnetic non-ionizing radiation and the physical modalities of electrotherapy, diathermy, ultraviolet light, ultrasound, hydrotherapy, naturopathic manipulative therapy, and therapeutic exercise. Doctors of naturopathic medicine may use, for diagnostic purposes physical and orificial examinations, X-rays, electrocardiograms, ultrasound, phlebotomy, clinical laboratory tests and examinations, and physiological function tests. Doctors of naturopathic medicine are not authorized to perform surgical procedures, practice emergency medicine, except as a good samaritan rendering gratuitous services in the case of emergency and except for the care of minor injuries, practice or claim to practice medicine and surgery, osteopathy, dentistry, podiatry, optometry, chiropractic, physical therapy, or any other system or method of treatment not authorized in this chapter.	Doctors of naturopathic medicine shall not prescribe, dispense, or administer any legend or controlled substances, except those natural medicines as authorized by this chapter. Doctors of naturopathic medicine with specialty certification in naturopathic childbirth, shall be authorized to use oxytocin and pitocin.	Likely not. Naturopathic licensees shall use the title "doctor of naturopathic medicine" and the recognized abbreviation "N.D." Doctors of naturopathic medicine shall have the exclusive right to use of the terms: "doctor of naturopathic medicine," "naturopathic doctor," "naturopath," ""doctor of naturopathy," "naturopathic medicine," "naturopathic health care," "naturopathy," and "N.D." N.H.R.S.A. § 328-E:3.

Figure 2. State scope of practice for naturopaths

State	Statutory authority	Definition of naturopathy	Rx authority	Use of term "physician"
Oregon	O.R.S. § 685.010	Naturopathic medicine is the discipline that uses physiotherapy, natural healing processes and minor surgery and has as its objective the maintaining of the body in, or of restoring it to, a state of normal health.	Yes. (Oregon Rules 850-060-0225). Naturopathic physicians may only prescribe, dispense, or administer those substances on the Oregon Naturopathic Formulary List.	Yes. Only licensees under this chapter may use any or all of the following terms, consistent with academic degrees earned: "Doctor of Naturopathy" or its abbreviation, "N.D.," "Naturopath" or "Naturopathic Physician." However, none of these terms, or any combination of them, shall be so used as to convey the idea that the physician who uses them practices anything other than naturopathic medicine. O.R. S. §685.020
Utah	U.C.A. § 58-71-102	Naturopathic medicine is a system of primary health care for the prevention, diagnosis, and treatment of human health conditions, injuries, and diseases using education, natural medicines and therapies to support and stimulate the individual's intrinsic self-healing processes by using naturopathic childbirth (if specified requirements are met), naturopathic mobilization therapy, physical medicine, minor office procedures, prescribing or administering natural medicine, prescribing medical equipment and devices, diagnosing by using medical equipment and devices, and administering therapy or treatment by the use of medical devices, prescribing barrier devices for contraception, dietary therapy, taking and using diagnostic x-rays, electrocardiograms, ultrasound, and physiological function tests, taking body fluids for clinical laboratory tests and using the results in diagnosis, taking a history from and conducting a physical examination upon a human patient and prescribing and administering natural medicines and medical devices.	Yes. (U.C.A. § 58-71-102) Natural medicines are food, food extracts, dietary supplements, all homeopathic remedies, and plant substances not designated as prescription drugs or controlled substances; over the counter medications; other nonprescription substances (the prescription or administration of which is not restricted under federal or state law); and prescription drugs that are not controlled substances as defined in [58-37-2], the prescription of which is consistent with the competent practice of naturopathic medicine, and the prescription of which is approved by the Naturopathic Formulary Advisory Peer committee. The Naturopathic Formulary can be found at U.C.A. R156-71-202.	Yes. Naturopathic licensees can use the designation "naturopathic physician," "naturopathic doctor," "naturopath," "doctor of naturopathic medicine," "doctor of naturopathy," "naturopathic medical doctor," "naturopathic medicine," "naturopathic health care," "naturopathy," "N.D.," "N.M.D." U.C.A. §58-71-102.
Vermont	V.S.A. § 4121, V.C.R. § 04-030-380,-3.7	Naturopathic medicine is a system of health care that utilizes education, natural medicines and natural therapies to support and stimulate a patient's intrinsic self-healing processes to prevent, diagnose and treat human health conditions and injuries. This includes administering or providing, for preventative and therapeutic purposes, nonprescription medicines, topical medicines, botanical medicines, homeopathic medicines, counseling, hypnotherapy, nutritional and dietary therapy, naturopathic physical medicine, naturopathic childbirth, therapeutic devices, barrier devices for contraception, and using diagnostic procedures such as physical and orificial examinations, electrocardiograms, diagnostic imaging techniques, phlebotomy, clinical laboratory tests and examinations, and physiological function tests. Naturopathic physical medicine is the use of the physical agents of air, water, heat, cold, sight, sound and light, ultrasound, hydrotherapy and exercise. Naturopathic medicine does not include physical therapy, physical rehabilitation or chiropractic.	Yes. (V.S.A. § 4121). An individual [licensed as a naturopathic physician] may administer or provide for preventative and therapeutic purposes nonprescription medicines, topical medicines, botanical medicines, homeopathic medicines, counseling, hypnotherapy, nutritional and dietary therapy, naturopathic physical medicine, naturopathic childbirth, therapeutic devices, barrier devices for contraception, and prescription medicine authorized by this chapter or by the formulary. The formulary can be found at Vermont Rules 13-140-061.	Yes. V.S.A. §26-81-4121(9).
Washington	R.C.W § 18.36A.040	Naturopathic medicine is the practice by naturopaths of the art and science of the diagnosis, prevention, and treatment of disorders of the body by stimulation or support, or both, of the natural processes of the human body. A naturopath is responsible and accountable to the consumer for the quality of naturopathic care rendered. The practice of naturopathic medicine includes manual manipulation (mechanotherapy), the prescription, administration, dispensing, and use, except for the treatment of malignancies, of nutrition and food science, physical modalities, minor office procedures, homeopathy, naturopathic medicines, hygiene and immunization, nondrug contraceptive devices, common diagnostic procedures, and suggestion; however, nothing in this chapter shall prohibit consultation and treatment of a patient in concert with a practitioner licensed under chapter 18.57 or 18.71 RCW *(osteopathic medicine provisions)*. No person licensed under this chapter may employ the term "chiropractic" to describe any services provided by a naturopath.	Yes. (RCW § 18.36A.020 and A.040). "Naturopathic medicines" means vitamins, minerals, botanical medicines, homeopathic medicines, hormones, and those legend drugs and controlled substances consistent with naturopathic medical practice in accordance with rules established by the Secretary. Controlled substances are limited to codeine and testosterone products that are contained in Schedules III, IV, and V in Chapter 69.50 RCW. A Legend Substance List is currently being updated.	Most likely/unclear. Statutory headings refer to "naturopathic physicians," but express authority to use the title "physician" cannot be located in state statutes or regulations.

Figure 3. State naturopath board operating information

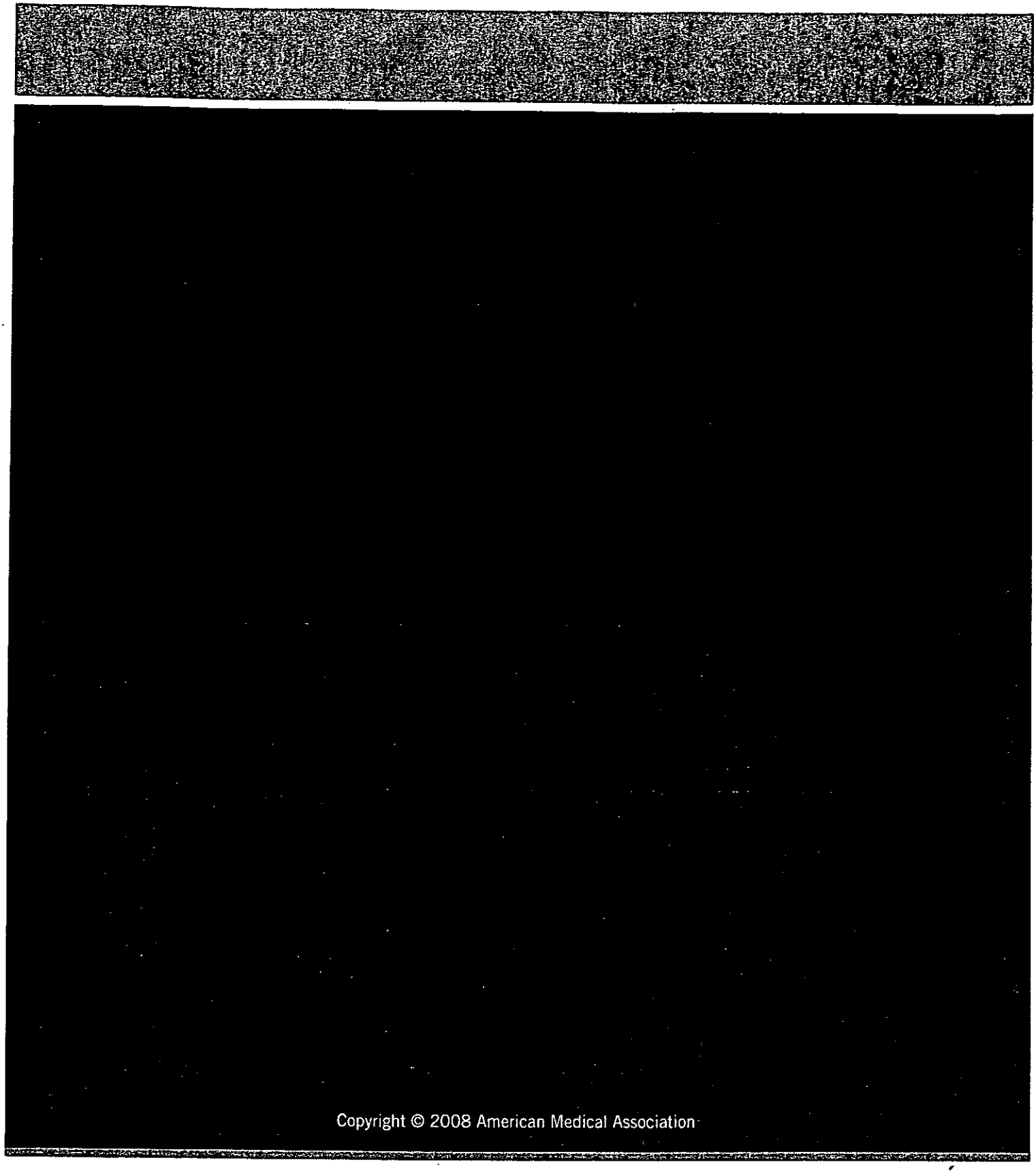
State	Regulatory board	Statutory authority	Board composition	Appointment procedure	Special procedures/Other
Alaska	Department of Commerce, Community, and Economic Development, Division of Occupational Licensing. *Division of Corporations, Business, & Professional Licensing*	A.S. § 08.01.010, § 08.01.050, § 08.01.070 and § 08.01.080	Licensing Examiner oversees operations because no separate board exists.	Not applicable.	The departments administrative duties are to set minimum qualifications for applicants for examinations and license, hold at least one examination each year and prepare and grade examinations. The Licensing Examiner reviews license applications, issues licenses, maintains licensing files, and responds to inquiries. The division itself has an investigative staff which oversees issues regarding naturopathy among other things.
Arizona	Naturopathic Physicians Board of Medical Examiners	A.R.S. § 32-1502- §32-1504	7 members: 4 naturopathic physician members and 3 public members.	Appointment by the Governor. Term = 5 years.	Not applicable.
California	Bureau of Naturopathic Medicine within the Department of Consumer Affairs	C.C.A. § 101 and C.C.A. § 3625	9 members: 3 licensed naturopathic doctors, 3 licensed physicians and surgeons, and 3 public members.	Governor appoints 2 physician/surgeon members, 2 naturopathic doctors, and 1 public member. The Senate Rules Committee appoints 1 physician/surgeon member and 1 public member. The Speaker of the Assembly appoints 1 naturopathic doctor and 1 public member. All members serve staggered 4-year terms.	Not applicable.

Figure 3. State naturopath board operating information

State	Regulatory board	Statutory authority	Board composition	Appointment procedure	Special procedures/Other
Connecticut	State Board of Natureopathic Examiners	C.A.S. § 19a-14, C.A.S. § 20-35, Conn. Gen. Stat. § 4-9a	3 members: 2 practicing naturopathic physicians and 1 public member.	Appointment by the Governor. Term = coterminous with the term of the Governor or until a successor is chosen whichever is later.	Not applicable.
District of Columbia	Advisory Committee on Naturopathic Medicine	D.C.C.A. § 3-1202.03, § 3-1204.01	3 members: 1 licensed physician, 1 licensed naturopathic physician (both with at least 3 years experience prior to appointment), and the Director of the Department of Health.	Appointed by the Mayor to 3-year terms.	Not applicable.
Hawaii	Board of Examiners in Naturopathy	H.R.S.A. § 455-4, H.R.S.A. § 26-34	5 members: 3 licensed naturopathic physicians and 2 public members.	Appointment by the Governor. Term = 4 years.	Not applicable.
Idaho	Board of Naturopathic Medical Examiners	I.C.S.A. § 54-5108	5 members: 4 licensed naturopathic physicians and 1 public member.	Appointment by the Governor. Term = 5 years.	Not applicable.
Kansas	1. Kansas State Board of Healing Arts 2. Naturopathic Advisory Council	K.A.S. § 65-7202- 65-7203, K.S.A § 65-7214	1) 15 members: 12 licensed professionals and 3 public members 2) 5 Members: 3 naturopathic physicians, 1 President of the Board of Healing Arts, 1 Public member.	1) Appointment by the Governor. Term = 4 years 2) Naturopathic physicians appointed by the State Board of Healing Arts, president and public member appointed by the Governor. Term = 3 years	Naturopathic Advisory Council will advise the Board.
Maine	Board of Complementary Health Care Providers	32 M.R.S. § 12502	7 members: 2 licensed acupuncturists, 2 naturopathic medicine practitioners who are licensed or eligible for license, 1 public member, 1 allopathic or osteopathic physician, and 1 licensed pharmacist.	Appointment by the Governor. Term = 3 years.	Not applicable.

Figure 3. State naturopath board operating information

State	Regulatory board	Statutory authority	Board composition	Appointment procedure	Special procedures/Other
Montana	Board of Alternative Healthcare	M.C.A. § 2-15-1730	6 members: 2 naturopathic doctors, 2 licensed midwives, 1 medical doctor, and 1 public member. Three members must have been residents in the state for at least 3 years.	Appointment by the Governor with Senate approval. Term = 4 years.	Not applicable.
New Hampshire	Naturopathic Board of Examiners	N.H.R.S.A. § 328-E:7, § 328-E:8	5 members: 4 naturopathic doctors and 1 public member. Two of the four doctors must have at least 3+ years experience.	Appointment by the Governor. Term = 5 years.	Not applicable.
Oregon	Board of Naturopathic Examiners	O.R.S. § 685.160	7 members: 5 licensed naturopathic physicians and 2 public members.	Appointment by the Governor. Term = 3 years.	Not applicable.
Utah	Naturopathic Physicians Licensing Board	Utah Code Ann. § 58-71-201, Utah Code Ann. § 58-1-201	5 members: 3 licensed naturopathic physicians and 2 public members.	Appointment by the Executive Director of the Division of Occupational and Professional Licensing with approval by the Governor. Term = 4 years.	Not applicable.
Vermont	Office of Professional Regulation	81 V.S.A. § 4125, 81 V.S.A. § 4126	Director of the Office of Professional Regulations and 2 advisor appointees which are naturopathic physicians.	Appointment by the Secretary of State. Term= 3 years.	Not applicable.
Washington	Naturopathic Physicians Advisory Committee	A.R.C.W. § 18.36A.070	5 members: 3 licensed naturopathic physicians and 2 public members.	Appointment by the secretary of Health. Term = 4 years.	Not applicable.



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SB

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SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/26/09

FURTHER: Finance

Date of 5-Day Notice: 1/29/09
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/2/09

Health and Social Services Committee considered SENATE BILL NO. 82

SB 82 MEDICAID FOR ADULT DENTAL SERVICES

"An Act providing for an effective date by delaying the effective date of the change of coverage of adult dental services under Medicaid; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS	1/22	✓			1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Thomas	✓			
	Ellis				X
	PACKHAM	✓			
	Dyson	✓			
CHAIR:	DAVIS	✓			

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

January 28, 2009

Honorable Bettye Davis, Chair
Senate Health & Social Services Committee
State Capitol Room 30
Juneau, AK 99801

Dear Senator Davis:

The Department of Health and Social Services respectfully requests a hearing in the Senate Health & Social Services Committee on Senate Bill 82, "An Act providing for an effective date by delaying the effective date of the change of coverage of adult dental services under Medicaid; and providing for an effective date."

The bill extends the termination date for enhanced adult dental services under Medicaid for five years. The Legislature authorized an enhanced program in 2006. The program provides preventative and restorative services to needy eligible adults under the Medicaid program.

A copy of Governor Palin's transmittal letter providing additional information on the bill and the associated fiscal note should be on file with the committee.

Your favorable consideration of this request will be appreciated.

Sincerely,

Wilda Laughlin
Legislative Liaison

cc: Gerald Gallagher, Legislative Director, Office of the Governor

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
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Sponsor Statement
January 29, 2009

SB 82, "An Act providing for an effective date by delaying the effective date of the change of coverage of adult dental services under Medicaid; and providing for an effective date."

This legislation is necessary to keep operating the Adult Preventative Dental Medicaid program beyond this fiscal year. In April 2007, Alaska began providing preventive and restorative dental care for adults age 21 and older enrolled in Medicaid for a trial period established by the Legislature to evaluate the new program. In the past, Medicaid only treated emergency dental as defined by minimum treatment for relief of pain and acute infection for adult Medicaid recipients. Without reauthorization of the services in the 2009 legislative session, the preventative and restorative dental services will sunset June 30, 2009.

This coverage expansion was added because infections in the mouth are no different than infections in other parts of the body in that they can affect the health and wellbeing of the individual. Dental infections cause pain and lost time at work, and affect overall health. Further, some of these emergent dental cases end up in the hospital emergency room for treatment and result in palliative care for pain relief but not dealing with the dental need causing the problem. Waiting until a dental emergency occurs can result in more expensive dental care and often was resulting in the need to extract teeth under previous level of Medicaid dental coverage for adults. Decayed and missing teeth can affect employability and job advancement opportunities.

Services provided under the Adult Preventative Dental Medicaid program must be preauthorized and are subject to a $1,150 annual cap per individual. Services include exams, cleanings, fillings, root canals and dentures. Total program costs have been limited to fiscal limits set by the legislature, ensuring that total program spending remains within the budgeted amount. This bill extends the sunset date for the Adult Preventative Dental program from June 30, 2009 to June 30, 2014.

The Adult Preventative Dental Medicaid program helps protect and promote the health of Alaskans by improving affordable access to dental care services to the nearly 40,000 eligible adult Alaskans enrolled in Medicaid annually. During fiscal year 2008 about 7,600 adults received treatment under this program with about 250 dental providers participating in the program. Total expenditures for these services in fiscal year 2008 were $4.6 million.

While the Department does not have evidence of immediate savings from the enhanced dental coverage to date, it continues to believe that the Medicaid program will eventually experience savings as long term access to preventive dental care reduces the need for more intensive dental procedures and improves the overall health status of adult Medicaid recipients, reducing the cost of treating other diseases. We will continue to analyze Medicaid data to determine if the evidence supports this hypothesis. Until then, the Department believes it is important to maintain this program that has such potential to reduce complications of other diseases and improve the quality of life for so many Alaskans.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 82
(S) Publish Date: 1/26/09

Identifier (file name): 0130-DHSS-APDM-12-22-08
Dept. Affected: Health and Social Services
Title: Extending coverage of Medicaid adult dental services
RDU: Adult Preventative Dental Medicaid
Component: Adult Preventative Dental Medicaid
Sponsor: Rules Committee
Requester: Governor
Component Number: 541

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	0.0	6,133.8	7,246.1	7,484.2	7,722.2	7,960.2	0.0
Miscellaneous							
TOTAL OPERATING	**0.0**	**6,133.8**	**7,246.1**	**7,484.2**	**7,722.2**	**7,960.2**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0	3,531.8	4,309.8	4,429.4	4,570.2	4,711.1	0.0
1003 GF Match	0.0	2,602.0	2,936.3	3,054.8	3,152.0	3,249.1	0.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**6,133.8**	**7,246.1**	**7,484.2**	**7,722.2**	**7,960.2**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill extends the sunset date for the Adult Preventative Dental program from June 30, 2009 to June 30, 2014. On July 1, 2014 dental services for adult Medicaid recipients will revert to emergent dental services (treatment for immediate relief of pain and acute infection). During FY2008 about 7,600 adults received treatment under this program. Forecasted expenditures are based on an analysis of paid claims. The estimated federal portion is based on projected federal financial participation rates for 2010 through 2014. The fiscal note amount for 2010 anticipates continuation of the adult dental program without anticipating program growth. FY 2010 projections will be updated to reflect the most recent trends during the course of the legislative session.
(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 269-7827
Division: Health Care Services
Date/Time 12/22/08 12:00 PM

Approved by: William Hogan, Commissioner
Date 12/22/2008
Dept. Health & Social Services

FISCAL NOTE # 1

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB 82

ANALYSIS CONTINUATION

In April 2007, Alaska began providing preventive and restorative dental care for adults age 21 and older enrolled in Medicaid. The Legislature established a three year trial period to evaluate the new program, which will end June 30, 2009, if not reauthorized. Services provided under the Adult Preventative Dental Medicaid program must be preauthorized and are subject to a $1,150 annual cap per individual. Services include exams, cleanings, fillings, root canals and dentures. Total program costs are limited to fiscal limits set by the legislature, ensuring that total program spending remains within the budgeted amount.

The Adult Preventative Dental Medicaid program helps protect and promote the health of Alaskans by improving affordable access to dental care services to the nearly 40,000 eligible adult Alaskans enrolled in Medicaid annually. During fiscal year 2008 about 7,600 adults received treatment under this program. In the past, Medicaid only treated emergency pain relief and acute infection for adult dental needs. This coverage expansion was added because infections in the mouth are no different than infections in other parts of the body. Dental infections cause pain and lost time at work, and affect overall health. Waiting until a dental emergency occurs can result in more expensive dental care. Missing teeth can affect employability.

The Alaska Mental Health Trust Authority contributed to state matching funds during the first three years of the program but will not do so after June 30, 2009. Fund source calculations for this fiscal note assume only GF match for the state portion. The federal portion is estimated for 2010 through 2014 based on the proportion of tribal and Title XIX reimbursable costs as forecast for 2010, and the estimates of federal matching percentages for 2010 through 2014. Approximately 18% of the claims are eligible for Indian Health Services and 100% federal reimbursement. The remaining 82% of claims are eligible for regular FMAP, which is projected to average 51.21% for state FY2010, 50.36% for FY2011 and 50% for FY 2012 to FY 2014.

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

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Sectional Analysis

SB 82, "An Act providing for an effective date by delaying the effective date of the change of coverage of adult dental services under Medicaid; and providing for an effective date."

Section 1 provides for the repeal date of the enhanced (preventative and restorative) dental services on June 30, 2014.

Section 2 provides for adult dental services to revert back to emergent services on July 1, 2014 (dental services for immediate relief of pain and acute infection) after repeal of the enhanced dental services.

Section 3 provides for an effective date.

ALASKA PUBLIC HEALTH ASSOCIATION

Committed To Advancing Alaska's Public Health Since 1978

ALPHA

ALPHA RESOLUTION 5-2008

Support for Enhanced Dental Services for Adult Medicaid Recipients

Sponsor: Alaska Dental Access Coalition
Brad Whistler, DMD

WHEREAS, recognizing that decayed or missing teeth can be a significant factor in employability and/or job advancement, welfare recipients who received rehabilitative dental treatment (including fillings, extractions, and dentures) were "...twice as likely to receive favorable or neutral employment outcomes as they were to receive unfavorable employment outcomes."[1]

WHEREAS, acknowledging that improvement in dental care access helps those most in need, the American Dental Association recommends adult preventive and restorative dental services be included in all state Medicaid programs. Tribal health programs and community health centers share this service expansion initiative and stand ready to implement increased dental care to those most in need.

WHEREAS, knowing that studies show links between oral health and other systemic/chronic disease including diabetes and cardiovascular disease,[2] enhanced dental services may lead to reduced Medicaid expenses for clients with chronic diseases.

WHEREAS, understanding that maternal periodontal disease is linked with pre-term, low birth-weight (PTLBW) births, good oral health in pregnant women may result in a reduction in health care expenses for children with poor birth outcomes. One recent study indicated women with periodontal disease are 7.5 times more likely to have a PTLBW baby.[3]

WHEREAS, setting an annual maximum limit on non-emergent Medicaid dental services, such as the existing $1,150 annual limit per adult Medicaid recipient, controls Medicaid expenditures - it also encourages the dentist and client to discuss priorities and treatment options. The

[1] "Dental Treatment Highly Effective in Helping Welfare Recipients Gain Employment", University of California – San Francisco School of Dentistry, press release, March 10, 2004.
[2] Okero, CA et al., "Tooth Loss and Heart Disease: Findings from the Behavioral Risk Factor Surveillance System" *American Journal of Preventive Medicine*, 2005; 29:5 (supplement 1)
[3] Lieff S, Hared H, McKaig R et al., "Periodontitis and Preterm Low Birth Weight in Pregnant Women" *Journal of Dental Research*, 2000;79(supplemental):608

current amount of the annual limit allows for adult Medicaid recipients to receive a complete set of dentures over a two-year period.

WHEREAS, recognizing that studies show increased risks of early childhood caries in infants with mothers/caregivers who have active dental decay due to transmission of bacteria,[4] Alaskan children will experience better dental health and less dental infection and less dental infection if parents/caregivers can have their treatment needs met prior to the infant's teeth erupting..

WHEREAS, acknowledging that much of the focus on dental decay is on children, adults remain at high risk for two common health problems: dental decay and periodontal disease.

THEREFORE BE IT RESOLVED, that the Alaska Public Health Association supports and will advocate for continued coverage of non-emergent dental services (e.g., preventive and routine restorative dental services), specifically the legislative reauthorization of the services in the 2009 legislative session, for adult Medicaid recipients. .

BE IT FURTHER RESOLVED that the Alaska Public Health Association as an organization as well as individual Board Members and other Members will engage in low and no-cost advocacy efforts to promote coverage expansion such as, but not limited to, the following:

- Circulation of advocacy action requests to membership
- Circulation of advocacy action requests to partners and other individuals
- Posting of ALPHA resolutions on the Alaska Public Health Association's website and/or making this resolution available
- Participation in email advocacy campaigns
- Contact with policy makers via phone, letter, email and/or in-person meetings
- Public testimony in legislative hearings, town hall meetings, and other public forums
- Contribution of op-ed articles and/or letters to the editor
- Contributions to radio programs via calling-in or scheduled interviews
- Distribution of this resolution statement to policy makers and key officials such as the Governor's office and, at a minimum, members of Senate and House HESS and Finance Committees.

Fiscal & Public Health Impact Statement

Fiscal Impact on ALPHA: This action will result in minor costs associated with sending this resolution and accompanying cover letter to the Governor and key political leaders.

Public Health Impact: The enhanced dental services for adult Medicaid recipients makes available preventive and restorative dental services, in addition to the existing dental emergency services, for the 41, 000 adults enrolled in the Medicaid program.

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[4] Li Y et al., "Characterization of Maternal Mutans Streptococci Transmission in an African American Population." *Dental Clinics of North America* 2003; 47(1):87–101.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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SB 82, "An Act providing for an effective date by delaying the effective date of the change of coverage of adult dental services under Medicaid; and providing for an effective date."

Hearing: Senate HSS Committee
Date: Jan. 29, 2009, 1:30 P.M.

DHSS testimony will be provided by:
Brad Whistler, DHSS dental officer

Other possible testimony in support:
Delisa Culpepper, Chief Operating Officer Alaska Mental Health Authority

Name and direct line of staff member assigned to legislation:
Brad Whistler, 465-8628
Legislative Liaison: Wilda Laughlin, 465-1613

Please teleconference in the Anchorage LIO

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SARAH PALIN, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

To: **Members of the Senate HSS Committee**

From: **The Alaska Commission on Aging**

Date: **January 31, 2009**

Subject: **Support Letter for SB 82 (Senate Rules Committee by request of Governor Palin)**

The Alaska Commission on Aging (ACoA) encourages support of SB 82, a bill to reauthorize preventive and restorative dental services for adult Medicaid recipients sponsored by the Senate Rules Committee at the request of Governor Palin. Medicaid coverage for these services will sunset June 30, 2009 without legislative reauthorization.

Good nutrition is vital for health and wellness across the life span and depends on oral health. Dental pain, missing, and decayed teeth can affect employment and job advancement, contribute to missed work, and complicate management of other chronic diseases. Vulnerable older Alaskans are at risk of improper nutrition due to dental problems that may affect their dietary choices. Seniors are more prone to developing dental infections that have been associated with periodontal disease, diabetes, pneumonia, and other chronic diseases including cardiovascular disease.

Children are also at risk of developing dental infection. Research has shown that the bacteria involved with the dental decay process are typically passed from parent to child and from grandparent to grandchild, in situations where the grandparent is the primary caregiver. Part of the efforts to reduce dental decay in young children relates to reducing the level of dental infection in the caregiver (Berkowitz 2003). Those with dental coverage are more likely to access dental services for their children or grandchildren. Additionally, dental infections due to periodontal disease have been associated with adverse pregnancy outcomes (Lieff, Hared, and McKaig: 2000).

In addition to the health issues involved, decayed or missing teeth can be a factor in employability, which is of concern to all persons seeking employment, regardless of age. Preventive and restorative dental services result in fewer tooth extractions for Medicaid clients and offer increase chance of employment.

Currently, Medicaid dental services are limited to expensive emergency care for immediate relief of pain and acute infection, with no coverage for preventative and restorative dental care. These limited services often lead to extraction of permanent teeth. Services offered by the adult dental Medicaid program help contain future Medicaid costs for emergency dental work, assist in chronic disease prevention, and promote healthy lifestyles.

Since inception on April 1, 2007 through September 30, 2008, this program has served 9,267 unduplicated persons with 283 providers participating who have performed 42,268 procedures. During FY 2008 alone, 7,470 Alaskans received services through this program.

Because infections in the mouth are no different than infections in other parts of the body, ACoA believes that the enhanced Medicaid adult dental program should continue for as long as possible. Currently, the limit for services is $1,150 per year per Medicaid beneficiary. We suggest that the cap for services be re-considered in

light of the current costs for providing dental care. We understand that the average cost for dentures has increased to $1,700 or $1,800 for one set. According to estimates from the National Dental Advisory Service, for example, the estimated median charge in Alaska for a set of dentures is in excess of $2,900.

ACoA supports SB 82 and believes that this program is a wise public investment that will help reduce expensive emergency dental needs, associated costs in health care, and enhance health and wellness for elderly Alaskans. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879), should you have any questions regarding our position. Thank you for your consideration.

Sincerely,

Sharon Howerton-Clark
Chair Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

CC: Senator Bettye Davis, Chair
Senator Joe Paskvan, Vice-Chair
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

Don Burrell

RECEIVED
FEB 0 2 2009

From: david logan [drdave@acsalaska.net]
Sent: Saturday, January 31, 2009 12:47 PM
To: Sen. Johnny Ellis; Sen. Bettye Davis; Sen. Fred Dyson; Sen. Joe Paskvan; Sen. Joe Thomas
Subject: SB65 and SB82
Attachments: Alaska Dental Society Medicaid Priority List.doc

Senate HESS Committee Members

This week all Legislators will receive a mailing from the Alaska Dental Society (ADS) on dental issues in Alaska. One of our focus areas this legislative session will be on dental Medicaid and changes we believe are long overdue to the Medicaid system. At this point in the legislative session we offer cautious support for SB65 and its companion bill HB26. We have had preliminary discussions with the House sponsor, Rep. Hawker but were unable to discuss our position with committee members before Monday's hearing. The ADS feels it would be better to repeal the sunset date rather than extending as the Governor's bill, SB82 does.

A letter outlining the ADS position on Medicaid will be in our packet of information; I have copied a portion below:

A limited "Adult Dental" Medicaid program that provides for basic preventative and restorative services to adults is set to sunset this year. The Alaska Dental Society **cautiously supports** the continuation of this program and the expansion of our Alaska Denali Kid Care Program under the State Children's Health Insurance Program (SCHIP).

While the intent of both of these programs is good -- to increase the level of dental care within the state, the fact is that the existing Medicaid delivery system for dental benefits is already severely strained and discourages dentists from participating.

Therefore the ADS recommends that bills repealing the sunset of the adult Medicaid program and extending adult benefits and bills expanding eligibility for the Denali Kid Care include meaningfully changes to the Medicaid program that will remove barriers to participation by providers.

To this end, the ADS has been working with coalitions of health care groups, advocacy groups, along with representatives of the Medicaid Division and private practitioners over the past two years. Progress has been made on some of the issues, while others remain a "work in progress." The ADS has become convinced that without legislative a mandate some or all of the progress that has been made may fall by the wayside.

The ADS is planning an informal meeting in February with legislators, the Medicaid program leaders and other stakeholders. We will be asking about dates shortly and hope that a time can be chosen to allow as many to participate as possible.

A separate sheet is enclosed listing some of the key issues and reasons change is needed is attached

If there are any questions on the issues raised I can be reached at drdave@acsalaska.net or 723-2884.

David Logan, DDS
Legislative Chair, Alaska Dental Society

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
and ALASKA MENTAL HEALTH BOARD

SARAH PALIN, GOVERNOR

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January 30, 2009

Honorable Senator Bettye Davis
Alaska State Capitol, Room 30
Juneau, Alaska 99801

Re: Support for Reauthorization of Adult Dental Medicaid Program

Senator Davis:

The Alaska Mental Health Board and Advisory Board on Alcohol and Drug Abuse appreciate your acknowledgement of the need for continued access to preventative and restorative dental care for Alaskans living in poverty. For Alaskans experiencing a serious disability that prevents them from maintaining employment, lack of income and insurance often results in a lack of dental care. This can have serious health consequences.

We know that a variety of factors contribute to poor dental health among Alaskans experiencing serious mental illness and substance use disorders. Many of the medications prescribed to manage the symptoms of the most serious mental illnesses cause dental and oral health problems. Due to the barriers to preventive dental care that existed before Alaska began its Adult Dental Medicaid program, many people now require significant dental care critical to their overall health. By continuing this program — and its preventative dental care services — we can reduce the need for more costly critical services in these populations.

In FY2008, approximately 7,600 Alaskan adults received dental care under this program. By providing access to quality preventative and restorative care to these Alaskans, we improved their ability to secure employment, maintain employment, make healthy dietary choices, manage existing chronic diseases, and reduce risk factors related to pre-term births, diabetes, and cardiovascular disease. For this reason, we support the reauthorization of the Adult Dental Medicaid Program.

Thank you for your work, and please let us know if the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse can assist in the effort to pass this important legislation.

Sincerely,

Debi Keith, Chair
AMHB

Lonnie Walters, Chair
ABADA

4181

AARP

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Anchorage, AK 99503

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February 2, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 65 (Davis)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage your colleagues on the Senate Health and Social Services Committee to support SB 65, authored by you and co-sponsored by your Committee colleague Senator Johnny Ellis.

SB 65 would eliminate the sunset date on the adult dental benefit in the Medicaid program. This program has proven to be invaluable over the past years not only for dental exams, prevention, and treatment but also for providing dentures, primarily to older Alaskans in long term care facilities. In addition, adults who had low incomes and qualified for Medicaid were able to see a dentist and have the restorative work completed that allowed them to be able to successfully participate in job interviews.

Older Alaskans who have dental problems, missing teeth, or are in need of dentures often have accompanying nutrition problems. These nutrition problems can exacerbate other health issues and create an overall deterioration in health status. AARP believes that dental care is essential to quality health care. Funding for dental care should be considered sensible prevention with the long term possibility of saving Medicaid funds that would not need to be spent on more serious health care problems resulting from poor oral health status.

The current program has a limit of $1,150 per year per Medicaid beneficiary. Originally this figure was used because it was the amount that would pay for either upper or lower dentures. We understand that the average cost for dentures has gone up to $1,700 or $1,800 for just one set. We recommend that some appropriate increase in the annual benefit be included with the passage of SB 65. If possible, some form of "cost of dentures" inflation could be built into the program to keep up with dental inflation.

AARP requests an "AYE" vote on SB 65.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

Alaska Dental Society Medicaid Priority List

- Removal of dentistry from state audits.
  - Superseded by federal audits
  - General consensus that this can be done
- Reimburse provider for treatment if patient is eligible for services at initial treatment date.
  - Currently payment will be denied if patient is eligible when treatment started but ineligible when treatment completed.
  - Key dental procedures such as crowns and dentures require 2-3 weeks to be completed after treatment is begun.
  - Insurance industry standard is 30 days to complete treatment if patient is eligible for benefits at time of initial treatment
- Provide yearly reimbursement adjustments.
  - Yearly increases will provide consistency and fairness to offset cost of delivering care. The 8 year gap between rate adjustments before fees were adjusted last year caused providers to drop out.
  - Set reimbursement at 65th percentile of UCR from a verifiable source.
- Remove eligibility from non federally mandated recipients who chronically abuse system.
  - Patients who schedule appointments and fail to show or cancel
  - Patients who use travel benefits then fail to show for appointments
  - Patients who engage in drug seeking
- Have Medicaid act as secondary insurance for non EPSDT recipients
  - Current system for patients with private insurance and Medicaid is confusing
  - Cost to Medicaid system would be less then acting as sole primary payer and forgoing private insurance
- Remove Hold Harmless provision from provider agreement
  - Opinion from AG's office it can be removed
  - Little legal consequence
  - Barrier to participation by providers

Advisory Board on Alcoholism and Drug Abuse

abada amhb

Alaska Mental Health Board

Governor's Council on Disabilities and Special Education

Alaskan Seniors Living Longer Growing Stronger

from the Alaska Commission on Aging

The TRUST

The Alaska Mental Health Trust Authority

Reauthorize preventative and restorative dental services for adult Medicaid recipients

The Governor's Council on Disabilities and Special Education, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, and Alaska Commission on Aging, in collaboration with the Alaska Mental Health Trust Authority, jointly support the reauthorization of preventive and restorative dental services for adult Medicaid recipients. Medicaid coverage for these services will sunset June 30, 2009 without legislative reauthorization.

- The Department of Health and Social Services reports that approximately 7,600 adult Medicaid recipients received these dental services in FY08 with 252 participating dental providers.
- The American Dental Association recommends adult preventive and restorative dental services be included in all state Medicaid programs, and as former U.S. Surgeon General C. Everett Koop stated, "You're not healthy without good oral health."[i]
- Trust beneficiaries continue to list dental services as a priority unmet health needs.
- Dental pain, missing and decayed teeth and infection can affect employment and job advancement, contribute to missed work, dietary choices for seniors, and complicate management of other chronic diseases.[ii]
- Individuals on public assistance who receive rehabilitative dental treatment (including fillings, extractions, and dentures) were ". . . twice as likely to receive favorable or neutral employment outcomes as they were to receive unfavorable outcomes."[iii]
- Dental infections due to periodontal disease have been associated with adverse pregnancy outcomes (e.g., pre-term births)[iv], management problems for individuals with diabetes, risks for pneumonia in nursing homes, and other chronic diseases including cardiovascular disease.[v]
- The bacteria involved with the dental decay process are typically passed parent to child. Part of the efforts to reduce dental decay in young children relates to reducing the level of dental infection in the caregiver.[vi] Additionally, parents with dental coverage are more likely to access dental services for their children.
- The coverage of preventive and restorative dental care for adult Medicaid recipients along with necessary behavioral changes, over the long term, offer the potential for

reduced utilization of emergent dental services (e.g., accessing the hospital emergency room for management of a dental infection).

Supporters: AARP-Alaska, Alaska Public Health Association, Alaska Dental Society All-Alaska Pediatric Partnership, ANTHC and Alaska Primary Care Association.

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[i] Oral Health America, http://www.oralhealthamerica.org/whoweare.html, noting quote from C. Everett Koop, former U.S. Surgeon General.

[ii] Association of State and Territorial Health Officials (ASTHO), "The oral health and chronic disease connection", available at: http://www.astho.org/templates/display_pub.php?pub_id=327, May 2002.

[iii] "Dental Treatment Highly Effective in Helping Welfare Recipients Gain Employment", University of California – San Francisco School of Dentistry", press release, March 10, 2004.

[iv] Lieff S, Hared H, McKaig R, et al., "Periodontitis and Preterm Low Birth Weight in Pregnant Women", *Journal of Dental Research*, 2000; 79(supplemental):608.

[v] U.S. Department of Health and Human Services (USDHHS), *Oral Health in America: A Report of the U.S. Surgeon General*, USDHSS, National Institute of Dental and Craniofacial Research, National Institutes of Medicine, 2000.

[vi] Berkowitz, RJ, "Causes, treatment and prevention of early childhood caries: a microbiologic perspective", *Journal of the Canadian Dental Association*, 69(5):304-307b, 2003.

SB 87

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/28/09

FURTHER: Finance

Date of 5-Day Notice: 2/4/09
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/9/09

Health and Social Services Committee considered SENATE BILL NO. 87

SB 87 MEDICAL ASSISTANCE ELIGIBILITY

"An Act expanding medical assistance coverage for eligible children and pregnant women; relating to cost sharing for certain recipients of medical assistance; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS		✓			1
DHS		✓			2
DHS		✓			3
DHS		✓			4

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Ellis	X			
	Thomas				✓
	Askvan	X			
CHAIR:	Davis	X			

Lynda Zaugg

From: Thomas Obermeyer
Sent: Monday, February 09, 2009 8:26 AM
To: Lynda Zaugg; Sen. Bettye Davis; Don Burrell
Subject: FW: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

NCSL staff attend hearing via teleconf

From: Jennifer Saunders [mailto:jennifer.saunders@ncsl.org]
Sent: Monday, February 09, 2009 7:50 AM
To: Thomas Obermeyer
Cc: Martha King; Jennifer Breshears
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Martha King and I will be on the call this afternoon to answer questions.

As we discussed on the phone on Friday, Alaska's SCHIP program is a Medicaid expansion program and therefore must comply with Medicaid's cost-sharing rules as specified under the Deficit Reducation Act of 2005.

The following document summarizes these requirements and I would refer you to the summary on page 1 under the heading "Options for Premiums and Cost-sharing" and the "Important Links" on the bottom of page 2.
See the document here: http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf

Under provisions of the Deficit Reduction Act of 2005, states generally cannot impose cost sharing on children in families with income below 150 percent of the federal poverty guidelines except in certain circumstances. In addition, even at more moderate-income levels, federal rules exempt some special services from any cost sharing requirements.

To create cost sharing requirements that differ from the Medicaid requirements, states can do so by submitting a waiver to and obtaining approval from the Centers for Medicare and Medicaid (CMS) or by creating a stand-alone SCHIP program.

For more information about cost sharing and SCHIP, please see the following CMS website:
http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp
(Scroll down to see the information under the heading "Cost Sharing.")

Best regards,
Jennifer

Jennifer B. Saunders, MSW
Research Analyst
Health Program
National Conference of State Legislatures
7700 East First Place

Lynda Zaugg

From: Don Burrell
Sent: Monday, February 09, 2009 8:48 AM
To: Thomas Obermeyer; Lynda Zaugg
Subject: Support for SB 13 & SB 87

Karen McBride called in today at 8:42am to express her support for both SB 13 & SB 87 which will be heard in H.S.S. this afternoon.

Just passing the word along.

MCBRIDE, KAREN L
8981 RENDON DR
ANCHORAGE AK 99507
District: 30-840 Party: D Sex: F

Don Burrell Jr.
Legislative Aide
Office of Senator Bettye Davis
State Capitol Building, Rm. 30
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P 907-465-3822
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STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
and ALASKA MENTAL HEALTH BOARD

SA[redacted] GOVERNOR

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431 N. Franklin Street, Suite 200
JUNEAU, ALASKA 99811-0608
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February 9, 2009

Senator Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room 30
Juneau, Alaska 99801

Re: Support for Expanding Eligibility for Denali KidCare

Senator Davis:

The Alaska Mental Health Board and Advisory Board on Alcohol and Drug Abuse appreciate your recognition of the need for quality health care for Alaska's children. An estimated 19,670 of Alaska's children live in poverty. For them, Denali KidCare is an important safety net – and the way we can insure that our children grown to be healthier and happier adults.

Medicaid-enrolled children who are up-to-date on their well-child checkups through age two years are 48% less likely to experience an avoidable hospitalization. Children with incomplete care are 60% more likely to visit an emergency department for any cause compared to children who are up-to-date on their well-child care. By providing regular preventative care to our children, we save on the cost and trauma of unnecessary hospitalizations.

Denali KidCare is especially important for children with serious emotional disturbances and other mental health needs. In Alaska, more than 75% of children with special health care needs who have Denali KidCare receive the mental health services they need. This is far better than the national rate for uninsured children: only 56.8% of uninsured children with special health care needs receive the necessary mental health services.

Children of families whose income exceeds the current 175% FPIG ceiling, but who still lack resources or insurance to pay for their children's health care, go without necessary health care. The costs of health care have continued to rise, and with that the number of uninsured children who go without care rises. In 2007, nearly 16% of uninsured children in the United States went without necessary care because the costs were prohibitive.

Thank you for your work, and please let us know if the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse can assist in the effort to pass this important legislation.

Sincerely,

Debi Keith, Chair
AMHB

L S Walters

Lonnie Walters, Chair
ABADA

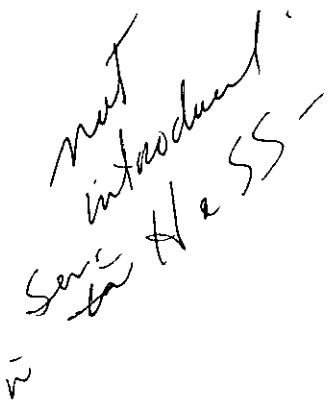
4191

Differences between SB 87 and the proposed CS for SB 87

1. The CS removes the requirement for a 20% co-pay for families earning above 250% of the federal poverty level (page 5, lines 10-13). This requirement was removed in response to concerns from the Department of Health and Social Services that it would be difficult to administer. Federal regulations prohibit states from collecting more than 5% of an eligible family's income in premiums and co-pays. Since health care providers have up to a year to submit claims to the state, it's challenging for DHSS to know when the 5% threshold has been met. Given that the premiums proposed in SB 87 are significant, it was decided to drop the additional requirement for a co-pay.

2. The effective date of the bill was moved back six months to enable the DHSS to work out any glitches in its new Medicaid payment system, which is scheduled to go on-line on June 2010.

3. Two new sections (6 and 7) were added to the bill. Section 6 states that the Act will only take effect if the U.S. Department of Health and Human Services has approved a revised Denali KidCare Plan from the state and provided sufficient funding for the expanded program. Section 7 requires the commissioner of DHSS to notify the reviser of statutes when the plan has been approved and sufficient funding provided.



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Mischel
2/3/09

CS FOR SENATE BILL NO. 87( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR WIELECHOWSKI

A BILL

FOR AN ACT ENTITLED

"An Act expanding medical assistance coverage for eligible children and pregnant women; relating to cost sharing for certain recipients of medical assistance; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SHORT TITLE. This Act may be known as the No Child Left Uninsured Act.

*** Sec. 2.** AS 47.07.020(b) is amended to read:

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the

aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed $1,656 a month but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under 21 years of age who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(8) persons under 21 years of age and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under 21 years of age not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 - 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them;

(12) disabled persons, as described in 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under applicable federal regulations or guidelines, is less than 250 percent of the official poverty line applicable to a family of that size according to the United States Department of Health and Human Services, and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be

individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is not eligible under another provision of this section shall pay a premium or other cost-sharing charges according to a sliding fee scale that is based on income as established by the department in regulations;

(13) persons under 19 years of age who are not covered under (a) of this section and whose household income does not exceed **200** [175] percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(14) pregnant women who are not covered under (a) of this section and whose household income does not exceed **200** [175] percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(15) persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII).

*** Sec. 3.** AS 47.07 is amended by adding a new section to read:

Sec. 47.07.022. Extended medical assistance coverage for children; costs. (a) In addition to the persons specified in AS 47.07.020, a person who resides in the state and who meets the criteria under (b) of this section is eligible for extended medical assistance coverage equivalent to the mandatory and optional services described under AS 47.07.030 if the person submits an annual application and contribution as specified in (c) of this section.

(b) The department shall administer a program of extended medical assistance coverage for a person

(1) who is under 19 years of age;

(2) whose household income is between 200 and 300 percent of the federal poverty guideline as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2); and

(3) whose parent or legal guardian certifies that the person is not covered under a health insurance policy.

(c) The program administered under this section must include an annual

application and sliding scale contribution, payable under terms specified in regulations adopted by the department. The regulations must

(1) include the option of an assignment of an applicant's permanent fund dividend and the permanent fund dividend of a parent, legal guardian, or other authorized representative of an applicant; and

(2) set the annual contribution amount between $240 and $1,200, beginning with $240 for a person whose household income is between 201 percent and 225 percent of the federal poverty guideline and increasing progressively based on the person's household income.

*** Sec. 4.** AS 47.07.042(d) is amended to read:

(d) In addition to the requirements established under (a) and (b) of this section, the department **shall** [MAY] require premiums or cost-sharing contributions from recipients who are eligible for benefits under **AS 47.07.022. The** [AS 47.07.020(b)(13) AND WHOSE HOUSEHOLD INCOME IS BETWEEN 150 AND 175 PERCENT OF THE FEDERAL POVERTY LINE. IF THE DEPARTMENT REQUIRES PREMIUMS OR COST-SHARING CONTRIBUTIONS UNDER THIS SUBSECTION, THE] department

(1) shall adopt in regulation a sliding scale for those premiums or contributions based on household income;

(2) may not exceed the maximums allowed under federal law; and

(3) shall implement a system by which the department or its designee collects those premiums or contributions.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of secs. 1 - 4 of this Act.

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONTINGENT EFFECT. Sections 2 - 4 of this Act take effect only if, before

January 1, 2011, the United States Department of Health and Human Services has approved all the changes in secs. 2 - 4 and provided sufficient funding for the changes.

*** Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

NOTIFICATION OF REVISOR. The commissioner of health and social services shall notify the revisor of statues of whether the United States Department of Health and Human Services has approved and provided funding for all the changes in secs. 2 - 4 of this Act before January 1, 2011.

*** Sec. 8.** Section 5 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 9.** Except as provided in sec. 8 of this Act, this Act takes effect January 1, 2011.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 9, 2009

SUBJECT: Sectional Summary (Work Order No. 26-LS0425\R)

TO: Senator Bill Wielechowski
Attn: Michele Sydeman

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Provides a short title for the bill.

Section 2. Amends optional medical assistance provisions for persons under 19 years of age and for pregnant women to increase an income eligibility standard in relation to the federal poverty guideline.

Section 3. Requires the Department of Health and Social Services to administer a program to extend mandatory and optional medical assistance coverage for persons under 19 years of age whose household income is above sec. 2's limits but below a set percentile range of the federal poverty guideline, and imposes contribution and copayment amounts for the coverage.

Section 4. Requires the Department of Health and Social Services to set premium and cost-sharing contributions for persons under 19 years of age and who meet eligibility criteria under sec. 3.

Section 5. Authorizes the Department of Health and Social Services to adopt regulations needed under the bill before the effective date of the bill.

Section 6. Makes secs. 2 - 4 effective only if the U.S. Department of Health and Social Services approves the changes made by those sections before January 1, 2011.

Section 7. Requires the Commissioner of the Department of Health and Social Services to notify the revisor of statutes of federal approval.

Section 8. Provides an immediate effective date for sec. 5.

Section 9. Provides a January 1 2011, effective date for secs. 1 - 4 and secs. 6 - 7.

JMM:ljw
09-075.ljw

ALASKA STATE LEGISLATURE

Co-chair, Joint Armed Services Committee
•
Co-chair, Resources Committee
•
Vice chair, Judiciary Committee
•
World Trade Committee

State Capitol, Rm. 115
Juneau, AK 99801
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SENATOR BILL WIELECHOWSKI

January, 26 2009

2/4

Senator Bettye Davis, Chair
Senate HESS Committee
Room 30, State Capitol
Juneau, Alaska 99801

I am writing to request a hearing on SB 87, "An act expanding medical assistance coverage for eligible children and pregnant women; relating to cost sharing for certain recipients of medical assistance; and providing for an effective date."

The intent of this bill is to make health insurance accessible to all children in Alaska, while asking those families who can afford it to make a meaningful financial contribution towards their coverage.

S.B. 87 raises the eligibility limit for participation in Denali KidCare from 175% to 200% of the federal poverty level (FPL). This proposal puts Alaska in line with other states, 41 of which allow participation by families at or above 200% of the FPL. Alaska currently has one of the lowest eligibility rates in the nation.

This bill would also allow families with incomes up to 300% of the FPL to buy into Denali KidCare using a sliding fee scale. Many children from working families in Alaska are unable to afford private insurance and go without coverage, which results in poorer health and greater costs in the long-run. Premiums for coverage would range from $240 annually for a participants living at 201% of the FPL to $1,200 annually. In addition, a 20 % co-pay would be required for those living at 250% and greater of the FPL. Those with the greatest means would reimburse the state roughly 90% of program costs.

Thank you for your consideration of this request.

Sincerely,

Senator Bill Wielechowski

4201

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB087
() Publish Date:

Identifier (file name): SB087-DHSS-BHMS-02-06-09
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Behavioral Health Services
Component: Behavioral Health Medicaid Services
Sponsor: Wielechowski
Requester: Senate HSS
Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims			2,283.6	2,438.8	2,604.7	2,781.8	2,971.0
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**2,283.6**	**2,438.8**	**2,604.7**	**2,781.8**	**2,971.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts			1,289.9	1,370.0	1,463.1	1,562.6	1,668.9
1003 GF Match			993.6	1,068.9	1,141.6	1,219.2	1,302.1
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**2,283.5**	**2,438.9**	**2,604.7**	**2,781.8**	**2,971.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill raises the income level for existing categories of pregnant women and children under Denali Kidcare to 200% of federal poverty guidelines (FPG) and creates a new category of eligibility for children between 200 and 300% of FPG subject to premiums and co-payments. The bill makes most provisions effective on July 1, 2010.

More than 200 pregnant women and nearly 3,000 children will qualify for medical assistance under this bill. This fiscal note represents the portion of benefit costs paid through the Behavioral Health Medicaid Services component.

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 334-2520
Division: Health Care Services
Date/Time 2/4/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/6/2009
DHSS Finance Management Services

FISCAL NOTE

STATE OF ALASKA

BILL NO. SB087

2009 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

The Behavioral Health Medicaid Services component is allocated 1/3 of the total benefit costs for children (reduced by co-payments). Benefit costs for pregnant women and collections for premiums are reflected in another component (Medicaid Services).

Summary of All Components:
Total additional enrollment/year: 3,197 (2,979 children and 218 pregnant women)
Total additional benefit cost/year less premiums & co-payments: $6,365.6 ($3,657.2 fed/$1,483.0 GF/$1,225.4 SDPR)
Total premiums collected/year: $1,225.4 SDPR
Total co-payment offset/year: $547.7

Assumptions:
176-200% FPG (no cost-sharing): 1,277 children; $1,300 annual benefit cost per person; 65% federal match
176-200% FPG (no cost-sharing): 218 pregnant women; $2,934 annual benefit cost per person; 50% federal
201-250% FPG (premiums): 851 children; $2,780 annual benefit cost per person; 50% federal
251-300% FPG (premiums & co-payments): 851 children; $2,780 annual benefit cost per person; 50% federal

Requiring cost sharing may discourage enrollment. Half as many children in the groups that require premiums or co-payments will enroll compared to the group with no cost sharing. Native families with access to tribal providers will not choose to enroll their children because they can access health care services without paying premiums or making co-payments.

Children in the 176-200% FPG group are assumed to have an annual average cost similar to those in 151-175% FPG. Children above 200% are assumed to have an average cost similar to all Denali KidCare enrollees.

Uninsured children under age 19, between 201% and 300% of the prevailing FPG will be required to pay premiums to the state ranging between $240 and $1,200 per year per child. The average premium across all income groups is $720. Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service. Co-payments are payable to the health care provider at the time of service and offset benefit costs. Federal law limits total out-of-pocket expenses to 5% of household income and precludes cost sharing for certain services, such as family planning, hospice and emergency services. The ceiling on cost sharing is not a factor in calculations for this fiscal note. The annual cost per person is expected to be lower than the average out-of-pocket limit, however, some children will likely reach cost sharing limits.

Fund sources are based on historical federal collections. We assume the SCHIP allotment remains at the FFY2009 level. The SCHIP allotment, which receives 65% federal match, is sufficient to fund costs for the additional 1,277 children in the 176-200% FPG group. Costs for the remaining children will be reimbursed at the regular Medicaid match rate of 50%. Pregnant women are not eligible for SCHIP and all their costs will be reimbursed at 50%. Collections for premiums are statutory designated program reciepts. Co-payments are offsets to benefits. Benefit cost projections for 2012 through 2015 assume 6.8% annual growth.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB087
() Publish Date:

Identifier (file name): SB087-DHSS-MAA-02-06-09
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Health Care Services
Component: Medical Assistance Administration
Sponsor: Wielechowski
Requester: Senate HSS
Component Number: 242

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	83.0		332.0	332.0	332.0	332.0	332.0
Travel							
Contractual	159.4		162.6	162.6	162.6	162.6	162.6
Supplies	7.8		2.6				
Equipment	7.5		2.5				
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**257.7**	**0.0**	**499.7**	**494.6**	**494.6**	**494.6**	**494.6**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	128.9		249.9	247.3	247.3	247.3	247.3
1003 GF Match	128.8		249.8	247.3	247.3	247.3	247.3
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**257.7**	**0.0**	**499.7**	**494.6**	**494.6**	**494.6**	**494.6**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	3.0		4	4	4	4	4
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill raises the income level for existing categories of pregnant women and children under Denali Kidcare to 200% of federal poverty levels (FPL) and creates a new category of eligibility for children between 200% and 300% of FPL subject to premiums and copays.

The Division of Health Care Services estimates that it will need a total of 4 FTE's to collect and manage the premium collection and co-pay activities required by SB087.

Continued on Page 2

Prepared by: William Streur, Deputy Commissioner
Phone 334-2520
Division: Health Care Services
Date/Time

Approved by: Alison Elgee, Assistant Commissioner
Date 2/6/2009
DHSS Finance Management Services

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB087

ANALYSIS CONTINUATION

System enhancements to the MMIS will cost approximately $150,000. These changes would accommodate the new Federal Poverty Level indicator and co-pay requirements and would be a one time cost in FY2010.

There will be increased referrals to the Department of Law for collections and appeals, this will result in approximately $125,000 in the contractual line starting in FY2011.

The Division of Health care Services anticipates the the following caseload increase from the passage of SB087:

For 176%-200% FPG (no cost-sharing): 1,277 kids and 218 pregnant women.
For premiums at 201%-300% FPG and co-payments at 251%-300% FPG: 851 kids at 201%-250% FPG and 851 kids from 251%-300% FPG
Total SB87 coverage: 3,197

We estimate two Accounting Technician I's, and a Medical Assistant Administrator I position will be needed to manage this additional work beginning in FY2010. In FY2011 a Medical Assistant Administrator II will be needed. The new extended Medicaid program increases complexity of the eligibility determination work and results in increased contact with applicants and enrollees.

Total Administrative Costs:
The increase in Medicaid applications and caseload creates the need for two Accounting Technician I, a Medical Assistant Administrator I, and a Medical Assistant Administrator II, all located in Anchorage. These annual costs are estimated to be:

2 Accounting Technician I's, $142.0 (Range 12 at a cost of $71.0, including benefits, per position).
1 Medical Assistant Administrator I, $89.0 (Range 16 at a cost of $89.0, including benefits, per position).
1 Medical Assistant Administrator II, $101.0 (Range 18 at a cost of $101.0, including benefits, per position).

It is assumed that one quarter year's personal services funding will be needed in FY10 to hire and train staff, the two Accounting Technician I's and the one Medical Assistant Administrator I in the Accounting and Recovery section, at the cost of $100.2, in order to be able to accept applications and make eligibility determinations effective July 1, 2010. The Medical Assistant Administrator II will be filled in FY2011.

With the additional caseload, a one time supplies cost will be incurred in FY2010, for computers and software with a cost of $2.6 for each additional staff for a total of $7.8 for three staff hired in FY2010 and $2.6 in FY2011 for the 4th new position. Annual costs for office space, phones and other contractual costs are calculated at a cost of $9.4, per additional staff for a total of $37.6 (prorated for 1/4 year in FY2010).

One time costs for office furniture (chairs, cubicle partitions, and cubical funiture) for three positions in FY2010 is estimated at $2.5 per person for a total of $7.5. In FY2011 furniture costs is estimated at $2.5.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB087
() Publish Date:

Identifier (file name): SB087-DHSS-MS-02-06-09
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Health Care Services
Component: Medicaid Services
Sponsor: Wielechowski
Requester: Senate HSS
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims			4,082.1	4,443.0	4,828.5	5,240.1	5,679.8
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**4,082.1**	**4,443.0**	**4,828.5**	**5,240.1**	**5,679.8**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts			2,410.6	2,603.2	2,821.9	3,055.5	3,304.9
1003 GF Match			446.1	614.4	781.2	959.2	1,149.5
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts SDPR			1,225.4	1,225.4	1,225.4	1,225.4	1,225.4
TOTAL	**0.0**	**0.0**	**4,082.1**	**4,443.0**	**4,828.5**	**5,240.1**	**5,679.8**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill raises the income level for existing categories of pregnant women and children under Denali Kidcare to 200% of federal poverty guidelines (FPG) and creates a new category of eligibility for children between 200 and 300% of FPG subject to premiums and co-payments. The bill makes most provisions effective on July 1, 2010.

More than 200 pregnant women and nearly 3,000 children will qualify for medical assistance under this bill. This fiscal note represents the portion of benefit costs paid through the Medicaid Services component.

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 334-2520
Division: Health Care Services
Date/Time 2/4/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/6/2009
DHSS Finance Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB087

ANALYSIS CONTINUATION

Health Care Services, Medicaid Services component is allocated 2/3 of the total costs for children (reduced by co-payments), all of the costs for pregnant women, and all of the collections for premiums. The Medicaid services component is responsible for all collections of premiums for the entire Medicaid program.

Summary of All Components:
Total additional enrollment/year: 3,197 (2,979 children and 218 pregnant women)
Total additional benefit cost/year less premiums & co-payments: $6,365.6 ($3,657.2 fed/$1,483.0 GF/$1,225.4 SDPR)
Total premiums collected/year: $1,225.4 SDPR
Total co-payment offset/year: $547.7

Assumptions:
176-200% FPG (no cost-sharing): 1,277 children; $1,300 annual benefit cost per person; 65% federal match
176-200% FPG (no cost-sharing): 218 pregnant women; $2,934 annual benefit cost per person; 50% federal
201-250% FPG (premiums): 851 children; $2,780 annual benefit cost per person; 50% federal
251-300% FPG (premiums & co-payments): 851 children; $2,780 annual benefit cost per person; 50% federal

Requiring cost sharing may discourage enrollment. Half as many children in the groups that require premiums or co-payments will enroll compared to the group with no cost sharing. Native families with access to tribal providers will not choose to enroll their children because they can access health care services without paying premiums or making co-payments.

Children in the 176-200% FPG group are assumed to have an annual average cost similar to those in 151-175% FPG. Children above 200% are assumed to have an average cost similar to all Denali KidCare enrollees.

Uninsured children under age 19, between 201% and 300% of the prevailing FPG will be required to pay premiums to the state ranging between $240 and $1,200 per year per child. The average premium across all income groups is $720. Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service. Co-payments are payable to the health care provider at the time of service and offset benefit costs. Federal law limits total out-of-pocket expenses to 5% of household income and precludes cost sharing for certain services, such as family planning, hospice and emergency services. The ceiling on cost sharing is not a factor in calculations for this fiscal note. The annual cost per person is expected to be lower than the average out-of-pocket limit; however, some children will likely reach cost sharing limits.

Fund sources are based on historical federal collections. We assume the SCHIP allotment remains at the FFY2009 level. The SCHIP allotment, which receives 65% federal match, is sufficient to fund costs for the additional 1,277 children in the 176-200% FPG group. Costs for the remaining children will be reimbursed at the regular Medicaid match rate of 50%. Pregnant women are not eligible for SCHIP and all their costs will be reimbursed at 50%. Collections for premiums are SDPR. Co-payments are offsets to benefits. Benefit cost projections for 2012 through 2015 assume 6.8% annual growth.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB087
() Publish Date:

Identifier (file name): SB087-DHSS-PAFS-02-06-09
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Public Assistance
Component: Public Assistance Field Services
Sponsor: Wielechowski
Requester: Senate HSS
Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	237.0		948.1	948.1	948.1	948.1	948.1
Travel	3.8		15.0	15.0	15.0	15.0	15.0
Contractual	298.1		192.4	192.4	192.4	192.4	192.4
Supplies	3.0		23.5	23.5	23.5	23.5	23.5
Equipment	150.0						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**691.9**	**0.0**	**1,179.0**	**1,179.0**	**1,179.0**	**1,179.0**	**1,179.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	345.9		589.5	589.5	589.5	589.5	589.5
1003 GF Match	346.0		589.5	589.5	589.5	589.5	589.5
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**691.9**	**0.0**	**1,179.0**	**1,179.0**	**1,179.0**	**1,179.0**	**1,179.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	13.0		13.0	13.0	13.0	13.0	13.0
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation increases the income standards for covering children and pregnant women under Denali KidCare to 200% of the federal poverty level (FPL), up from 175%.

This legislation also provides new Medicaid coverage for children in higher income categories. To qualify, children must be under age 19, have no insurance coverage, and their family income must be between 200% and 300% of the FPL. Families will be required to pay premiums to the State of Alaska ranging between $240 and $1,200 per year per child. Families with income above 250% of the FPL will also be responsible for co-payments equal to 20% of the cost of their children's medical service, payable to the provider at the time of service.
(continued on next page)

Prepared by: Ellie Fitzjarrald
Phone (907) 465-5847
Division: Public Assistance
Date/Time 2/4/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/6/2009
DHSS Finance Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB087

ANALYSIS CONTINUATION

Assumptions:

This fiscal note represents the administrative costs for managing the increase in applications, customer service, and eligibility determinations associated with expanding medical assistance coverage for pregnant women and children up to 200% of poverty, and instituting a new program for higher income groups that includes cost sharing. In addition to determining eligiblity based on income and household size, division staff will be required to calcuate the amount of the household's premium obligation, make adjustments to premium payments when household income changes, inform households and the Division of Health Care Services of the amount to be collected, confirm payment of the premium before Medicaid benefits are issued and suspend eligibilty when premiums are not collected. The casework complexity involved with this Medicaid exansion creates the need for additional eligibility staff and administrative support. Lead staff will be needed to provide outreach to medical providers and community service providers and the public to explain the program, initially and ongoing. An analyst is needed for the development of policy and processes and the creation of systems and supports for expanded medical coverage .

We estimate 13 positions will be needed to support this Medicaid program expansion:
2 Administrative Support Staff to provide customer service, manage phone lines, and clerical support ;
5 Eligibility Technicians to make decisions on applications and calculate premiums;
4 Lead Eligibilty Techicians to perform statewide outreach, quality assurance, training on program rules, and other lead worker duties;
1 Eligibility Supervisor to oversee and manage the work of the new staff ; and
1 Public Assistance Analyst for the development and management of the program policy and procedures and creation of systems and supports for the expanded coverage.

Modifications to DPA's Eligibility Information System (EIS) will also be necessary to facilitate the exchange of information between the Division of Public Assistance and the Division of Health Care Services regarding the calculation and payment of premiums .

FY 11- FY15 Total Annual Administrative Costs: $1,179.0

Personal Services: 13 staff at an annual cost of $948.1 (includes salary and benefits)
Travel: $15.0 for statewide outreach activities.
Contractual: $192.4 annual cost for phones/lease ($14.8 x 13 staff)=$192.4.
Supplies: $23.5 which includes $12.0 for Denali KidCare identification cards, renewal forms, and notices; $5.0 for outreach materials; and $6.5 for office supplies ($0.5 x 13 staff = $6.5).

FY10 Start-Up Costs: $691.9

Personal Services: $237.0 One quarter year's funding will be needed in FY10 to hire and train staff in order to be able to accept applications and make eligibility determinations effective July 1, 2010.
Travel: $3.8 to start community , public, and provider awareness about the new program.
Equipment: $150.0 for one time purchases which include a multi-function printer and personal computers, software, and workstations, and associated costs for 13 staff ($20.0 plus $10.0 x 13 = $150.0).
Contractual: $298.1 which includes $250.0 for modifications to DPA's Eligibility Information System (EIS) and $48.1 for phones and space to locate the additional staff.
Supplies: $3.0 for printing applications, outreach materials and office supplies.

ALASKA STATE LEGISLATURE

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Member, World Trade Committee

SENATOR BILL WIELECHOWSKI

Sponsor Statement for SB 87: No Child Left Uninsured

The intent of SB 87 is to make health insurance accessible to all children in Alaska, while asking those families who can afford it to make a substantial financial contribution towards their coverage. By ensuring that all children have access to health services, SB 87 will reduce costs to the state and its citizens over the long run.

An estimated 18,000 children in Alaska lack health insurance and the number is growing. According to the Robert Wood Johnson Foundation, the number of children covered by private health insurance has declined by 31% in the last decade. The vast majority of these children are from working families.

Uninsured children have much higher health risks than do covered children. They are more likely to develop chronic illnesses such as asthma and diabetes and to suffer from acute conditions such as eye and ear infections. While many lack a regular doctor and don't receive preventative care, they are four times more likely than insured children to use emergency rooms when medical attention is needed.

The high cost of this emergency care is often borne by other Alaskans, including businesses that purchase health insurance for their employees. For example, Providence and Alaska Regional hospitals provided $89 million in uncompensated care in 2006. These costs are passed on to other hospital users through higher charges for medical services, which ultimately results in increased premiums. These costs could be reduced by insuring that all children have access to health insurance.

SB 87 raises the eligibility limit for participation in the Denali KidCare program to 200% of the federal poverty level (FPL), currently $36,000/year for a single parent and child. This change puts Alaska in line with other states, 41 of which allow participation by families at or above this level. Roughly 70% of the costs of this program are currently covered by the federal government.

SB 87 would also allow families with incomes up to 300% of the FPL to buy into Denali KidCare using a sliding fee scale for premiums and a 20% co-pay. Those with the greatest means would reimburse the state roughly 90% of its costs. Participants would have to certify that they don't have access to health insurance at work.

With the "No Child Left Uninsured Act," Alaska joins states from Idaho to Illinois that are working to ensure that all children have access to health insurance. Please support this critical legislation.

ALASKA STATE LEGISLATURE

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Co-chair, Resources Committee
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Vice chair, Judiciary Committee
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World Trade Committee

Falling Through the Cracks: The Unmet Health Needs of Alaska's Uninsured Children

- The number of uninsured children in Alaska is estimated to be 17,880 or 9% of the population 18 and under (Urban Institute and Kaiser Commission on Medicaid and the Uninsured).

- Over the last decade, Alaska has seen a large decline (31%) in the number of children covered by private health insurance (Robert Wood Johnson Foundation).

- Nationally, more than 80% of uninsured children are from working families (Kaiser Commission on Medicaid and the Uninsured).

- Uninsured children have much higher health risks than do covered children. They receive less preventative care and are diagnosed at more advanced stages of illness (Kaiser Commission on Medicaid and the Uninsured).

- Uninsured children are more likely to develop viral soar throats, eye and ear infections, serious dental problems, and chronic conditions such as asthma and diabetes. They are more than 5 times as likely as insured children to have an unmet need for medical care and 9 times more likely not to have a regular doctor. They are also 4 times more likely to use emergency rooms (*Pediatrics* 105 and 113; Care for Children, *New England Journal of Medicine* 330; The Urban Institute).

- Almost 1/3 of uninsured children received no medical treatment during a 1-year period between 2002 and 2003 (Health Affairs 23, no. 5, September/October 2004).

- Uninsured children are 25% more likely to miss school than insured children (Children's Defense Fund Minnesota). Continued illness affects school performance and, in the long run, workforce participation (Southern Institute on Children and Families). A National Institute of Medicine study indicates that lack of insurance results in lost national economic productivity of $65-$130 billion annually.

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World Trade Committee

Impact of the Uninsured on the Broader Population

- Hospitals often serve as primary care treatment facilities for those without access to other health care. Providence and Alaska Regional Hospitals in Anchorage report providing $89 million in uncompensated care in 2006. In 2005, the total cost of health care in Alaska for the uninsured (excluding costs paid out-of-pocket by the uninsured) was $125 million (Families USA).

- These costs are passed on to other Alaskans, businesses and government, raising premiums and out-of-pocket expenses for individuals, employers, and the State of Alaska.

- According to new research, private employers in Alaska pay an average of $1,466 more per family and $565 more per individual in health insurance premiums to cover the costs of health care for the uninsured. By 2010, this is expected to increases to $2,248 per family and $857 per individual (Families USA).

- The cost to the State of Alaska of providing health insurance for its 14,786 full-time, executive branch employees is estimated to be $18.9 million higher because health providers shift the cost of caring for the uninsured. (March 2006, Legislative Research Report).

- Some $17 billion is spent in the U.S. annually on unnecessary hospitalizations, according to a 2004 study in *Pediatrics*. The study, which surveyed parents and doctors of children admitted to the hospital, found that 13-46% of the admissions could have been avoided with better care at home or by primary care physicians.

- Nationally, individuals unable to pay medical bills are filing for bankruptcy at unprecedented rates. Between 1980 and 2001, medically driven bankruptcies increased 23 times (American Medical Association, 2005). Half of the 1.5 million American families that filed for bankruptcy in 2001 cited medical bills as the cause (Health Affairs, Feb. 2005).

- The pay-off from providing health insurance for low-income children is substantial. According to governing.com, "Immunizations, annual visits to a pediatrician, dental care, and screening for vision, hearing and developmental problems are all long-term money savers for the health care system as a whole." For example, every $1 spent on a mumps/measles/rubella shot, saves $26, according to Washington State Dept. of Health research.

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World Trade Committee

Background on Denali KidCare

- Denali KidCare provides health insurance for children through age 18 and pregnant women who meet income guidelines. There is no cost for eligible children, teens and pregnant women. However, youth who are 18 may be required to pay a limited amount for some services.

- Denali KidCare pays for doctor's visits; eye exams and glasses; dental cleanings and fillings; hearing tests and aids; hospital care; speech, physical and mental health therapy; substance abuse treatment; lab tests; prescription drugs; and other care.

- Roughly 7,600 children were covered by Denali KidCare as of December 2006.

- Prior to the passage of SB 105 in 2003 (which lowered the eligibility guidelines for the program) 4,992 children with family incomes between 151% and 200% of the federal poverty level (FPL) were covered. Since passage, 3,440 fewer children with family incomes between 151% and 200% of the FPL are enrolled.

- The cost per child of providing this coverage is about $1,300/year.

- In recent calls to private insurers, the cost of a health insurance plan for a family of 3 (pregnant woman with two children) ranged from $8,000-$17,000 annually. Unlike Denali KidCare, this coverage comes with a $500 deductible, 20% co-pay, and no vision, dental or hearing benefits.

- **Alaska has one of the lowest program eligibility rates in the nation** (175% of the FPL). Forty-one states allow participation by families at or above 200% of the FPL. Seven have rates at or above 300% of the FPL.

- The federal government currently reimburses 70% of the cost of the Denali KidCare program up to the state's allocated funding level. After that, the reimbursement rate declines to 58%.

- In fiscal year 2006, the cost of Denali KidCare (also known as the State Children's Health Insurance Program) was $25.9 million, of which $18.2 million was paid by the federal government.

Why Coverage for Pregnant Women is Important:

- Alaska has one of the nation's highest documented pregnancy-associated mortality ratios – 58 per 100,000 live births during 1990-1999 (DHSS). National data indicate that women who receive no prenatal care are at increased risk of pregnancy-related death.

- Only 58% of women in Alaska receive adequate prenatal care, compared with 75% nationally.

- Mothers having late or no prenatal care are more likely to have low birth weight or pre-term infants and are at increased risk for pregnancy-related mortality and complications of childbirth (DHSS).

- The average cost of hospital care for a premature baby was $75,000 in 2001, compared with $1,300 for a healthy, full-term infant. The March of Dimes Prenatal Data Center reports that premature babies cost about $13.1 billion annually.

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A Primer on the "No Child Left Uninsured" Act

- The intent of this bill is to make health insurance accessible to all children in Alaska, while asking those families who can afford it to make a meaningful financial contribution towards their coverage.

- The bill raises the eligibility limit for participation in Denali KidCare from 175% to 200% of the federal poverty level (FPL). This was the eligibility limit for the program until 2003, when SB 105 substantially lowered the limit.

- 200% of the FPL is currently $36,000/year for a single parent and child. The FPL is adjusted annually for inflation.

- This proposal puts Alaska in line with other states, 41 of which allow participation by families at or above 200% of the FPL. Seven states set the limit at or above 300% of the FPL. Alaska currently has one of the lowest eligibility rates in the nation.

- This bill would also allow families with incomes up to 300% of the FPL to buy into Denali KidCare using a sliding fee scale. Many children from working families in Alaska are unable to afford private insurance and go without coverage, which results in poorer health and greater costs in the long-run.

- Premiums for coverage would range from about $240-$1,200 annually depending on income. In addition, a 20% co-pay would be required. (This is still significantly less than the cost of comparable private health insurance.) Parents and/or guardians would have to certify that eligible children do not have other insurance coverage. Those with the greatest means would reimburse the state 90% of program costs.

- Several states have taken steps in recent years to ensure that all children have access to health insurance. For example, in Connecticut, uninsured children from families making 300% or more of the FPL can buy into "All Kids." In Illinois, coverage is available to any child that has been uninsured for 12 months or more, with the cost determined on a sliding scale basis. Similar proposals under are under consideration in Oregon, Wisconsin, Washington, California and New Mexico, among other states.

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Anchorage Daily News

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Bill boosts health care for children

CHIP: But final approval of measure remains uncertain.

By GEORGE BRYSON
gbryson@adn.com
(01/15/09 23:45:12)

More than 8,000 uninsured Alaska children could receive new health care benefits if a bill approved by the U.S. House on Wednesday is also approved by the Senate and signed into law next week as expected by then-newly inaugurated President Barack Obama.

The expansion of the State Child Health Insurance Program (CHIP), known in Alaska as Denali KidCare, could provide new health care coverage to more than 4 million uninsured kids nationwide, roughly half of all uninsured American children.

Almost half of the estimated 19,000 uninsured children in Alaska could be covered by the legislation too, according to an analysis by Families USA, a national nonprofit organization that advocates for high-quality, affordable health care for all Americans.

But that assumes that Alaska legislators in Juneau would be willing to provide the 35 percent matching funds for a program that would expand Denali KidCare coverage to families that earn up to 300 percent of the federal poverty level. Currently Alaska only provides coverage to families that earn up to 175 percent of the poverty threshold.

Created in 1997, CHIP provides health coverage to children in working families with incomes that are too high to qualify for Medicaid but too low to make private insurance affordable.

Legislation to reauthorize and expand the program was twice passed by Congress in 2007 -- with all three members of Alaska's congressional delegation voting in favor -- but President Bush vetoed both bills.

Obama, by comparison, released a statement Wednesday applauding House passage of the CHIP legislation and urged the Senate to quickly do the same -- "so that it can be one of the first measures I sign into law when I am president."

Alaska Congressman Don Young this week voted in favor of the House bill. "Economically we are going through some hard times now, and the health of our children should not suffer because of it," Young said.

On the Senate side, Republican Lisa Murkowski and Democrat Mark Begich are both expected to support the bill, which was approved Thursday by the Senate Finance Committee.

In remarks after her vote in favor of expanding the children's health care program a year ago, Murkowski said CHIP was necessary to ensure these children are not left out.

Recently sworn in as the state's junior senator after his close victory over longtime Alaska Sen. Ted Stevens, Begich campaigned on a platform that explicitly called for expanding Denali KidCare, which also provides health care to low-income pregnant women. Passage of the child health bill

would provide $32.3 billion over four years to continue coverage for seven million children currently covered by the program and to extend coverage to four million more.

Find George Bryson online at adn.com/contact/gbryson or call 257-4318.

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SB 96

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/4/09

FURTHER: (Judiciary) Finance

Date of 5-Day Notice: 2/19/09
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/2/09

Health and Social Services Committee considered SENATE BILL NO. 96

SB 96 CHILD SUPPORT/ CASH MEDICAL SUPPORT

"An Act relating to nonpayment of child support; relating to certain judicial and administrative orders for medical support of a child; relating to periodic review and adjustment of child support orders; relating to relief from administrative child support orders; relating to child support arrearages; relating to medical support of a child and the Alaska Native family assistance program; amendir . Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 96 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
REV	12/12			✓	1

PRI[illegible]US FISCAL NOTE(S):

De[illegible]ent	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
[signature]	PASKVAN	X			
[signature]	Thomas			✓	
[signature]	ELLIS			X	
CHAIR: [signature]	DAVIS	X			

SENATE COMMITTEE REPORT

DATE: 3/3/09

FURTHER: (Finance)

DATE TURNED IN TO OFFICE: 3/16/09

Judiciary Committee considered SENATE BILL NO. 96

SB 96 CHILD SUPPORT/ CASH MEDICAL SUPPORT

"An Act relating to nonpayment of child support; relating to certain judicial and administrative orders for medical support of a child; relating to periodic review and adjustment of child support orders; relating to relief from administrative child support orders; relating to child support arrearages; relating to medical support of a child and the Alaska Native family assistance program; amending Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

and recommends:

[✓] be ~~replaced~~ previous with [ ] **SCS** or [✓] **CS** SB 96 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
REV	12/15/08			✓	

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
Jane Therriault	THERRIAULT			✓	
	Wielechowski			✓	
	Wielechowski			✓	
CHAIR:	French	✓			

26-LS0485\P
Mischel
4/7/09

CS FOR SENATE BILL NO. 96( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

A BILL

FOR AN ACT ENTITLED

"An Act relating to nonpayment of child support, to the definition of the term "state" for the purposes of the Uniform Interstate Family Support Act, to certain judicial and administrative orders for medical support of a child, to periodic review and adjustment of child support orders, to relief from administrative child support orders, to child support arrearages, and to medical support of a child and the Alaska Native family assistance program; amending Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DEFINITION OF "STATE"; LEGISLATIVE INTENT. (a) It is the intent of the legislature that in order to bring Alaska into conformity with the nationwide Uniform Interstate Family Support Act (UIFSA), as approved by the American Bar Association on

February 9, 1993, and as in effect on August 22, 1996, including any amendments officially adopted as of that date by the National Conference of Commissioners on Uniform State Laws, it is necessary to amend AS 25.25.101 to include "an Indian tribe" and "the United States Virgin Islands" in the definition of "state."

*** Sec. 2.** AS 11.51.122(a) is amended to read:

(a) A person commits the crime of aiding the nonpayment of child support in the second degree if the person knows that an obligor has a duty under an administrative or judicial order for periodic payment of child support, **for cash medical support,** or for the provision of health care coverage for a child under a medical support order **or a cash medical support order, or both** and

(1) being a person with a statutory duty to disclose information to a child support enforcement agency intentionally withholds the information when it is requested by a child support enforcement agency;

(2) being an employer of the obligor, intentionally withholds information about the residence or employment of the obligor, the eligibility of the obligor's children for coverage under the employer's health insurance plan, or the cost of the coverage of the children under the plan, when that information is requested by a child support enforcement agency or when the employer is required by state or federal law to report the information without a request by a child support enforcement agency; or

(3) intentionally participates in a commercial, business, employment, or other arrangement with the obligor, knowing at the time that the arrangement is made that it will allow the obligor to avoid paying all or some of the support when it is due or to avoid having a lien placed on assets for the payment of delinquent support; receipt of a substantial asset for less than fair market value from an obligor after the obligor's support order has been established constitutes a rebuttable presumption that the person receiving the asset knew that the transfer would allow the obligor to avoid paying all or some of the support or to avoid having a lien placed on the asset.

*** Sec. 3.** AS 25.25.101(19) is amended to read:

(19) "state" means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, **the United States Virgin Islands**, or

any territory or insular possession subject to the jurisdiction of the United States; the term "state" includes **an Indian tribe and** a foreign jurisdiction that has enacted a law or established procedures for issuance and enforcement of support orders that are substantially similar to the procedures under this chapter or under the Uniform Reciprocal Enforcement of Support Act or the Revised Uniform Reciprocal Enforcement of Support Act;

*** Sec. 4.** AS 25.27.060(c) is amended to read:

(c) In a court or administrative proceeding where the support of a minor child is at issue, the court or agency, as applicable, may order either **parent** or both parents to pay the amount necessary for support, maintenance, nurture, and education of the child. Regardless of whether a support order for periodic payments is issued, the court or agency shall issue a medical support order**, a cash medical support order, or both**. The medical support order shall require health care insurance coverage for the child if health care insurance coverage is available to either parent **or both parents** for the child at a reasonable cost. The court or agency shall consider whether the child is eligible for services through the Indian Health Service or other insurance coverage before ordering either parent **or both parents** to provide health care coverage through insurance**, cash medical support,** or other means **or a combination of insurance, cash medical support, or other means**. The court or agency shall allocate equally the cost of health care insurance for the child between the parents unless there is good cause to allocate the costs unequally. If the obligor has the duty to make periodic payments for non-medical child support, the obligor's periodic payments shall be decreased by the amount of the other parent's portion of payments for health insurance ordered by the court or agency and actually paid by the obligor. If the obligor has a duty to make periodic payments for non-medical child support, the periodic payments shall be increased by the obligor's portion of payments for health insurance if the other parent is ordered to and actually does obtain and pay for insurance. The court or agency shall allocate equally between the parents the cost of reasonable health care expenses not covered by private insurance unless there is good cause to allocate the costs unequally. One parent shall reimburse the other parent for the first parent's share of the uncovered expenses paid by the parent within 30 days after receipt by the first

parent of the bill for the health care, payment verification, and, if applicable, a health insurance statement indicating what portion of the cost is uncovered. The medical support order must meet the requirements of AS 25.27.063. Upon a showing of good cause, the court may order the parents required to pay support to give reasonable security for payments.

*** Sec. 5.** AS 25.27.160(c) is amended to read:

(c) If the agency is establishing only [A] medical support [ORDER], the notice and finding of financial responsibility must state

(1) that health care insurance shall be provided for the child to whom the duty of support is owed if health care insurance is available to the alleged obligor at a reasonable cost and that the alleged obligor and the other parent shall share equally the cost of the health care insurance and the costs of reasonable health care expenses not covered by insurance;

(2) **the sum of periodic payments of cash medical support for which either parent or both parents are found to be responsible under this chapter;**

(3) the name of the alleged obligee and the obligee's custodian;

(4) [(3)] that the alleged obligor may appear and show cause in a hearing held by the agency why the finding is incorrect, should not be finally ordered, and should be modified or rescinded, because

(A) no duty of support is owed;

(B) health care insurance for the child is not available to the alleged obligor at a reasonable cost;

(C) adequate health care is available to the child through the Indian Health Service or other insurance coverage; or

(D) there is good cause to allocate the costs of health insurance, **cash medical support,** or uninsured health care expenses unequally between the parents;

(5) [(4)] that, if the person served with the notice under this subsection does not request a hearing within 30 days, a copy of the medical support order will be sent to the person's employer under AS 25.27.063(b) without further notice or hearing

for inclusion of the child in family health coverage if it is available through the person's employer.

*** Sec. 6.** AS 25.27.193 is amended to read:

Sec. 25.27.193. Periodic review or adjustment of support orders. As necessary to comply with 42 U.S.C. 666, the agency, by regulation, shall provide procedures and standards for the modification, through **a three-year cycle of** [PERIODIC] review or adjustment, of a support order. Regulations adopted under this section must include procedures for periodic notice of the right to request review, procedures for hearings, and standards for adjustments regarding future periodic support payments. A modification under this section may be made without a showing of a material change in circumstances.

*** Sec. 7.** AS 25.27.195(a) is amended to read:

(a) A clerical mistake in an administrative order issued by the agency or an error arising from an oversight or omission by the agency may be corrected by the agency at any time [ON THE MOTION OF AN OBLIGOR].

*** Sec. 8.** AS 25.27.195(b) is amended to read:

(b) **The** [UPON THE MOTION OF AN OBLIGOR, THE] agency may, at any time, vacate an administrative support order issued by the agency under AS 25.27.160 that was based on a default amount rather than on the obligor's actual ability to pay.

*** Sec. 9.** AS 25.27.900(2) is repealed and reenacted to read:

(2) "arrearage" means a debt that is past due and equal to at least one monthly obligation under the support order for one or more of the following:

(A) monetary support;

(B) cash medical support;

(C) payment of health care costs or maintenance of health insurance;

(D) reimbursement of related costs;

(E) payment of attorney fees and legal costs and other fees;

(F) penalty, interest, and other relief as required by a support order;

*** Sec. 10.** AS 25.27.900(12) is amended to read:

(12) "support order" means any judgment, decree, or order that is issued by a tribunal for the support and maintenance of a child or of a parent with whom the child is living; "support order" includes a judgment, decree, or order

(A) on behalf of a child who has reached the age of majority if the judgment, decree, or order was lawfully issued; and

(B) for any or all of the following:

(i) monetary support, including arrearages;

(ii) payment of health care costs or maintenance of health insurance;

(iii) **payment of cash medical support;**

(iv) reimbursement of related costs;

(v) [(iv)] payment of attorney fees and legal costs and other fees; or

(vi) [(v)] penalty, interest, and other relief as required by a tribunal;

*** Sec. 11.** AS 47.07.025(b) is amended to read:

(b) Through the child support services agency or on its own behalf, the department may garnish the wages, salary, or other employment income of a person who

(1) is required by a medical support order**, cash medical support order, or both,** under AS 25.27.060(c) to provide **insurance or cash** coverage of the costs of medical care to a child who is eligible for medical assistance under this chapter;

(2) has received payment from a third party for the costs of the services; and

(3) has not used the payments to reimburse, as appropriate, the other parent or custodian of the child, the provider of the services, or the department.

*** Sec. 12.** AS 47.27.200(o) is amended to read:

(o) The applicability of AS 25.27 in the case of a recipient under an Alaska Native family assistance program includes the following:

(1) an obligor is liable to the Alaska Native family assistance program

in the amount of the family assistance provided by the program to a child to whom the obligor owes a duty of support except that, if a support order has been entered, the liability of the obligor for assistance provided by an Alaska Native family assistance program may not exceed the amount of support provided for in the support order, and, if a medical **support order, cash medical support order, or both,** [ORDER OF SUPPORT] has been entered, the liability of the obligor for assistance granted under AS 47.07 may not exceed the amount of support provided for in the medical **support order, cash medical support order, or both** [ORDER OF SUPPORT]; the child support services agency shall send notice of accruing liability under this paragraph in the same manner as required under AS 25.27.120(c), and, if the agency fails to comply with the notice requirement of this paragraph, interest does not accrue on the liability to the Alaska Native family assistance program unless a support order or medical support order**, or cash medical support order**, as applicable, has been entered;

(2) the child support services agency may appear in an action authorized under AS 25.27.045 at the agency's own discretion if an obligor under AS 25.27 is liable to the Alaska Native family assistance program under (1) of this subsection;

(3) an Alaska Native family assistance program to which the child support services agency erroneously disburses an overpayment of child support under an income withholding order is liable to the state for the amount disbursed, plus interest at the rate imposed under AS 25.27.062(*l*)(1);

(4) when the right to receive child support has been assigned to an Alaska Native family assistance program, an agreement under AS 25.27.065(a) that has not been adopted as an administrative order of the child support services agency is not effective during a period when the obligee is receiving assistance under an Alaska Native family assistance program;

(5) the child support services agency, on behalf of an Alaska Native family assistance program, shall take all necessary action permitted by law to enforce child support orders entered under AS 25.27, including petitioning the court for orders to aid in the enforcement of child support;

(6) if an obligor under AS 25.27 is liable to an Alaska Native family

assistance program under (1) of this subsection, the state is subrogated to the rights of the obligee to take actions authorized under AS 25.27.130(a);

(7) notwithstanding AS 25.27.130(c), the recovery of an amount for which an obligor under AS 25.27 is liable that exceeds the total assistance granted under AS 47.07 and this chapter shall be paid to the obligee;

(8) except as provided in AS 25.27.130(f), if an obligee under AS 25.27 is not receiving assistance under AS 47.07 or this chapter at the time the state recovers money in an action under AS 25.27.130(d) or (1) of this subsection, the recovery of any amount for which the obligor is liable shall be distributed to the obligee for support payments, including medical support payments, that had become due and unpaid since the termination of assistance under AS 47.07 or this chapter under a support order in favor of the obligee;

(9) after payment to the obligee under (8) of this subsection, the state may retain an amount not to exceed the total unreimbursed assistance paid on behalf of the obligee under AS 47.07 or this chapter;

(10) if an alleged obligor is liable to an Alaska Native family assistance program under (1) of this subsection, and a support order has not been entered, the child support services agency may, at its own discretion, undertake an action to establish paternity and a duty of support using the procedures prescribed in AS 25.27 and may enforce a duty of support using the procedures prescribed in AS 25.27; the agency may also institute administrative proceedings to determine the paternity of a child born out of wedlock upon application of an Alaska Native family assistance program; the agency may not recover costs of genetic tests required under this paragraph from a person who is a recipient of assistance under an Alaska Native family assistance program;

(11) when a hearing officer makes a determination under AS 25.27.170(d), the hearing officer shall, in addition to the factors described in AS 25.27.170(e), consider the amount of the alleged obligor's liability to an Alaska Native family assistance program under (1) of this subsection;

(12) notwithstanding AS 25.27.255(a), the child support services agency may not pay to an obligee any money that has been assigned to an Alaska

Native family assistance program.

*** Sec. 13.** The uncodified law of the State of Alaska is amended by adding a new section to read:

INDIRECT COURT RULE AMENDMENT. AS 25.27.060(c), amended by sec. 4 of this Act, has the effect of changing Rule 90.3, Alaska Rules of Civil Procedure, by changing standards for issuance of medical and other support orders by the court.

*** Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. This Act applies to actions filed on or after the effective date of this section and to motions filed on or after the effective date in proceedings filed before, on, or after the effective date of this section.

*** Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Revenue may proceed to adopt regulations necessary to implement this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before July 1, 2009.

*** Sec. 16.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONDITIONAL EFFECT. Section 4 of this Act takes effect only if sec. 13 of this Act receives the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

*** Sec. 17.** Section 15 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 18.** Except as provided in sec. 17 of this Act, this Act takes effect July 1, 2009.

Alaska State Legislature

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Senator Bettye Davis

3/30 - 1st hearing - Set aside

Date: 3/16/2009

To: Senator Stedman, Co-Chair
Senate Finance Committee

From: Senator Bettye Davis BD

Re: CS for SB 96 "An act relating to nonpayment of child support, to the definition of the term "state" for the purposes of the Uniform Interstate Family Support Act, to certain judicial and administrative orders for medical support of a child, to periodic review and adjustment of child support orders, to relief from administrative child support order, to child support arrearages, and to medical support of a child and the Alaska Native family assistance program: amending Rule 90.3, Alaska Rules of civil Procedure; and providing for an effective date."

This is a request that you schedule a hearing on CS for SB 96 at the earliest possible date.

Please find attached a copy of the CS for SB 96, the bill, a sponsor statement, a fiscal note and a sectional analysis. Your attention to this request would be appreciated. Thank you.

26-LS0556\C~~B~~
Mischel
4/116/09

CS FOR SENATE BILL NO. 105(HSS~~EDC~~)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES~~EDUCATION~~ COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, Ellis

A BILL

FOR AN ACT ENTITLED

"An Act relating to continuing the secondary public education of a homeless student; relating to the purpose of certain laws as they relate to children; relating to tuition waivers and medical assistance for a child placed in out-of-home care by the state; relating to foster care; relating to children in need of aid; and relating to out-of-home care transition to independent living."

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

*** Section 1.** AS 14.03 is amended by adding a new section to read:

Sec. 14.03.096. Continuing the public education of a homeless student. (a) Except as provided in (b) and (d) of this section, the governing body of a school district shall comply with the requirements for continuing the public education of a homeless student in the student's school of origin and for providing comparable education and transportation services for the remainder of the current school year or, if the student is attending school for a summer term, for the remainder of the summer

term, under 42 U.S.C. 11431 - 11435 (McKinney-Vento Homeless Education Assistance Improvement Act of 2001), as those provisions existed on February 1, 2009.

(b) The requirements in (a) of this section do not apply if the student moves to a school district other than the school district in which the student's school of origin is located.

(c) If a homeless student is transferred to a school other than the student's school of origin, the school of origin shall provide a copy of the student's records to the student's new school within seven~~7~~ school days after notification of the transfer. The student's new school shall allow the student to attend school while awaiting the transfer of records under this subsection.

(d) A school district is required to comply with this section only

(1) if the legislature appropriates funds for the purpose; and

(2) to the extent possible using funds appropriated for the purpose.

(e) In this section,

(1) "homeless student" has the meaning given in 42 U.S.C. 11434a for "homeless child or youth," and the phrase "awaiting foster care placement" in that definition shall be interpreted to include all students who are placed in out-of-home care and in the custody of the Department of Health and Social Services under AS 47.10.080(c) or who are committed to the custody of the Department of Health and Social Services under AS 47.12.120(b)(1) or (3);

(2) "school of origin" means the school in which the student was last enrolled.

*** Sec. 2.** AS 14.43 is amended by adding a new section to read:

Article 3A. Free Tuition for a Person Who Was in Out-of-Home Care.

Sec. 14.43.086. Free tuition and fees for a person who was in out-of-home care. (a) A person who enrolls as a student in good standing in a state-supported educational institution in the state is entitled to a waiver of tuition, fees, and room and board expenses if the person provides adequate proof that the person

(1) was in the custody of the state under AS 47.10 or AS 47.14;

(2) was placed in out-of-home care for a period of not less than six

consecutive months on or after the person became 16 years of age; and

(3) is under 29 years of age.

(b) The amount of the waiver to which a person is entitled under this section is the amount of unmet need for tuition, room, and board expenses, as determined by the institution~~commission~~, after deducting funding for the school year from education loans, grants, or scholarships received by a person eligible for a waiver.

(c) The proceeds of an education loan, grant, or scholarship received by a person eligible for a waiver under this section must be paid to the educational institution to offset the person's tuition, fees, and room and board expenses.

(d) A state-supported educational institution in the state is required to provide a waiver under (a) of this section only if the legislature appropriates funds for the purpose of offsetting waivers under this section. If an appropriation is not sufficient to fully offset waivers for each person entitled to a waiver under (a) of this section, the institution may offer full or partial waivers to eligible applicants as funding permits and at the discretion of the institution.

(e) In this section, ~~* Sec. 3. AS 14.43.160 is amended by adding a new paragraph to read:~~

~~(7)~~ "out-of-home care" has the meaning given in AS 47.14.400.

*** Sec. 34.** AS 36.30.850(b)(42) is amended to read:

(42) grants and contracts with qualified entities for services under AS 47.18.330 for the **out-of-home** [FOSTER] care transition program;

*** Sec. 4.5.** AS 47.05.060 is amended to read:

Sec. 47.05.060. Purpose and policy relating to children. The purpose of this title as it relates to children is to secure for each child the care and guidance, preferably in the child's own home, **as well as an adequate education,** that will serve the moral, emotional, mental, **intellectual,** and physical welfare of the child and the best interests of the community; to preserve and strengthen the child's family ties unless efforts to preserve and strengthen the ties are likely to result in physical or emotional damage to the child, removing the child from the custody of the parents only as a last resort when the child's welfare or safety or the protection of the public cannot be adequately safeguarded without removal; and, when the child is removed from the family, to secure for the child adequate custody**, education,** and care and

adequate planning for permanent placement of the child.

*** Sec. 5.~~6.~~** AS 47.05.065 is amended to read:

Sec. 47.05.065. Legislative findings related to children. The legislature finds that

(1) parents have the following rights and responsibilities relating to the care and control of their child while the child is a minor:

(A) the responsibility to provide the child with food, clothing, shelter, education, and medical care;

(B) the right and responsibility to protect, nurture, train, and discipline the child, including the right to direct the child's medical care and the right to exercise reasonable corporal discipline;

(C) the right to determine where and with whom the child shall live;

(D) the right and responsibility to make decisions of legal or financial significance concerning the child;

(E) the right to obtain representation for the child in legal actions; and

(F) the responsibility to provide special safeguards and care, including appropriate prenatal and postnatal protection for the child;

(2) it is the policy of the state to strengthen families and to protect children from child abuse and neglect; the state recognizes that, in some cases, protection of a child may require removal of the child from the child's home; however,

(A) except in those cases involving serious risk to a child's health or safety, the Department of Health and Social Services should provide time-limited family support services to the child and the child's family in order to offer parents the opportunity to remedy parental conduct or conditions in the home that placed the child at risk of harm so that a child may return home safely and permanently; and

(B) the state also recognizes that when a child is removed from the home, visitation between the child and the child's parents or guardian and family members reduces the trauma for the child and enhances the likelihood

that the child will be able to return home; therefore, whenever a child is removed from the parental home, the Department of Health and Social Services should encourage frequent, regular, and reasonable visitation of the child with the child's parent or guardian and family members;

(3) it is the policy of the state to recognize that, when a child is a ward of the state, the child is entitled to reasonable safety, adequate care, and adequate treatment and that the Department of Health and Social Services as legal custodian and the child's guardian ad litem as guardian of the child's best interests and their agents and assignees, each should make reasonable efforts to ensure that the child is provided with reasonable safety, adequate care, and adequate treatment for the duration of time that the child is a ward of the state;

(4) it is in the best interests of a child who has been removed from the child's own home for the state to apply the following principles in resolving the situation:

(A) the child should be placed in a safe, secure, and stable environment;

(B) the child should not be moved unnecessarily;

(C) a planning process should be followed to lead to permanent placement of the child;

(D) every effort should be made to encourage psychological attachment between the adult caregiver and the child;

(E) frequent, regular, and reasonable visitation with the parent or guardian and family members should be encouraged; [AND]

(F) parents and guardians must actively participate in family support services so as to facilitate the child's being able to remain in the home; when children are removed from the home, the parents and guardians must actively participate in family support services to make return of their children to the home possible; **and**

(G) the child should continue to attend the child's school of origin as provided under AS 14.03.096;

(5) numerous studies establish that

(A) children undergo a critical attachment process before the time they reach six years of age;

(B) a child who has not attached with an adult caregiver during this critical stage will suffer significant emotional damage that frequently leads to chronic psychological problems and antisocial behavior when the child reaches adolescence and adulthood; and

(C) it is important to provide for an expedited placement procedure to ensure that all children, especially those under the age of six years, who have been removed from their homes are placed in permanent homes expeditiously.

* Sec. 6.~~7.~~ AS 47.07.020(b) is amended to read:

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in **out-of-home care** [FOSTER HOMES] or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed $1,656 a month but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under 21 years of age who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(8) persons under 21 years of age and not covered under (a) of this section [,] who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under 21 years of age not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 - 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or

intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them;

(12) disabled persons, as described in 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under applicable federal regulations or guidelines, is less than 250 percent of the official poverty line applicable to a family of that size according to the United States Department of Health and Human Services, and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is not eligible under another provision of this section shall pay a premium or other cost-sharing charges according to a sliding fee scale that is based on income as established by the department in regulations;

(13) persons under 19 years of age who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(14) pregnant women who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(15) persons who have been diagnosed with breast or cervical cancer

and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII)**;**

(16) persons under 21 years of age who were in the custody of the department under AS 47.10 or AS 47.14 and who were placed in out-of-home care for a period of not less than six consecutive months on or after reaching 16 years of age.

* **Sec. 7.~~8.~~** AS 47.07.020 is amended by adding a new subsection to read:

(o) In this section, "out-of-home care" has the meaning given in AS 47.14.400.

* **Sec. 8.~~9.~~** AS 47.10.080(c) is amended to read:

(c) If the court finds that the child is a child in need of aid, the court shall

(1) order the child committed to the department for placement in an appropriate setting for a period of time not to exceed two years or in any event not to extend past the date the child becomes 19 years of age, except that the department or the child's guardian ad litem may petition for and the court may grant in a hearing

(A) one-year extensions of commitment that do not extend beyond the child's 19th birthday if the extension is in the best interests of the child; and

(B) **one-year extensions of commitment that do not extend beyond the child's 21st birthday** [AN ADDITIONAL ONE-YEAR PERIOD OF STATE CUSTODY PAST 19 YEARS OF AGE] if the continued state custody is in the best interests of the person and the person consents to it;

(2) order the child released to a parent, adult family member, or guardian of the child or to another suitable person, and, in appropriate cases, order the parent, adult family member, guardian, or other person to provide medical or other care and treatment; if the court releases the child, it shall direct the department to supervise the care and treatment given to the child, but the court may dispense with the department's supervision if the court finds that the adult to whom the child is released will adequately care for the child without supervision; the department's supervision may not exceed two years or in any event extend past the date the child reaches 19 years of age, except that the department or the child's guardian ad litem may petition for and the court may grant in a hearing

(A) one-year extensions of supervision that do not extend

beyond the child's 19th birthday if the extensions are in the best interests of the child; and

(B) an additional one-year period of supervision past 19 years of age if the continued supervision is in the best interests of the person and the person consents to it; or

(3) order, under the grounds specified in (o) of this section or AS 47.10.088, the termination of parental rights and responsibilities of one or both parents and commit the child to the custody of the department, and the department shall report quarterly to the court on efforts being made to find a permanent placement for the child.

* **Sec. 9.~~10.~~** AS 47.10.080 is amended by adding a new subsection to read:

(v) A social worker employed by or under contract with the department shall, not less than monthly, conduct visits with a child committed to the custody of the department under (c) of this section. The visits must be of sufficient substance and duration to address issues pertinent to case planning and service delivery to ensure the child's safety, permanency, and well-being. The majority of the visits conducted under this subsection must be at the location of the child's current placement. Nothing in this paragraph creates a private right of action against the department or the department's contractors. In this subsection, "visit" means face-to-face contact between social worker and child.

* **Sec. 10.~~11.~~** AS 47.10.990(3) is amended to read:

(3) "child" means a person **who is**

(A) under 18 years of age**;**

(B) [AND A PERSON] 19 years of age if that person was under 18 years of age at the time that a proceeding under this chapter was commenced**; and**

(C) under 21 years of age if that person is living in out-of-home care;

* **Sec. 11.~~12.~~** AS 47.10.990 is amended by adding a new paragraph to read:

(33) "out-of-home care" has the meaning given in AS 47.14.400.

* **Sec. 12.~~13.~~** AS 47.18.300(a) is amended to read:

(a) The department, in coordination with local public and private agencies, shall design, develop, and implement **an out-of-home care** [A FOSTER CARE] transition program to provide support and services to individuals who

(1) reach or have reached the age of 16 or older while in state **custody and placed in out-of-home** [FOSTER] care and have not yet reached 23 years of age; and

(2) meet other eligibility criteria established by the department under (b) of this section.

*** Sec. 13.~~14.~~** AS 47.18.310 is amended to read:

Sec. 47.18.310. Program design. The department, in coordination with local public and private agencies, shall design the program as a continuation of the training efforts related to independent living skills that were initiated **for a child in state custody who was placed in out-of-home care and** [WHEN THE STATE FOSTER CARE RECIPIENTS WERE] identified as being likely to remain in **out-of-home** [STATE FOSTER] care until reaching **not less than** the age of 18. The program design must require that program participants are directly involved in identifying the program activities that will prepare them for independent living.

*** Sec. 14.~~15.~~** AS 47.18.320(a) is amended to read:

(a) Subject to the availability of an appropriation made for the purposes of AS 47.18.300 - 47.18.390, the program may provide

(1) education and vocational training;

(2) assistance in obtaining basic education and training;

(3) career and employment services;

(4) training in basic life skills;

(5) housing and utility assistance;

(6) mentoring and counseling; and

(7) other appropriate services to complement the efforts of former state foster care recipients **or a child who was in state custody and placed in out-of-home care** to achieve self-sufficiency.

*** Sec. 15~~16~~.** AS 47.18 is amended by adding a new section to read:

Sec. 47.18.335. Monetary living expense stipend. (a) The department shall

provide a monthly monetary living expense stipend for a period not to exceed nine months in an amount described in (b) of this section to an individual ~~eligible for services under the program~~ who

(1) has left out-of-home care at age 18 or older;

(2) is participating in services in the program; and

(3) has ~~a~~ monthly contact with a social worker involved in the program.

(b) A stipend provided under this section shall be in an amount necessary to meet an eligible individual's living expense as determined~~set~~ by the department. The amount may not exceed

(1) for the first six months of eligibility, ~~that is not more than~~ the daily rate provided to a licensed foster parent; or

(2) for a period not to exceed three additional months during the period that follows the first six months of eligibility, half of the daily rate provided to a licensed foster parent.

(c) The department shall pay the stipend provided under this section until the later of the date that the individual

(1) reaches 21 years of age; or

(2) has left out-of-home care for six months.

(d) ~~for necessary living expenses. The stipend shall continue for a period of not more than one year and shall end before the individual is 23 years of age.~~ The department may adopt regulations to implement this section.

*** Sec. 16~~17~~.** AS 47.18.390(1) is amended to read:

(1) "program" means the **out-of-home** [FOSTER] care transition program authorized under AS 47.18.300 - 47.18.390;

*** Sec. 17.~~18.~~** AS 47.18.390(3) is repealed and reenacted to read:

(3) "out-of-home care" has the meaning given in AS 47.14.400.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 16, 2009

SUBJECT: Definition of "state" in the Uniform Interstate Family Support Act (CSSB 96( ); Work Order No. 26-LS0485\E)

TO: Senator Bette Davis
Chair of the Senate Health and Social Services Committee
Attn: Lynda Zaugg

FROM: Donald M. Bullock Jr.
Legislative Counsel

Enclosed is a draft CS that includes the amended definition of "state" for purposes of the Uniform Interstate Family Support Act (UIFSA). The amended definition is in sec. 2 of the draft bill and is reflected in the title. Please review this draft carefully to ensure that it is consistent with your intent.

The definition of "state" in AS 25.25.101(19) is amended to include the United States Virgin Islands and Indian tribes. The amendment now encompasses all jurisdictions named in the definition of "state" in the UIFSA. Thus, the substance of the definition in AS 25.25.101(19) matches that in the UIFSA.

However, the definition in the amendment still varies from the most recent version of UIFSA that was last amended or revised in 2001.[1] The differences do not seem to be substantive, but you may wish to ask the Department of Law whether this is the time to align the definition of "state" in the state's version of UIFSA as closely as possible with the most recent official version of UIFSA.

If I may be of further assistance, please advise.

DMB:med
09-004.med

Enclosure

[1] The latest version of the UIFSA is published on the Internet at *http://www.law.upenn.edu/bll/archives/ulc/uifsa/final2001.pdf* (accessed Feb. 13, 2009). Federal law requires that UIFSA, as amended and as in effect on August 22, 1996, must be effective in each state. 42 U.S.C. 666. Thus the latest version of UIFSA is not required under current federal law.

Alaska State Legislature

Senator Bettye Davis, Chair
Senator Joe Paskvan, Vice Chair
State Capitol, Room 30
Juneau, Alaska 99801
Phone: (907) 465-3822
Fax: (907) 465-3756

Committee Members:
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

Senate Health & Social Services Committee

February 13, 2009

To: Legislative Legal

From: Lynda Zaugg, aide to Sen. Davis

Re: CS for ~~SB 96~~
#26-LS0485\R

Sen. Davis is requesting a CS for SB 96 to include the information attached under "Amendment" pg1 and pg2.

Attachments: DOL letter dated 2/9/09
"Amendment"

Alaska State Legislature

Senator Bettye Davis, Chair
Senator Joe Paskvan, Vice Chair
State Capitol, Room 30
Juneau, Alaska 99801
Phone: (907) 465-3822
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Attachments: DOL letter dated 2/9/09
"Amendment"

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

SARAH PALIN, GOVERNOR

1031 W 4TH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501-5903
PHONE: (907) 269-5100
FAX: (907) 278-3458

February 9, 2009

Honorable Bettye Davis
Senate
State Capitol
MS 3100, Room 30
Juneau, AK 99801-1182

RE: UIFSA Amendment
SB 96

Dear Senator Davis:

SB 96 is currently in the Senate Health and Social Services Committee. We are contacting you to request your assistance in adding an amendment to SB 96 (see attachment) that will ensure that Alaska continues to receive federal funding for child support programs. That funding amounted to 17 million dollars in the 08 fiscal year.

Specifically, we are proposing to amend a definition in Alaska's Uniform Interstate Family Support Act (AS 25.25.101(19)) in order to make Alaska's law consistent with the Uniform Act approved by the National Conference of Commissioners on Uniform State Laws. A brief explanation of the history of AS 25.25 will illustrate the issue.

In 1995, Alaska enacted a version of the Uniform Act that contained a different definition of "state" than contained in the Uniform Act. The following year, 1996, Congress passed legislation that mandated that States adopt the Uniform Act in order to be eligible to receive federal funding for child support programs. In Alaska's Uniform Interstate Family Support Act (UIFSA), the definition of "state" does not include two entities that are included in the Uniform Act. Those two entities are "the United States Virgin Islands" and "an Indian tribe." The amendment we are proposing would eliminate that difference.

I should also tell you that the State of Alaska recently requested a waiver from the U.S. Department of Health and Human Services concerning this issue. On January 29, 2009, we learned that our request had been denied. So, we are now in a

position where we must change the existing definition of "state" to conform to the Uniform Act, or risk losing our federal funds for child support programs.

We believe that the amendment does not constitute a substantive change to the jurisdiction of the State of Alaska in the area of child support programs. Specifically, it is our view that while enactment of the amendment is required in order to ensure that the State will continue to receive its share of federal child support funding, this change will not alter or diminish the authority of the State of Alaska in the area of child support programs.

That being said, if the amendment is enacted there is one difference that will result from this proposed change. Specifically, employers will be required to comply with income-withholding orders issued by an Indian tribe. I would note that in this context, "employer" includes all employers in Alaska, including the State of Alaska. The usual rights to contest the validity or enforcement of an order by an obligor would still apply to such an order.

The purpose of UIFSA is to unify state laws relating to child support orders, to provide efficient procedures for collecting child support in interstate cases, and to eliminate multiple support orders that were permitted under prior child support laws. We believe the proposed amendment is consistent with this purpose.

If have any questions on this matter please do not hesitate to contact me.

Sincerely yours,

TALIS J. COLBERG
ATTORNEY GENERAL

By: Stacy K Steinberg
Stacy K. Steinberg
Chief Assistant Attorney General

SKS/sks

26G-1
(2/09/2009)
(11:38 a.m.)

AMENDMENT

OFFERED IN THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

BY _____

TO: SB 96

Page 1, line 1, following "**support;**":

Insert:

"**relating to the definition of 'state' for purposes of the Uniform Interstate Family Support Act;**"

Page 2, following line 18:

Insert:

"*** Sec. 2.** AS 25.25.101(19) is amended to read:

(19) "state" means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, **the United States Virgin Islands,** or any territory or insular possession subject to the jurisdiction of the United States; the term "state" includes **an Indian tribe; and** a foreign jurisdiction that has enacted a law or established procedures for issuance and enforcement of support orders that are substantially similar to the procedures under this chapter or under the Uniform Reciprocal Enforcement of Support Act or the Revised Uniform Reciprocal Enforcement of Support Act;"

Renumber the following bill sections accordingly.

Page 8, line 16:

Delete "sec. 2"

Insert "sec. 3"

Page 8, line 31:

Delete "Section 2"

Insert "Section 3"

Delete "sec. 11"

Insert "sec. 12"

Page 9, line 3:

Delete "Section 13"

Insert "Section 14"

Page 9, line 4:

Delete "sec. 15"

Insert "sec. 16"

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/4/09

FURTHER: Judiciary
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: _____

Health and Social Services Committee considered SENATE BILL NO. 96

SB 96 CHILD SUPPORT/ CASH MEDICAL SUPPORT

"An Act relating to nonpayment of child support; relating to certain judicial and administrative orders for medical support of a child; relating to periodic review and adjustment of child support orders; relating to relief from administrative child support orders; relating to child support arrearages; relating to medical support of a child and the Alaska Native family assistance program; amending Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 96 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
REV	12/12			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	PASKVAN	X			
	Thomas			✓	
	ELLIS			X	
CHAIR:	DAVIS	X			

Putzier
4/16/09

AMENDMENT

OFFERED IN THE HOUSE FINANCE COMMITTEE

TO: HCS CSSB 96 (JUD)

Page 2, line 8, following "order.":

Delete "In adopting UIFSA conforming amendments, the legislature does not intend to grant or restrict tribal jurisdiction to enter, modify, or enforce child support orders, and the amendments are not intended, either directly or impliedly, to acknowledge, expand, or restrict tribal jurisdiction."

Insert "In adopting UIFSA conforming amendments, the legislative intent is

(1) to remain neutral on the issue of the underlying child support jurisdiction, if any, for the entities listed in the amended definition of "state";

(2) not to expand or restrict the child support jurisdiction, if any, of the listed "state" entities in the amended definition; and

(3) not to assume or express any opinion about whether those entities have child support jurisdiction either in fact or in law."

Sen. Bettye Davis

RECEIVED
APR 15 2009

From: Jessie Archibald [jarchibald@ccthita.org]
Sent: Wednesday, April 15, 2009 2:42 PM
To: Sen. Bettye Davis; Nancy Barnes; Rep. Reggie Joule; Kaci Schroeder; Kendra Kloster; Rep. Max Gruenberg; Rep. Beth Kerttula; anna.kim@alaska.gov; Rep. John Coghill; Rynnieva Moss
Cc: Robert Loescher; Jessie Archibald
Subject: Agreement on Intent provision for House CS for CS for SB No. 96 (JUD)
Attachments: peter.pdf; Newest 4-16-09 Legislative Testimony.doc

This e-mail is written for Bob Loesher:

Please find attached a communication from Peter Putzier, Alaska Department of Law, and proposed revisions to Section (b) intent language.

Additionally, please find attached our proposed testimony in support of the legislation when it is heard before the House Finance Committee at 1:30 p.m. this Thursday.

If the state attorney general and the administration is able to secure concurrence of this revision with other legislative parties, the Central Council would support a committee substitute amendment to the legislation as indicated in the attachments to this e-mail and in our newest draft testimony.

If you have any comments, questions, or concerns on this matter, we would appreciate it if you would call me at 723-8516 or reply to this e-mail.

Best Wishes,

Bob Loescher
Central Council Tlingit & Haida Tribal Judiciary Committee

Legislative Testimony

Robert Loescher
Tribal Judiciary Committee Member
Central Council Tlingit & Haida Indian Tribes of Alaska

HEARING: (H) FIN Apr 16 1:30 PM HOUSE FINANCE 519 TELECONFERENCE TELECONFERENCE

RE: House CS for CS for SB 96 (JUD)

My name is Bob Loescher. I am a member of the Central Council Tlingit & Haida Indians of Alaska Tribal Judiciary Committee. Our testimony today is in support of the enactment of House CS for CS for Senate Bill No. 96 (JUD) with a proposed revised and amended Section (b), as follows:

> (b) The proposed changes made in AS 25.25.101(19) under sec. 3 of this Act are conforming amendments that will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions. UIFSA does not determine the authority of an Indian tribe to enter, modify, or enforce a child support order. ~~In adopting UIFSA conforming amendments, the legislature does not intend to grant or restrict tribal jurisdiction to enter, modify, or enforce child support orders, and the amendments are not intended, either directly or impliedly, to acknowledge, expand, or restrict tribal jurisdiction.~~ In adopting UIFSA conforming amendments, the legislative intent is to remain neutral on the issue of the underlying child support jurisdiction, if any, for the entities listed in the amended definition of "state." This legislation will not expand or restrict the child support jurisdiction, if any, of the listed "state" entities in the amended definition, nor does this legislation assume or express any opinion about whether those entities have child support jurisdiction either in fact or in law.

Mr. Chairman and members of the committee, we request that you amend the legislation as proposed above. We fully support the enactment of this law with these revisions.

4253

Jessie Archibald

RECEIVED
APR 15 2009

From: Putzier, Peter K (LAW) [peter.putzier@alaska.gov]
Sent: Wednesday, April 15, 2009 1:23 PM
To: Jessie Archibald
Subject: SB 96
Attachments: Amended UIFSA Intent Language (proposed).doc

Jessi:

Thank you for meeting today to discuss SB 96. I found it helpful to hear directly from you and Mr. Loescher.

I understand that we have an agreement to the language in the attached document. I have included the deleted language, and the proposed addition, for your convenience. If you spot something that doesn't look right, please call me so we can fix it. (952-2034, or (temporary) office phone, 465-4927).

Thank you.

Peter Putzier
Assistant Attorney General
Email: peter.putzier@alaska.gov

The new intent language, subsection (b) would read as follows:

(b) The proposed changes made in AS 25.25.101(19) under sec. 3 of this Act are conforming amendments that will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions. UIFSA does not determine the authority of an Indian tribe to enter, modify, or enforce a child support order. ~~In adopting UIFSA conforming amendments, the legislature does not intend to grant or restrict tribal jurisdiction to enter, modify, or enforce child support orders, and the amendments are not intended, either directly or impliedly, to acknowledge, expand, or restrict tribal jurisdiction.~~ In adopting UIFSA conforming amendments, the legislative intent is to remain neutral on the issue of the underlying child support jurisdiction, if any, for the entities listed in the amended definition of "state." This legislation will not expand or restrict the child support jurisdiction, if any, of the listed "state" entities in the amended definition, nor does this legislation assume or express any opinion about whether those entities have child support jurisdiction either in fact or in law.

Sen. Bettye Davis

From: Jessie Archibald [jarchibald@ccthita.org]

Sent: Wednesday, April 15, 2009 8:52 AM

To: representative_reggie_joule@legis.state.ak.us; kaci_Schroeder@legis.state.ak.us; sen.bettye.davis@legis.state.ak.us; Nancy.Barnes@legis.state.ak.us; kendra_kloster@legis.state.ak.us; randall.ruaro@alaska.gov

Cc: Robert Loescher; Eddie Brakes; Jessie Archibald

Subject: Robert Loescher legislative testimony for House Finance

Importance: High

Attachments: T & H AMENDMENT.doc; T & H AMENDMENT CLEAN COPY (2).doc; New 3-14-09 Legislative Testimony.doc

To: Senator Bettye Davis
Representative Reggie Joule
Representative Bill Thomas
Representative Kathy Munoz

RECEIVED
APR 15 2009

This e-mail is written for Robert Loescher:

Attached is my revised position statement to be given at the House Finance Committee regarding the Tribe's objection to section (b) language. The hearing date is set for tomorrow at 1:30 p.m. Also attached is Central Council's counter proposal regarding this section. The first copy of the amendment shows what language we want inserted and language we want deleted. The second copy of the amendment is a clean copy of the amendment we wish to propose.

We truly request your support for our request to amend SB 96.

Jessie M. Archibald
Tribal Child Support Attorney
Central Council Tlingit and Haida
320 West Willoughby Ave. Suite 300
Juneau, Alaska 99801
Phone: (907) 463-7114
jarchibald@ccthita.org

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AMENDMENT

LS04585/C SB 96

Page 2, lin2 5:

Insert new subsection:

(b) The legislature recognizes that child support enforcement is a program of legislative policies and procedures developed and administered by federal, state and tribal entities that address the establishment of paternity and enforcement of support orders with UIFSA as the guide for the promotion of the general economic welfare in the best interest of dependent children, as required by the federal regulations. The proposed changes made in AS 25.25.101(19) under sec.3 of this Act are conforming amendments that will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions. UIFSA does not determine the authority of an Indian tribe to enter, modify, or enforce a child support order. ~~[In adopting UIFSA conforming amendments, the legislature does not intend to grant or restrict tribal jurisdiction to enter, modify, or enforce child support orders, and the amendments are not intended, either directly or impliedly, to acknowledge, expend, or restrict tribal jurisdiction.]~~

AMENDMENT

LS04585/C SB 96

Page 2, lin2 5:

Insert new subsection:

The legislature recognizes that child support enforcement is a program of legislative policies and procedures developed and administered by federal, state and tribal entities that address the establishment of paternity and enforcement of support orders with UIFSA as the guide for the promotion of the general economic welfare in the best interest of dependent children, as required by the federal regulations. The proposed changes made in AS 25.25.101(19) under sec.3 of this Act are conforming amendments that will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions. UIFSA does not determine the authority of an Indian tribe to enter, modify, or enforce a child support order.

Legislative Testimony

Robert Loescher
Tribal Judiciary Committee Member
Central Council Tlingit & Haida Indian Tribes of Alaska

HEARING: (H) FIN Apr 16 1:30 PM HOUSE FINANCE 519 TELECONFERENCE TELECONFERENCE

RE: SB 96 and HB 192 Section (b)

Before discussing specific objections to Section (b) language in SB 96 and HB 192, I would like to acknowledge support for SB 178, that requires the state administration's proposed amendment to amend the Alaska Employment Security Act to include a "federally recognized Indian tribe." Failure to bring Alaska in compliance by adding this amendment could result in the loss of up to 131 million dollars. Now if we look at the cost of failing to be in compliance with the child support statute, which is 85 million dollars, the cost of these two words "Indian Tribe" would total a 216 million dollar negative impact to the state's operating budget.

Here is the current language in SB 96 and HB 192 regarding legislative intent:

(b) The proposed changes made in AS 25.25.101(19) under sec. 3 of this Act are conforming amendments that will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions. UIFSA does not determine the authority of an Indian Tribe to enter, modify or enforce a child support order. [In adopting UIFSA, conforming amendments, the legislature does not intend to grant or restrict tribal jurisdiction to enter, modify, or enforce child support orders, and the amendments are not intended, either directly or impliedly, to acknowledge, expand, or restrict tribal jurisdiction.]

The above underlined and bracketed language is what the Central Council Tribe objects to.

Counter-Proposal:

1) Eliminate section (b) language. Accept the SB 96 Legislative intent language prior to insertion of (b) intent language.
2) Alternatively, delete the last sentence of section (b) and add the following language as a preface to (b):

"The legislature recognizes that child support enforcement is a program of legislative policies and procedures developed and administered by Federal, State and Tribal entities that address the establishment of paternity and enforcement of support orders with UIFSA as the guide for the promotion of the general economic welfare in the best interest of dependent children, as required by the federal regulations."

4259

Introduction:

First of all, we have a problem with the last sentence in section (b) because it states that the legislature does not acknowledge tribal jurisdiction. We object to this language because "Indian Tribes" do exist in Alaska.

Central Council Tlingit and Haida Indian Tribes of Alaska is a federally recognized tribe. By granting federal recognition, the U.S. government acknowledges that Central Council has the immunities and privileges available to all other federally recognized Indian Tribes by virtue of their government to government relationship with the United States as well as the responsibilities, powers and limitations and obligations of such tribes. Along with this federal recognition, Central Council possesses the inherent right and sovereignty to govern ourselves to oversee the internal affairs of tribal members and family matters, which we native people have exercised for thousands of years.

The Alaska State Supreme Court in **John v. Baker**, 982 P.2d 738 Alaska,1999. Sep 08, 1999 addressed this very issue:

Issue: Do Alaska Native Tribes have inherent, non-territorial sovereignty allowing them to resolve domestic disputes between their own members?

Held: Alaska Native tribes, by virtue of their inherent powers as sovereign nations, do possess inherent, non-territorial sovereignty to resolve domestic disputes between tribal members. State and tribal courts have concurrent jurisdiction so long as the children are members or eligible for membership with the Tribe.

Next, Central Council objects to the above bracketed and underlined language in SB 96 and HB 192 for the following reasons:

1. Overall purpose of UIFSA is to provide a procedural vehicle for efficient processing of interstate child support cases.

2. The problem with the underlined, bracketed sentence is that it appears to be "disclaimer" language. The concern is when the state CSSD sees this language, what will it do with our child support orders when we request services, such as PFD garnishment, or when we request CSSD to provide any other service that it should be providing to our child support program?

3. Will the State CSSD tell us "Sorry, we do not "acknowledge" your authority to establish, enforce or modify child support orders, so we will not provide this single action PFD

service." This is contrary to federal rules requiring states and Tribes to cooperate towards the common goal of providing child support.

4. This language will put Alaska out of compliance with the intent of the UIFSA requirement that the definition of State includes the word, "Indian Tribe." The federal regulations require states and tribes to cooperate to ensure children and families receive child support services in interstate cases.

5. There are two separate federal regulations that govern the relationship between states and tribes for child support services.

    a. 45 CFR 302 details the state plan requirement for states to cooperate with other states in interstate child support cases. Section 302.36(a) (2) was modified to require states to provide the full range of services available under its child support program to all Tribal federally funded child support programs.

    b. 45 CFR 309.120 provides that the Tribe must extend the full range of services available in its plan to respond to all requests from and cooperate with State and other Tribal federally funded programs.

6. The problem is the proposed "disclaimer" language included in the section (b) amendment sends mixed messages to the CSSD agency, telling them they can't provide the Tribe with the full range of services because CSSD cannot acknowledge the Tribe's authority to create, enforce or modify child support orders.

7. Does this mean that every time our agency wants assistance from the State, that the state CSSD will say, "Sorry, we cannot acknowledge you." Thus, specifically, we have difficulty with the inclusion of the word, "acknowledgement" in section (b). The State CSSD's answer should be, "Yes, we will provide your agency with the full range of services." If the answer is in the negative, "No, we cannot provide services" then the State will be out of compliance with federal regulations.

8. The consequence of leaving the intent language in section (b) would be that the state CSSD will be out of compliance with 45 CFR 302 if it will not provide Tribes with the full range of services that it must provide to all other States and Tribes with federally funded child support programs.

9. This harms children and families and is contrary to the very intent of federal funding for all child support programs. Central Council has already seen this happen by CSSD refusing to recognize the Tribe's child support orders for PFD garnishments. This PFD garnishment service was provided to all other states and Tribes, but CSSD refused to provide this service to the Central Council.

Conclusion:

In conclusion, we come before you to ask for an amendment to delete the above underlined and bracketed language in our testimony or in the alterative, to delete the last sentence of section (b) and insert the language from our counter-proposal number two.

AMENDMENT

OFFERED IN THE HOUSE

TO: HCS CSSB 96(JUD)

Page 2, line 11:

Delete "acknowledge, expand,"

Insert "expand"

to

Leg leg.

465-2029

4/13/09

from Lynch Zaugg
Sen B Davis's office.

Re. att- amendment.

Sen Davis - request another amendment - follow the att. words - except —
strike "acknowledge" in line 11 -

AMENDMENT

LS04585/C SB 96

BY COGHILL

Page 2, lin2 5:

Insert new subsection:

(b) The proposed changes made in AS 25.25.101(19) under sec. 3 of this Act are conforming amendments that will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions. UIFSA does not determine the authority of an Indian tribe to enter, modify, or enforce a child support order. In Alaska, the scope of tribal authority to enter, modify, or enforce a child support order is an unsettled legal question. In adopting UIFSA conforming amendments, the legislature does not intend to grant or restrict tribal jurisdiction to enter, modify, or enforce child support orders, and the amendments are not intended, either directly or impliedly, to acknowledge, expand, or restrict tribal jurisdiction.

delete

State of Alaska

Department of Revenue

Administrative Services Division

SARAH PALIN, GOVERNOR

333 Willoughby Avenue, 11th Floor

P.O. Box 110400

Juneau, Alaska 99811-0405

Phone: (907) 465-2300

Fax: (907) 465-2394

April 11, 2009

The Honorable Jay Ramras
Chair, Judiciary Committee
Alaska House of Representatives
Alaska State Capitol, Room 120
Juneau, AK 99801

Dear Representative Ramras;

There is only one difference between the Senate CS for SB 96 and the House CS for HB 192. On page 2 of both bills, Sec 1 included paragraph (a) of intent language but the Senate CS inadvertently left out paragraph (b) which is in CSHB 192 as follows:

"(b) The proposed changes made in AS 25.25.101(19) under sec. 3 of this Act are conforming amendments that will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions. UIFSA does not determine the authority of an Indian tribe to enter, modify, or enforce a child support order. In Alaska, the scope of tribal authority to enter, modify, or enforce a child support order is an unsettled legal question, due in part to the lack of Indian country in most of the state. In adopting UIFSA conforming amendments, the legislature does not intend to grant or restrict tribal jurisdiction to enter, modify, or enforce child support orders, and the amendments are not intended to either directly or impliedly, to acknowledge, expand, or restrict tribal jurisdiction."

The Department supports including this intent language in CSSB 96 if that bill is to pass (H)JUD and move to (H)FIN for further consideration

Thank you for working with us on this issue.

Sincerely,

V Blaisdell

Ginger Blaisdell
Director

Legislative Testimony

Jessie M. Archibald
Staff Attorney, Tribal Child Support Unit
Central Council Tlingit & Haida Indian Tribes of Alaska
320 West Willoughby Ave., Suite 300
Juneau, Alaska 99801
HEARING: (H) JUD Apr 13 8:00 AM CAPITOL 120 TELECONFERENCE

My name is Jessie Archibald. I represent the Central Council Tlingit and Haida Indian Tribes of Alaska Tribal child support program. I would like to request that my written testimony be entered into the record. The purpose of my testimony is to explain the Tribe's objection to the Section 1. (b) language regarding the Definition of "State"; Legislative Intent, contained in CS for House Bill 192 (HHS), and respectfully request that section (b) language be deleted.

Reasons for Objections:

1. Section (b) language is not necessary because UIFSA has built in procedures for the non-registrant to raise objections about the issuing tribunal's subject matter jurisdiction, personal jurisdiction, and other matters that may make a specific order not entitled to recognition and enforcement in Alaska's tribunals.

2. The language specifically segregates out tribal child support orders for particular scrutiny, and carries a not-very-thinly-veiled implication that that scrutiny should be hostile, and even suggests that the legislature is pre-judging the validity of an objection based on a lack of Indian country, essentially endorsing the principal that a child support obligor should able to duck a child support obligation by objecting on that basis. The legislature should leave those issues to the individual litigants and the courts.

3. Child support is hard enough without the legislature of the State of Alaska putting into the statutes language that allows deadbeat parents to use legislative intent language to try to get out from under from having to pay support.

As an alternative, the Tribe would like to propose the following legislative intent language:

Section 1. The uncodified law of the State of Alaska is amended by adding a new section to read:

DEFINITION OF "STATE": LEGISLATIVE INTENT. (a) ....

(b) The legislature recognizes that child support enforcement programs are administered by Federal, State and Tribal entities that address the establishment of paternity and enforcement of

4267

support orders with the intent of promoting the general economic welfare and the best interest of dependent children. UIFSA provides a vehicle for the non-registrant to raise objections about the issuing tribunal's subject matter jurisdiction, personal jurisdiction, and other matters that may make a specific order not entitled to recognition and enforcement in Alaska's tribunals. The intent of the legislature is that tribal child support orders should be subject to the same types of objections, and to the same extent, as child support orders from tribunals of other jurisdictions. It is the intent of the legislature is to provide a procedural vehicle for Tribal child support orders for such orders to be registered in Alaska state tribunals in the same manner child support orders from other tribunals are registered. This legislation is not intended to prejudge the validity of any specific order or the validity of any objections to a specific order.

Short Description of Central Council Tribe's Child Support Program

1. Initially, federal funding was only provided to States that operate federally funded and approved child support programs.

2. More recently, with the adoption of the Final Rule on Child Support Enforcement Programs at 45 CFR 309, federally recognized Indian Tribes became eligible to receive federal funding to operate their own child support programs.

3. With the adoption of the Final Rule, the enforcement of child support has now become a Federal-State-Tribal partnership.

4. To receive federal funding for child support, the Tribe is required to adopt a plan that meets the requirements outlined in 45 CFR 309 which is the Final Rule on Child Support Enforcement Programs.

5. Central Council received federal funding and approval to operate a Tribal Child Support Program in March of 2007.

6. When Alaska initially was required to adopt UIFSA, it did not include the definition of "State" to include an Indian Tribe.

7. Now that Alaska Tribes are beginning to receive federal funding to operate child support programs, it is necessary for Alaska to amend the State UIFSA in order to come into compliance with the rest of the nation.

8. Alaska stands alone as the only state that has not adopted the federal uniform guidelines that define "state" to include an Indian Tribe, probably because when Alaska first adopted the

federal version of UIFSA, it was not considered that Tribes would be receiving federal grants to operate child support programs.

9. The Tribal Child support program is located within the Tribe's Employment and Training Department. Our program is referred to as the "Tribal Child Support Unit."

10. The Tribe's goal is to ensure that Tlingit and Haida children receive the financial and emotional support of both their parents. The program strives to support and affirm the traditions of the Tribe and families. We believe that child support should be a reliable source of income for families. TCSU focuses its efforts on the needs of children, and in doing so, we empower parents to ensure their children's needs are met. Our program has a cooperative approach to establishing and enforcing support obligations.

11. Here are some statements we want to hear our children shout out:

- I'm playing football this year, thanks Dad!
- I made the basketball team, thanks Mom!
- Thanks Dad, I'm getting good grades in school!
- I'm playing soccer this year...thank you Mom!
- I'm going to camp this summer, thank you Dad!
- Even though you're not with me, I know you care! Thanks Mom!

End

AMENDMENT

LS0458/C SB 96

BY COGHILL

Page 2, lin2 5:

Insert new subsection:

(b) The proposed changes made in AS 25.25.101(19) under sec. 3 of this Act are conforming amendments that will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions. UIFSA does not determine the authority of an Indian tribe to enter, modify, or enforce a child support order. ~~In Alaska, the scope of tribal authority to enter, modify, or enforce a child support order is an unsettled legal question.~~ In adopting UIFSA conforming amendments, the legislature does not intend to grant or restrict tribal jurisdiction to enter, modify, or enforce child support orders, and the amendments are not intended, either directly or impliedly, to acknowledge, expand, or restrict tribal jurisdiction.

Change Passed

5 Y's
2 N's
Amdmt #1 pass.

CS 96 - ver C w amdmt #1

Jessi Archbald - attd. of Thyr/Hydra -

1) not necessary

2)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB 96 HCSCS(JUD)**
() Publish Date:

Identifier (file name): SB96 HCSCS(JUD)-DOR-CSS-04-13-09
Title: Cash Medical Support for Minor Children
Sponsor: Senate Health and Social Services Committee
Requester: House Finance Committee

Dept. Affected: Revenue
RDU: Child Support Services Division
Component: Child Support Services Division
Component Number: 111

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Debt Service							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1092 MHTAAR							
Bond Proceeds							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation does not require any additional funding.

Prepared by: John Mallonee
Division: Child Support Services Division
Phone: 269-6801
Date/Time: 4/02/2009 at 12:00 PM

Approved by: Ginger Blaisdell, Director
Administrative Services Division
Date: 4/13/2009

(Revised 9/10/2008 OMB)

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State of Alaska

Department of Revenue

Administrative Services Division

SARAH PALIN, GOVERNOR
333 Willoughby Avenue, 11th Floor
P.O. Box 110400
Juneau, Alaska 99811-0405
Phone: (907) 465-2300
Fax: (907) 465-2394

April 11, 2009

The Honorable Jay Ramras
Chair, Judiciary Committee
Alaska House of Representatives
Alaska State Capitol, Room 120
Juneau, AK 99801

Dear Representative Ramras;

There is only one difference between the Senate CS for SB 96 and the House CS for HB 192. On page 2 of both bills, Sec 1 included paragraph (a) of intent language but the Senate CS inadvertently left out paragraph (b) which is in CSHB 192 as follows:

"(b) The proposed changes made in AS 25.25.101(19) under sec. 3 of this Act are conforming amendments that will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions. UIFSA does not determine the authority of an Indian tribe to enter, modify, or enforce a child support order. ~~In Alaska, the scope of tribal authority to enter, modify, or enforce a child support order is an unsettled legal question,~~ due in part to the lack of Indian country in most of the state. In adopting UIFSA conforming amendments, the legislature does not intend to grant or restrict tribal jurisdiction to enter, modify, or enforce child support orders, and the amendments are not intended to either directly or impliedly, to acknowledge, expand, or restrict tribal jurisdiction."

The Department supports including this intent language in CSSB 96 if that bill is to pass (H)JUD and move to (H)FIN for further consideration

Thank you for working with us on this issue.

Sincerely,

Ginger Blaisdell
Director

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Date: 4/10/2009

To: Representative Ramras, Chair
House Judiciary Committee

From: Senator Bettye Davis

Re: CSSB 96 Child Support/Cash Medical Support

This is a request that you schedule a hearing on CSSB 96 at the earliest possible date.

Please find attached a copy of the bill, a sponsor statement, fiscal notes, and a sectional analysis. Your attention to this request would be appreciated. Thank you.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
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Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

SB 96

TITLE: "An Act relating to nonpayment of child support: relating to certain judicial and administrative orders for medical support of a child;."

FLOOR STATEMENT

SB 96 puts Alaska in compliance with the federal requirements which assures that Alaska's children receive the medical support to which they are entitled.

In addition, adoption of SB 96 assures 85 million in federal dollars to Alaska in funds for Child Support Enforcement and Tem. Assistance for Needy Families (TANF). I appreciate your support of this important bill.

SENATE COMMITTEE REPORT

DATE: 3/3/09

FURTHER: (Finance)

DATE TURNED IN TO OFFICE: 3/16/09

Judiciary Committee considered SENATE BILL NO. 96

SB 96 CHILD SUPPORT/ CASH MEDICAL SUPPORT

"An Act relating to nonpayment of child support; relating to certain judicial and administrative orders for medical support of a child; relating to periodic review and adjustment of child support orders; relating to relief from administrative child support orders; relating to child support arrearages; relating to medical support of a child and the Alaska Native family assistance program; amending Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

and recommends:

[✓] be ~~replaced~~ previous with [ ] **SCS** or [✓] **CS** SB 96 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
REV	12/15/08			✓	

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	THERRIAULT			✓	
	Wielechowski			✓	
	Wielechowski			✓	
CHAIR:	French	✓			

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/4/09

FURTHER: (Judiciary) Finance

Date of 5-Day Notice: 2/19/09
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/2/09

Health and Social Services Committee considered SENATE BILL NO. 96

SB 96 CHILD SUPPORT/ CASH MEDICAL SUPPORT

"An Act relating to nonpayment of child support; relating to certain judicial and administrative orders for medical support of a child; relating to periodic review and adjustment of child support orders; relating to relief from administrative child support orders; relating to child support arrearages; relating to medical support of a child and the Alaska Native family assistance program; amending Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 96 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
REV	12/12			✓	1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME:	DO PASS	DO NOT PASS	NO REC.	AMEND
	PASKVAN	X			
	Thomas			✓	
	ELLIS			X	
CHAIR:	DAVIS	X			

Lynda Zaugg

From: Steinberg, Stacy K (LAW) [stacy.steinberg@alaska.gov]
Sent: Friday, March 27, 2009 5:17 PM
To: Blaisdell, Ginger (DOR); Mallonee, John R (DOR); Putzier, Peter K (LAW); Lynda Zaugg
Subject: RE: SB 96 CSSD

Ginger:
The governor's office has summoned Peter and I to go to Juneau for the hearings. Peter's assistant is getting us plane and hotel reservations and arriving in Juneau Sunday evening.
Stacy

From: Blaisdell, Ginger (DOR)
Sent: Friday, March 27, 2009 5:13 PM
To: Mallonee, John R (DOR); Steinberg, Stacy K (LAW); Putzier, Peter K (LAW); Zaugg, Lynda (LAA)
Subject: FW: SB 96 CSSD

Darwin confirmed that the ANC LIO will be open on Monday.
Ginger

From: Blaisdell, Ginger (DOR)
Sent: Friday, March 27, 2009 4:40 PM
To: Peterson, Darwin R (LAA)
Subject: SB 96 CSSD

Linda Zaugg will introduce the bill and present the sponsor statement.

Calling in from the ANC LIO: can you confirm that it will be open on the holiday?

- John Mallonee, Director of Child Support Services Division
- Stacy Steinberg, Assistant AG, Department of Law, CSSD issue specialist
- Peter Putzier, Assistant AG, Department of Law, Tribal law specialist

I would like to come to the table to direct questions if that works for you.
Ginger

State of Alaska

Department of Revenue

Administrative Services Division

SARAH PALIN, GOVERNOR
333 Willoughby Avenue, 11th Floor
P.O. Box 110400
Juneau, Alaska 99811-0405
Phone: (907) 465-2300
Fax: (907) 465-2394

March 27, 2009

The Honorable John Coghill
Rules Chair, House of Representatives
Alaska State Capitol, Room 214
Juneau, AK 99801

Dear Representative Coghill;

In consideration of a letter of intent for HB 192 Child Support / Cash Medical, I am offering the following language that would clarify the changes to AS 25 and conform to Uniform Code.

> It is the intent of the legislature that in order to bring Alaska into conformity with the nationwide Uniform Interstate Family Support Act (UIFSA) as approved by the American Bar Association on February 9, 1993, and as in effect on August 22, 1996 including any amendments officially adopted as of such date by the National Conference of Commissioners on Uniform State Laws, it is necessary to amend AS 25.25.101 to include "an Indian tribe" and "the United States Virgin Islands" in the definition of "state."
>
> The proposed UIFSA amendments are conforming amendments which will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions. UIFSA does not determine the authority of an Indian tribe to enter, modify or enforce a child support order. In Alaska, the scope of tribal authority to enter, modify or enforce child support orders is an unsettled legal question, due in part to the lack of Indian country in most of the state. In adopting UIFSA conforming amendments, the legislature does not intend either to grant or restrict tribal jurisdiction, if any, which may exist to enter, modify, or enforce child support orders, and the amendments are not intended either directly or impliedly to acknowledge, expand or restrict tribal jurisdiction.

Thank you for working with us on this issue.

Sincerely,

Ginger Blaisdell
Director

DEPARTMENT OF HEALTH & HUMAN SERVICES

Administration for
Children and Families

2201 Sixth Avenue, RX-70
Seattle, WA 98121

MAR 27 2009

Mr. John Mallonee, Director
Child Support Services Division
550 West 7th Avenue, Suite 310
Anchorage, AK 99501

Dear Mr. Mallonee:

This is in response to your request for clarification of the potential Federal consequences if a State fails to enact laws to meet the State plan requirements with section 466(f) of the Social Security Act (the Act). The Act mandates that on and after January 1, 1998, each State must have in effect the Uniform Interstate Family Support Act (UIFSA), as approved by the American Bar Association on February 9, 1993, and as in effect on August 22, 1996, including any amendments officially adopted as of such date by the National Conference of Commissioners on Uniform States Laws. Specifically, Alaska State's UIFSA does not include Indian tribes in the definition of 'State'.

In order for a State to receive Federal funding for the operation of its child support enforcement program, it must have an approved State IV-D plan which meets the requirements of section 454 of the Social Security Act (the Act). One of those requirements, specified at section 454(20)(A), is that the State must have in effect all of the laws required by section 466.

When a State fails to comply with any statutory requirement, its plan is subject to disapproval by the Office of Child Support Enforcement (OCSE). In accordance with sections 452(a)(3) and 455(a)(1)(A) of the Act, there would then be no authority to expend Federal funds under Title IV-D to operate the State's child support enforcement program.

Therefore, a determination that a State IV-D plan is disapproved may result in immediate suspension of all Federal payments for the State's child support enforcement program, and such payments will continue to be withheld until the State IV-D plan can be approved by OCSE. This suspension includes the Federal share of administrative expenditures as well as any performance based incentive payments to the State.

In addition, in order to be eligible for a block grant for Temporary Assistance to Needy Families (TANF), section 402(a)(2) of the Act requires a State to certify that it will operate a child support enforcement program under the State plan approved under part D. Therefore, Alaska should be aware that TANF funds may also be at risk if the State does not enact conforming child support legislation.

4280

In Federal Fiscal Year (FFY) 2008, the Federal share of Alaska's IV-D expenditures was $14,657,800 and the State's TANF award amount was $46,732,590. In addition, Alaska received $1,794,516 in child support incentives for FFY 2007 (the latest year with available data).

We trust this statement of requirements and penalties clarifies our position. We are attaching our Action Transmittal 97-05 issued April 28, 1997 which outlines our procedures for determining that a State IV-D Plan is disapproved. Due to the gravity of the consequences that may result, we urge you to take all necessary steps to have the required UIFSA legislation enacted and implemented as soon as possible.

If you have any questions, please contact John Cheng at (206) 615-2566.

Sincerely,

Linda Gillett
Regional Program Manager, Region 10
Office of Child Support Enforcement

Enclosure: Action Transmittal 97-05

cc: Ms. Donna Bonar, Acting Commissioner, OCSE

PROGRAM INSTRUCTION

ACTION TRANSMITTAL

OCSE-AT-97-05

April 28, 1997

TO:STATE AGENCIES ADMINISTERING CHILD SUPPORT ENFORCEMENT PLANS APPROVED UNDER TITLE IV-D OF THE SOCIAL SECURITY ACT AND OTHER INTERESTED INDIVIDUALS

SUBJECT:Procedures for Determining That a State IV-D Plan is Disapproved

BACKGROUND:Title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), P.L. 104-193, made a number of amendments to sections 454 and 466 of the Social Security Act (the Act), requiring States to either establish new, or modify existing, procedures effective either October 1, 1996, March 1, 1997 or October 1, 1997. For States which require legislation in order to conform their State IV-D plans to the revised statute, section 395(b)(2) of PRWORA provides a grace period until not later than the 1st day of the 1st calendar quarter beginning after the close of the 1st regular session of the State legislature that begins after the date of enactment of PRWORA (August 22, 1996). In cases which require that the State constitution be amended, section 395(c) of PRWORA provides a grace period until one year after the effective date of the State constitutional amendment, but no later than five years after the date of enactment of PRWORA.

CSE is tracking the progress of each of the States in enacting the new State plan requirements and mandatory laws, and is noting the date when each State's 1997 legislative session ends in order to ascertain when these laws are required to be in effect and when the State must submit new or amended State plan material for approval by OCSE in order to operate a Child Support Enforcement program according to the requirements of title IV-D of the Act. If a State fails to submit the necessary State plan amendments, OCSE will have to determine that the State does not have an approvable State plan. A determination that a State IV-D plan is disapproved will result in immediate suspension of all Federal payments for the State=s child support enforcement program, and such payments will continue to be withheld until the State IV-D plan can be approved by OCSE.

STATUTORY

AUTHORITY:Section 455(a)(1)(A) of the Act specifies that funds appropriated under title IV-D shall be paid to States with approved State IV-D plans. There is no authority to expend Federal funds under title IV-D of the Act for the operation of a Child Support Enforcement program unless such State has an approved State IV-D plan.

Section 466 of the Act requires that all States, as a condition for approval of their State IV-D plan, must have in effect laws requiring the use of mandatory procedures to increase the effectiveness of their Child Support Enforcement programs. As a condition for State plan approval, section 454(20) of the Act provides that, to the extent required by section 466, States must have laws in effect and implement the procedures prescribed in or pursuant to such laws.

Section 454 of the Act sets the statutory requisites for the State IV-D plan. In addition, regulations at 45 CFR 301.10 define the State IV-D plan as a comprehensive statement submitted by the IV-D agency describing the nature and scope of its program. The State IV-D plan contains all the information necessary for the Office of Child Support Enforcement (OCSE) to determine whether the plan can be approved, as a basis for Federal financial participation in the State IV-D program.

Section 452(a)(3) of the Act requires that OCSE review and approve State plans for Child Support Enforcement programs under title IV-D of the Act. The authority to approve State plans is delegated to the Regional Office, but OCSE retains authority for determining that a State IV-D plan is not approvable.

As stated above, a determination that a State IV-D plan is disapproved will result in immediate suspension of all Federal payments for the State=s child support enforcement program, and such payments will continue to be withheld until the State IV-D plan can be approved by OCSE. If a State is dissatisfied with OCSE=s decision, reconsideration may be requested pursuant to 45 CFR 301.14. Withholding of Federal payments cannot be stayed pending reconsideration.

Section 402(a)(2) of the Act (as amended by PRWORA) provides that the chief executive officer of a State must certify that it will operate a child support enforcement program under an approved IV-D plan as a condition of eligibility for a TANF block grant under title IV-A of the Act. Therefore, States should be aware that TANF funds may also be at risk.

Although it is not required under Title IV-D of the Act, OCSE will give States an advance notice of "Intent to Disapprove" a previously approved State IV-D plan. The State will then be permitted the opportunity to waive reconsideration of the OCSE=s final decision and to exercise, prior to the State plan approval/disapproval decision, the right to a hearing under the procedures set forth a 45 CFR Part 213. If the State elects to pursue its hearing rights prior to issuance of OCSE's decision, no further administrative appeal will be allowed.

ATTACHMENT: Instructions for State Plan Disapproval

Timetable of Effective Dates

1997 Legislative Calendar

SUPERSEDED

MATERIAL: OCSE-AT-86-21

INQUIRIES: ACF Regional Administrators

/ S /

Anne F. Donovan

Acting Deputy Director

Office of Child Support Enforcement

Instructions for State Plan Disapproval

I. Notice of Intent to Disapprove

OCSE will issue a Notice of Intent to Disapprove a State Plan to the State umbrella agency head when it has been determined that either of the following situations exist:

Pursuant to the requirements at 45 CFR 301.13(d) the State IV-D plan no longer meets the requirements for an approved State plan based on relevant Federal statutes and guidelines.

Pursuant to the requirements at 45 CFR 301.13(e) or (f) the State IV-D plan or amendment submitted for approval does not meet the requirements under title IV-D of

the Act and regulations issued pursuant to the Act.

II. Notice Of Opportunity For Hearing

The Notice of Intent to Disapprove will provide opportunity for the State to request a hearing prior to the issuance of the final decision if the State waives its right to a reconsideration of OCSE's decision under 45 CFR 301.14. The State must request a hearing within 60 days of the date of the Notice of Intent to Disapprove. If the State does not request a hearing, OCSE shall proceed according to the procedures set forth under Determination to Withhold outlined below.

Upon request of the State for a hearing, OCSE will issue a Notice of Hearing which will state the time and place of the hearing, the issues which will be considered, and shall be published in the Federal Register. The hearing procedures contained in regulations at 45 CFR Part 213 shall apply to these proceedings.

III. Negotiations

As provided in regulations at 45 CFR 213.1(b) the hearing process does not preclude or limit negotiations between OCSE and the State, whether before, during or after the hearing to resolve the issues which are, or otherwise would be, considered at the hearing. Such negotiations and resolution of the issues are not part of the hearing, and are not governed by the hearing procedures, except as expressly provided for in such procedures.

IV. Determination to Withhold

If OCSE concludes that the State does not have an approved State IV-D plan under section I of these instructions, it will notify the State that further Federal payments under title IV-D of the Act will not be made to the State until a State IV-D plan is submitted and approved. Until a State IV-D plan is approved, no further Federal payments under title IV-D will be made to the State for any child support enforcement activities. Pursuant to 45 CFR 213.33, the effective date for the withholding of Federal funds shall not be earlier than the date of OCSE=s decision and shall not the later than the first day of the next calendar quarter following such decision.

V. Reconsideration

Any State which has not waived its right to reconsideration and is dissatisfied with OCSE=s decision that the State does not have an approvable State plan may request reconsideration of the decision pursuant to regulations at 45 CFR 301.14. Funding, however, will be suspended and may not be restored unless OCSE subsequently determines that the original decision to withhold Federal IV-D funding was incorrect.

CHILD SUPPORT LEGISLATION IN 104TH CONGRESS

TIMETABLE OF EFFECTIVE DATES FOR STATE REQUIREMENTS

Based on Dates in Text of Title III of PL 104-193

Personal Responsibility and Work Opportunity Reconciliation Act of 1996

Section 395 states that, except as specifically provided in the legislation, the effective date for provisions of PL 104-193 is 10/1/96 for provisions under "454 & 466 of the Act. Section 395 allows a grace period for State law changes and State constitutional amendments. For State law changes, the grace period is until the effective date of the State implementing provisions, but no later than the first day of the first quarter after the close of the first regular legislative session that begins after enactment of PL 104-193. For State constitutional amendments, the grace period is until one year after the effective date of the State constitutional amendment, but no later than five years after enactment of PL 104-193.

Requirements Effective 10/1/96

Income withholding ['314] -- '466(a)(1) and (b)

Locator networks; access to motor vehicle and law enforcement data ['315] -- '466(a)(12)

SSNs on applications for professional, commercial drivers, occupational and marriage licenses; on records of divorce decrees, support orders, and paternity determinations; and death records & certificates ['317] -- '466(a)(13)

Administrative enforcement in interstate cases ['323] -- '466(a)(14)

State laws providing expedited procedures, including:

Ordering genetic testing for paternity establishment; Issuing subpoenas for information and impose penalties for failure to respond; Requiring all entities in a State to promptly respond to inquiries by State agency and sanction failure to respond; Obtaining access to records of other State and local government agencies and records held by private entities including public utilities and financial institutions; Changing payee in cases subject to an assignment; Ordering income withholding; Securing assets to satisfy arrearages by intercepting or seizing periodic or lump-sum payments from a State or local agency and judgments, settlements, and lotteries; attach assets held by financial institutions; attach retirement funds; and impose liens; Increasing the amount of monthly support payments to include amounts for arrearages; Filing of information on location/identity of parties in State case registry upon entry of order; Statewide jurisdiction over orders and transfer of cases between local jurisdictions without additional filing; and Using of automated system to maximum extent feasible to implement expedited administrative procedures ['325] -- "466(c) & 454A(h)

State laws concerning paternity establishment, including:

Establish paternity before age 21 (retroactive to 8/16/84); Genetic tests in contested cases upon request w/sworn affidavits; Payment for genetic testing; Provide for a simple civil process for voluntarily acknowledging paternity with prior explanation/written notice to parents; Birth record agency must offer voluntary paternity establishment services, and other may; Name of father included on birth record only if both mother and father have signed an acknowledgment, or court or administrative authority has adjudicated paternity; Development of affidavit for voluntary acknowledgment of paternity which must be given full faith and credit in any other State; Procedures where voluntary acknowledgments and adjudication of paternity are filed with the State registry of birth records for comparison with State case registry; Admissibility of test results if performed by accredited laboratory; Rescission timeframe of 60 Days for signed voluntary paternity acknowledgments; elimination of judicial/administrative ratification proceedings on unchallenged paternity acknowledgments; Default orders; No right to jury trial in paternity cases; Issuance of temporary support orders in paternity cases; Evidentiary treatment of birth expenses/bills; and Opportunity for putative fathers to initiate paternity proceedings ['331(a)] -- '466(a)(5)

State plan requirements for paternity outreach activities ['332] -- '454(23)

Cooperation/good cause ['333] -- '454(29)

State use of definitions for collecting & reporting data ['343(b)] -- '454(30)

Simplified review & adjustment process ['351] -- '466(a)(10)

Voiding of fraudulent transfers ['364] -- '466(g)

Work requirement for persons owing child support ['365] -- '466(a)(15)

Reporting arrearages to credit bureaus ['367] -- '466(a)(7)

Liens on real/personal property by operation of law; full faith and credit to liens without registration of order ['368] -- '466(a)(4)

State law authorizing the suspension of licenses ['369] -- '466(a)(16)

International CSE -- State treatment of international requests ['371(b)] -- '454(32)

Financial institution data matches ['372] -- '466(a)(17)

Enforcing orders against grandparents in cases of minors ['373] -- '466(a)(18)

State cooperative agreements with Indian Tribes ['375(a)] -- '454(33)

Enforcement of orders for health care coverage ['382] -- '466(a)(19)

Explicit statutory requirement that Title IV-D services be provided to nonresident applicants; enforce child support & support due on behalf of child's custodian ['301(a)] -- "454(4)&(6)

Continuation of IV-D services for former recipients of IV-A assistance [301(b)] -- '454(25)

Requirements Effective 3/1/97

Use of forms by States in interstate cases ['324(b)] -- '454(9)(E)

Requirements Effective 10/1/97

Annual State self-reviews & reports ['342(a)] -- '454(15)

Data submitted on compliance with Federal performance requirements ['342(a)] --'454(15)

State privacy safeguards ['303(a)] -- '454(26)

State procedures-notices & copies of orders ['304(b)] -- 454(12)

State directory of new hires ['313] -- 454 (28)

ADP systems meeting all IV-D requirements enacted on or before Family Support Act ['344] -- '454(24)

Denial/restriction/revocation of passport if arrears greater than $5000 ['370] -- "452(k) & 454(31)

Requirements Effective 1/1/98

Adoption of UIFSA (with modifications) ['321] -- '466(f)

Requirements Effective 10/1/98

All support orders established or modified on or after 10/1/98 included in State central registry, which must be in place by 10/1/2000 ['311 and '344(a)(2)] -- '454A

Centralized automated unit for collections and disbursements ['312] -- '454(27)

Collection through State centralized collection unit of orders under wage withholding['312] -- '454B

State new hire reporting systems in existence prior to P.L. 104-193 must meet rest of new requirements ['313] -- '454(28)

Requirements Effective 10/1/99

End of optional exception period for local court collection of child support in lieu of State centralized collection unit ['312] -- '454B

Requirements Effective 10/1/2000

ADP systems must meet all IV-D requirements enacted on or before this law (with additional time tied to regulation issuance) ['344(A)(4)] -- '454(24)

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State of Alaska

Department of Revenue

Administrative Services Division

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March 20, 2009

The Honorable Bert Stedman
Chair, Senate Finance Committee
Alaska State Legislature
State Capitol, Room 516
Juneau, AK 99801

Dear Senator Stedman;

The Department of Revenue has requested a hearing to be scheduled for SB96 Child Support / Cash Medical. This bill was introduced by the Senate Health and Social Services Committee with support from the Governor. This letter outlines the need for the legislation to pass during this legislative session both for content of the bill and fiscal impact to the citizens of the state.

The Alaska Child Support Services Division (CSSD) needs to amend state law on three issues.

1. The requirement for cash medical support
2. The three year review cycle
3. The change of the definition of state in UIFSA

The first two amendments are less controversial and only require that child support orders include a provision for obligors to pay cash medical assistance to the custodial parent to help with health costs when insurance is not provided for that child, and that the division performs regular reviews of its cases.

The third amendment could be considered more sensitive. The Uniform Interstate Family Support Act (UIFSA) contains a definition of "state." Under federal law, all states must adopt the uniform act's definition of "state" that includes "the United States Virgin Islands" and "an Indian tribe." For Alaska, the impact of adopting a definition that would include Indian tribes, means Indian tribes can issue and serve income-withholding orders on employers. The obligor would be entitled to contest the jurisdiction of the tribe to issue the order and the usual rights to contest the validity or enforcement of an order by an obligor would still apply. The change would also affect the process for state recognition of tribal orders. A tribal child support order would be registered in the Alaska state courts under the UIFSA procedures instead of a comity process. These changes are consistent with the purpose of UIFSA. The purpose of UIFSA is to unify state laws relating to child support orders, to provide efficient procedures for collecting child support in interstate cases, and to eliminate multiple support orders that were permitted under prior child support laws.

One question raised by the changes required by UIFSA is whether the tribal amendment would result in an expansion of tribal authority. The Department of Law has examined this question and came to the

following conclusion:

> "UIFSA's underlying purpose is not to define jurisdiction. Nor does the state have the ability to define tribal jurisdiction. The overall purpose of UIFSA is simply to unify state laws relating to child support orders, to provide efficient procedures for collecting child support in interstate cases, and to eliminate multiple support orders that were permitted under prior child support laws. These purposes do not trigger broader jurisdictional concerns."

Intent language could be included in the introduced child support legislation (SB 96) to ease concerns of legislators who are not comfortable with issues related to Indian tribes. Or a letter of intent could be attached as a separate letter to the bill. I might suggest the following as an amendment:

LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that

(1) failure to bring AS 25.25.101 into compliance with the federal Social Security Act Title IV-D could result in the loss of approximately $17,000,000 in administrative funding;

(2) of the 33 states that have federally recognized tribes, Alaska is the only state that has not yet passed conforming legislation; and

(3) to bring Alaska into conformity with UIFSA, the legislature finds that it is necessary to amend AS 25.25.101 to include "an Indian tribe" and "the United States Virgin Islands" in the definition of "state."

(b) It is the intent of the legislature that this Act not alter or expand in any way the governmental relationship between federally recognized tribes and the state.

A zero fiscal note accompanies the legislation because passage of the bill would result in no additional impact to the Department of Revenue, Child Support Services Division. The fiscal impact to non-passage of SB96, or another like bill, could be detrimental to 62,000 Alaska's children under age 19. If the state remains out of compliance after this legislative session, CSSD could lose nearly the entire operating budget required to operate the child support activities mandated by state and federal law and could jeopardize the entire TANF block grant received by the Department of Health and Social Services, Division of Public Assistance. (The division currently has a budget of $174,000 General Funds.)

$11,000,000	Federal receipts paid through Title IV-D of the Social Security Act for child support services.
$12,708,403	Each year CSSD collects funds from families who also receive state benefits through the State's TANF (Temporary Assistance for Needy Families) program. The collections received on behalf of the children receiving funding through TANF are retained by CSSD and used as match to obtain additional federal funding for child support, $6,070,137 state match, and $6,638,266 to be used as part of the total federal receipts to be paid to CSSD for its services. *FY08 totals

$ 1,025,761	Annual collections from obligors whose children are in state foster care are sent to the Department of Health and Social Services to help pay for foster care costs. *FY08 totals
$ 860,560	Annual collections from obligors whose children are institutionalized are sent to the Department of Health and Social Services to help pay for non-federal foster care. *FY08 totals
$60,000,000	Federal TANF Block Grant is part of the Social Security Act. If any part of the Act is not in compliance, the State would risk losing the entire block grant. The majority of this funding is appropriated in the Department of Health and Social Services. Action Transmittal OCSE-AT-97-05 dated April 28, 1997 describes that CSSD funding would be lost and that non-compliance could also put at risk Title IV-A funding. The language from this Action Transmittal follows:

AUTHORITY:Section 455(a)(1)(A) of the Act specifies that funds appropriated under title IV-D shall be paid to States with approved State IV-D plans. There is no authority to expend Federal funds under title IV-D of the Act for the operation of a Child Support Enforcement program unless such State has an approved State IV-D plan.

Section 466 of the Act requires that all States, as a condition for approval of their State IV-D plan, must have in effect laws requiring the use of mandatory procedures to increase the effectiveness of their Child Support Enforcement programs. As a condition for State plan approval, section 454(20) of the Act provides that, to the extent required by section 466, States must have laws in effect and implement the procedures prescribed in or pursuant to such laws.

Section 454 of the Act sets the statutory requisites for the State IV-D plan. In addition, regulations at 45 CFR 301.10 define the State IV-D plan as a comprehensive statement submitted by the IV-D agency describing the nature and scope of its program. The State IV-D plan contains all the information necessary for the Office of Child Support Enforcement (OCSE) to determine whether the plan can be approved, as a basis for Federal financial participation in the State IV-D program.

Section 452(a)(3) of the Act requires that OCSE review and approve State plans for Child Support Enforcement programs under title IV-D of the Act. The authority to approve State plans is delegated to the Regional Office, but OCSE retains authority for determining that a State IV-D plan is not approvable.

As stated above, a determination that a State IV-D plan is disapproved will result in immediate suspension of all Federal payments for the State's child support enforcement program, and such payments will continue to be withheld until the State IV-D plan can be approved by OCSE. If a State is dissatisfied with OCSE's decision, reconsideration may be requested pursuant to 45 CFR 301.14. Withholding of Federal payments cannot be stayed pending reconsideration.

Section 402(a)(2) of the Act (as amended by PRWORA) provides that the chief executive officer of a State must certify that it will operate a child support enforcement program under an approved IV-D plan as a condition of eligibility for a TANF block grant under title IV-A of the Act. Therefore, States should be aware that TANF funds may also be at risk.

In conclusion:

1. Monthly distribution of child support payments to custodial parents averages $9,350,000.

2. One out of six citizens (approximately 125,000 people) in Alaska are somehow involved in a child support case.

3. If this legislation does not pass in the next 30 days, Alaska risks losing its entire child support services program and could lose its state TANF block grant that serves low-income citizens in every community.

Thank you for working with us on this issue.

Sincerely,

Ginger Blaisdell
Director

State of Alaska

Department of Revenue

Administrative Services Division

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March 16, 2009

The Honorable Hollis French
Chair, Senate Judiciary Committee
State Capitol, Room 417
Juneau, AK 99811

Dear Senator French,

This letter is in support of SB 96 to help inform the legislature of necessary actions required to bring Alaska into federal compliance with the federal law. If the state remains out of compliance after this legislative session, CSSD could lose more than $17 million federal dollars. This is nearly the entire operating budget required to operate the child support activities mandated by state and federal law.

The Alaska Child Support Services Division (CSSD) needs to amend state law on two issues. The first amendment is less controversial and only requires that child support orders include a provision for obligors to pay cash medical assistance to the custodial parent to help with health costs when insurance is not provided for that child.

The second amendment is more sensitive to certain legislators. The Uniform Interstate Family Support Act (UIFSA) contains a definition of "state." Under federal law, all states must adopt the uniform act's definition of "state" that includes "the United States Virgin Islands" and "an Indian tribe." For Alaska, the impact of adopting a definition that would include Indian tribes, means Indian tribes can issue and serve income-withholding orders on employers. The obligor would be entitled to contest the jurisdiction of the tribe to issue the order and the usual rights to contest the validity or enforcement of an order by an obligor would still apply. The change would also affect the process for state recognition of tribal orders. A tribal child support order would be registered in the Alaska state courts under the UIFSA procedures instead of a comity process. These changes are consistent with the purpose of UIFSA. The purpose of UIFSA is to unify state laws relating to child support orders, to provide efficient procedures for collecting child support in interstate cases, and to eliminate multiple support orders that were permitted under prior child support laws.

One question raised by the changes required by UIFSA is whether the tribal amendment would result in an expansion of tribal authority. The Department of Law has examined this question and came to the following conclusion:

> "UIFSA's underlying purpose is not to define jurisdiction. Nor does the state have the ability to define tribal jurisdiction. The overall purpose of UIFSA is simply to unify state laws relating to child support orders, to provide efficient procedures for collecting child support in interstate cases, and to eliminate multiple support orders that were permitted under prior child support laws. These purposes do not trigger broader jurisdictional concerns."

A letter of intent could be included in the introduced child support legislation (SB 96) to ease concerns of legislators who are not comfortable with issues related to Indian tribes. The letter of intent could be attached as a separate letter or as an amendment to the bill. I might suggest the following as an amendment:

LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that

(1) failure to bring AS 25.25.101 into compliance with the federal Social Security Act Title IV-D could result in the loss of approximately $17,000,000 in administrative funding;

(2) of the 33 states that have federally recognized tribes, Alaska is the only state that has not yet passed conforming legislation; and

(3) to bring Alaska into conformity with UIFSA, the legislature finds that it is necessary to amend AS 25.25.101 to include "an Indian tribe" and "the United States Virgin Islands" in the definition of "state."

(b) It is the intent of the legislature that this Act not alter or expand in any way the governmental relationship between federally recognized tribes and the state.

Thank you for working with us on this issue.

Sincerely,

VBlaisdell

Ginger Blaisdell
Director

CC: Stacy Steinberg, AAG, Department of Law
John Mallonee, Director, Child Support Services Division

Good job Ginger, thanks. Lynda

-----Original Message-----
From: Blaisdell, Ginger (DOR) [mailto:ginger.blaisdell@alaska.gov]
Sent: Tuesday, March 10, 2009 10:16 AM
To: Ford, Michael F (LAW); Steinberg, Stacy K (LAW); Mallonee, John R (DOR)
Cc: Cindy Smith; Lynda Zaugg
Subject: SB96 CSSD legislation in (S)JUD

I've scanned the documents that have been included in the Senate Judiciary committee packets for tomorrow's hearing (please print the latest version of the bill off of Basis). Mike Ford and I met briefly with Cindy Smith (Sen French) to review the bill. She does not anticipate any push back from the committee unless there are questions from Senator Therriault. We hope that SB96 will be heard tomorrow and then brought up quickly in the next meeting under "bills previously heard" to pass out and move on to Senate Finance.

The order of the meeting will be:
Linda Zaugg (Sen Davis) will read the sponsor statement to open the meeting discussion
John Mallonee will provide his presentation of the bill
Stacy Steinberg will be on line to answer any legal questions
Ginger will be available to direct questions to those on the phone

SB96 is the only bill scheduled to tomorrow.
Ginger

State of Alaska

Department of Revenue

Administrative Services Division

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March 3, 2009

The Honorable Hollis French
Chair, Senate Judiciary Committee
Alaska State Legislature
State Capitol, Room 417
Juneau, AK 99801-1182

Dear Senator French:

The Senate Health and Social Services Committee introduced legislation on behalf of the Division of Child Support Services (CSSD). SB 96 passed out of (S) HSS on Monday, March 2, 2009 and has been transmitted to Senate Judiciary Committee for consideration.

SB 96 addresses two time sensitive amendments to the Uniform Interstate Family Support Act (UIFSA) that will bring the Division into federal compliance. Briefly, the two changes are; 1) providing for cash medical assistance for children in custodial homes, and 2) clarifying the definition of "state" to include the US Virgin Islands and Indian tribes. If these two amendments are not adopted during this state fiscal year, the Department of Revenue will be at risk to lose more than $17 million federal receipts to support the fiduciary services provided by CSSD.

I respectfully request that CSSB96(HSS) be scheduled for hearing in the Senate Judiciary Committee as early as possible. CSSB96(HSS) carries with it a zero fiscal note.

If the Committee requires any additional information, please contact me.

Sincerely,

G Blaisdell

Ginger Blaisdell
Director

Alaska State Legislature

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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Date: 3/3/2009

To: Senator Hollis French, Chair
Judiciary Committee

From: Senator Bettye Davis

Re: CS for SB 96 "An Act relating to nonpayment of child support, to the definition of the term "state" for the purposes of the Uniform Interstate Family Support Act, to certain judicial and administrative orders for medical support of a child, to periodic review and adjustment of child support orders, to relief from administrative child support order, to child support arrearages, and to medical support of a child and the Alaska Native family assistance program; amending Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

This is a request that you schedule a hearing on CS for SB 96 at the earliest possible date.

Please find attached a copy of the CS for SB 96, the bill, a sponsor statement, a fiscal note and a sectional analysis. Your attention to this request would be appreciated. Thank you.

SB 35 Sponsor Statement
Revised 1/23/09

Ok, thanks

From: Laughlin, Wilda J (HSS) [mailto:wilda.laughlin@alaska.gov]
Sent: Monday, March 02, 2009 9:18 AM
To: Andy Moderow; Lynda Zaugg
Cc: Fick, Tyson C (CED); Fitzjarrald, Elinor A (HSS); Sherwood, Jon (HSS)
Subject: SB 61 hearing today

Just wanted to give you a heads up that I will be available to testify for the department on SB 61 this afternoon if needed. DPA director Ellie Fitzjarrald and HCS medical assistance administrator Jon Sherwood will be available to answer questions on the fiscal notes.
w.

Thomas Obermeyer

From: Blaisdell, Ginger (DOR) [ginger.blaisdell@alaska.gov]
Sent: Monday, February 02, 2009 8:42 AM
To: Rynnieva Moss; Thomas Obermeyer
Subject: FW: CSSD medical legislation
Attachments: Sponsor Statement for medical support bill.doc; Medical support bill one page highlight.doc

I hope this is helpful to both of you
Ginger

From: Mallonee, John R (DOR)
Sent: Thursday, January 29, 2009 3:56 PM
To: Blaisdell, Ginger (DOR)
Subject: RE: CSSD medical legislation

I haven't done one of these in a long time. So attached is my attempt. See what you think and let me know if they need to be changed. Any suggestions would be appreciated.

John Mallonee, Director
Child Support Services Division

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From: Blaisdell, Ginger (DOR)
Sent: Wednesday, January 28, 2009 10:17 PM
To: Burnett, Jerry D (DOR); Galvin, Patrick S (DOR); Mallonee, John R (DOR)
Subject: CSSD medical legislation

Representative Coghill is going to sponsor this bill in the House and is already getting it drafted.
Senator Davis will introduce this bill as a HSS Committee bill – I'm working with Tom Obermeyer to get it started.

John - Both offices have asked for a sponsor statement and a one page highlight list of what the legislation does. How quick can I get a one-page description? I'm happy to write the sponsor statement if need be.

Ginger

Lynda Zaugg

From: Thomas Obermeyer
Sent: Friday, January 30, 2009 2:09 PM
To: john.mallonee@alaska.gov; Ginger.blaisdell@alaska.gov
Cc: Lynda Zaugg; Don Burrell; Sen. Bettye Davis
Subject: Work Draft 26-LS0485\A 1/30/09 relating to nonpayment of child suport etc.
Attachments: 6-LS0485A.pdf child support

In response to your request for a bill sponsored by the Senate HSS Committee concerning child support matters in the 11/12/08 draft 09-0026 bill.doc which you dropped off at Senator Davis's office, Senator Davis asked that I have Legis. Legal Svcs. Prepare draft 26-LS0485\A which is attached.

Note that our draft differs somewhat from that which you submitted. After title change indicating "non payment of child support" and the attendant penalties for non-compliance which are criminal, our bill first addresses related criminal law under Title 11, and then moves into child support under Title 25.

Senator Davis asks for your careful review and approval before we request a final draft from Legislative Legal Services for reading across and assignment of bill number.

Tom Obermeyer
465-3762

Alaska State Legislature

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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

SB 96

TITLE: "An Act relating to nonpayment of child support: relating to certain judicial and administrative orders for medical support of a child;."

SPONSOR STATEMENT (B)

In July 2008, the federal government issued new medical support regulations that require states to have guidelines addressing how either or both parents will provide for a child's healthcare needs through accessible health insurance coverage, cash medical support, or both. Under the federal regulations, states must order either or both parents to purchase reasonably-priced, accessible health insurance coverage, provide cash medical support or both. Cash medical support may be required in those cases where no reasonably-priced health insurance coverage is accessible to the child. If a parent is ordered to pay cash medical support, the Child Support Services Division must enforce the ongoing cash medical support obligation as well as collect any cash medical support arrears. Failure to satisfy these mandated jeopardizes 17 million dollars in federal funding for the state's child support program.

This bill adds to existing law the authority for a tribunal to order either or both parents to pay cash medical support, if warranted. In addition, the bill directs CSSD to review child support orders for modification on a federally mandated three-year cycle. The bill adds cash medical support to the definition of arrearage and the definition of support order thereby enabling CSSD to use

its existing enforcement tools to collect a cash medical support obligation on behalf of the child. Finally, the bill removes the language limiting who may request the correction of a clerical mistake in an administrative order or request the vacation of an administrative order based upon a default income.

This bill puts Alaska in compliance with the federal requirements. As explained above, this bill will assure that Alaska's children receive the medical support to which they are entitled.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 27, 2009

SUBJECT: Sectional Summary (CSSB 96( ); (Work Order No. 26-LS0485\E))

TO: Senator Betty Davis
Attn: Lynda Zaugg

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds reference to cash medical support to the crime of aiding the nonpayment of child support in the second degree.

Section 2. Adds the Virgin Islands and Indian Tribes to the definition of "state."

Section 3. Amends order of support provision to include both parents, medical support, and insurance.

Section 4. Adds medical support to provision authorizing the initiation of administrative action to establish a duty of support.

Section 5. Amends periodic reviews of support orders to require a three year cycle of review.

Section 6. Deletes motion requirement for correcting an administrative mistake in a support order.

Section 7. Deletes motion requirement for vacating a support order that is based on a default amount.

Section 8. Redefines "arrearage" for child support purposes.

Section 9. Amends the definition of "support order" to include cash medical support.

Section 10. Amends garnishment provision to include insurance and cash medical support.

Section 11. Amends the Alaska Native family assistance program to include obligations for cash medical support.

Section 12. Provides for an indirect court rule amendment to Rule 90.3, Alaska Rules of Civil Procedure for changes made in the bill.

Section 13. Makes bill changes applicable to child support actions filed on or after the bill's effective date.

Section 14. Authorizes the Department of Revenue to proceed to adopt regulations needed under the bill.

Section 15. Provides for a conditional effect for the court rule amendment in sec. 12 only for two-thirds majority vote.

Section 16. Makes sec. 14 effective immediately.

Section 17. Provides for a July 1, 2009, effective date for all other bill sections.

JMM:ljw
09-125.ljw

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: 773-09-0026
() Publish Date:

Identifier (file name): CSSB96(HSS)-DOR-CSS-03-02-09
Dept. Affected: Revenue
Title: Cash Medical Support for Minor Children
RDU: Child Support Services Division
Component: Child Suppor Services Division
Sponsor
Requester: Governor
Component Number: 111

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation does not require any additional funding.

Prepared by: John Mallonee
Phone 269-6801
Division: Child Support Services Division
Date/Time 12/12/2008 / 5:00pm
Approved by: Jerry Burnett
Date 12/15/2008
Department of Revenue

(Revised 9/10/2008 OMB)

4304

Sen. Davis

Alaska State Legislature

House of Representatives

Office of the Chief Clerk

State Capitol, Room 216
Juneau, AK 99801-1182
Phone: (907) 465-3725
Fax: (907) 465-5334

Official Business

CONCUR

April 17, 2009

MESSAGE TO THE SENATE

Mister President:

The House passed CS FOR SENATE BILL NO. 96(FIN) with the following amendment(s):

HOUSE CS FOR CS FOR SENATE BILL NO. 96(FIN)
"An Act relating to nonpayment of child support, to the definition of the term 'state' for the purposes of the Uniform Interstate Family Support Act, to certain judicial and administrative orders for medical support of a child, to periodic review and adjustment of child support orders, to relief from administrative child support orders, to child support arrearages, and to medical support of a child and the Alaska Native family assistance program; amending Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

and it is returned for consideration.

Suzi Lowell

Suzi Lowell, Chief Clerk

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

SB 96

TITLE: "An Act relating to nonpayment of child support: relating to certain judicial and administrative orders for medical support of a child;."

SPONSOR STATEMENT (c)

SB 96 bring the state into compliance with federal government regulations adopted in July 2008, that require states to have guidelines addressing how either or both parents will provide for a child's healthcare needs. If a parent is ordered to pay for healthcare including cash medical support, the Child Support Services Division must enforce the ongoing medical support obligation as well as collect any cash medical support arrears. Failure to satisfy these mandated requirements jeopardizes 85 million dollars in federal funding for both Alaska's Child support program and Temporary Ass. To Needy Families (TANF).

1. This bill adds an Indian tribe and United States Virgin Island to the definition of state.

2. This bill adds to existing law the authority for a tribunal to order either or both parents to pay cash medical support, if warranted.

3. In addition, the bill directs Child Support Services Division (CSSD) to review child support orders for modification on a federally mandated three-year cycle.

4. The bill adds cash medical support to the definition of arrearage and the definition of support order thereby enabling CSSD to use its existing enforcement tools to collect a cash medical support obligation on behalf of the child.

5. Finally, the bill removes the language limiting who may request the correction of a clerical mistake in an administrative order or request the vacation of an administrative order based upon a default income.

SB 96 puts Alaska in compliance with the federal requirements which assure that Alaska's children receive the medical support to which they are entitled.

In addition, adoption of SB 96 assures 85 million in federal dollars to Alaska in funds for the Child Support Enforcement and Tem. Assistance for Needy Families (TANF) programs.

Alaska State Legislature

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Session: (Jan. - May)
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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Date: 4/13/2009

To: Representative Hawker, Co-Chair
Representative Stoltze, Co-Chair
House Finance Committee

From: Senator Bettye Davis BD

Re: CSCSSB 96 Child Support/Cash Medical Support

This is a request that you schedule a hearing on CSCSSB 96 at the earliest possible date.

Please find attached a copy of the CS for CS for SB 96, a sponsor statement, fiscal notes, and a sectional analysis. Your attention to this request would be appreciated. Thank you.

Alaska State Legislature

Interim: (May - Dec.)
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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

SB 96

TITLE: "An Act relating to nonpayment of child support: relating to certain judicial and administrative orders for medical support of a child;."

SPONSOR STATEMENT

In July 2008, the federal government issued new medical support regulations that require states to have guidelines addressing how either or both parents will provide for a child's healthcare needs through accessible health insurance coverage, cash medical support, or both. Under the federal regulations, states must order either or both parents to purchase reasonably-priced, accessible health insurance coverage, provide cash medical support or both. Cash medical support may be required in those cases where no reasonably-priced health insurance coverage is accessible to the child. If a parent is ordered to pay cash medical support, the Child Support Services Division must enforce the ongoing cash medical support obligation as well as collect any cash medical support arrears. Failure to satisfy these mandated jeopardizes 17 million dollars in federal funding for the state's child support program. ~~Alaska's request for a waiver was denied by the Federal government in January 2009.~~

This bill adds to existing law the authority for a tribunal to order either or both parents to pay cash medical support, if warranted. In addition, the bill directs CSSD to review child support orders for modification on a federally mandated three-year cycle. The bill adds cash medical support to the definition

of arrearage and the definition of support order thereby enabling CSSD to use its existing enforcement tools to collect a cash medical support obligation on behalf of the child. Finally, the bill removes the language limiting who may request the correction of a clerical mistake in an administrative order or request the vacation of an administrative order based upon a default income.

This bill puts Alaska in compliance with the federal requirements. As explained above, this bill will assure that Alaska's children receive the medical support to which they are entitled.

Alaska State Legislature

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Session: (Jan. - May)
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Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

SB 96

TITLE: "An Act relating to nonpayment of child support: relating to certain judicial and administrative orders for medical support of a child;."

SPONSOR STATEMENT (B)

In July 2008, the federal government issued new medical support regulations that require states to have guidelines addressing how either or both parents will provide for a child's healthcare needs through accessible health insurance coverage, cash medical support, or both. Under the federal regulations, states must order either or both parents to purchase reasonably-priced, accessible health insurance coverage, provide cash medical support or both. Cash medical support may be required in those cases where no reasonably-priced health insurance coverage is accessible to the child. If a parent is ordered to pay cash medical support, the Child Support Services Division must enforce the ongoing cash medical support obligation as well as collect any cash medical support arrears. Failure to satisfy these mandated orders jeopardizes 17 million dollars in federal funding for the state's child support program.

per 85 Home grant ch

This bill adds to existing law the authority for a tribunal to order either or both parents to pay cash medical support, if warranted. In addition, the bill directs CSSD to review child support orders for modification on a federally mandated three-year cycle. The bill adds cash medical support to the definition of arrearage and the definition of support order thereby enabling CSSD to use

its existing enforcement tools to collect a cash medical support obligation on behalf of the child. Finally, the bill removes the language limiting who may request the correction of a clerical mistake in an administrative order or request the vacation of an administrative order based upon a default income.

This bill puts Alaska in compliance with the federal requirements. As explained above, this bill will assure that Alaska's children receive the medical support to which they are entitled.

4/10

Alaska State Legislature

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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

SB 96

TITLE: "An Act relating to nonpayment of child support: relating to certain judicial and administrative orders for medical support of a child;."

SPONSOR STATEMENT (c)

SB 96 brings the state into compliance with the federal Uniform Interstate Family Services Act (UIFSA) that require states to have guidelines addressing how either or both parents will provide for a child's healthcare needs and to include an "Indian tribe" in the definition of state. Both amendments to Alaska's child support state plan are conforming amendments which will result in procedural changes in Alaska for enforcement and modification of child support orders from other jurisdictions.

If a parent is ordered to pay for healthcare including cash medical support, the Child Support Services Division must enforce the ongoing medical support obligation as well as collect any cash medical support arrears. Including an "Indian tribe" in the definition of state does not expand or restrict tribal jurisdiction.

Failure to satisfy these mandated requirements jeopardizes 85 million dollars in federal funding for both Alaska's Child support program and Temporary Assistance To Needy Families (TANF).

4/10

1. This bill adds an "Indian tribe" and "United States Virgin Islands" to the definition of state.

2. This bill adds to existing law the authority for a tribunal to order either or both parents to pay cash medical support, if warranted.

3. In addition, the bill directs Child Support Services Division (CSSD) to review child support orders for modification on a federally mandated three-year cycle.

4. The bill adds cash medical support to the definition of arrearage and the definition of support order thereby enabling CSSD to use its existing enforcement tools to collect a cash medical support obligation on behalf of the child.

5. Finally, the bill removes the language limiting who may request the correction of a clerical mistake in an administrative order or request the vacation of an administrative order based upon a default income.

SB 96 puts Alaska in compliance with the federal requirements which assure that Alaska's children receive the medical support to which they are entitled.

In addition, adoption of SB 96 assures 85 million in federal dollars to Alaska for the Child Support Enforcement and Temporary Assistance for Needy Families (TANF) programs.

I appreciate your support of this important bill.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSSB 96(HSS)
(S) Publish Date: 3/3/09

Identifier (file name): CSSB96(HSS)-DOR-CSS-03-02-09
Dept. Affected: Revenue
Title: Cash Medical Support for Minor Children
RDU: Child Support Services Division
Component: Child Suppor Services Division
Sponsor
Requester: Governor
Component Number: 111

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation does not require any additional funding.

Prepared by: John Mallonee
Phone 269-6801
Division: Child Support Services Division
Date/Time 12/12/2008 / 5:00pm
Approved by: Jerry Burnett
Date 12/15/2008
Department of Revenue

(Revised 9/10/2008 OMB)

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 27, 2009

SUBJECT: Sectional Summary (CSSB 96( ); (Work Order No. 26-LS0485\E))

TO: Senator Betty Davis
Attn: Lynda Zaugg

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds reference to cash medical support to the crime of aiding the nonpayment of child support in the second degree.

Section 2. Adds the Virgin Islands and Indian Tribes to the definition of "state."

Section 3. Amends order of support provision to include both parents, medical support, and insurance.

Section 4. Adds medical support to provision authorizing the initiation of administrative action to establish a duty of support.

Section 5. Amends periodic reviews of support orders to require a three year cycle of review.

Section 6. Deletes motion requirement for correcting an administrative mistake in a support order.

Section 7. Deletes motion requirement for vacating a support order that is based on a default amount.

Section 8. Redefines "arrearage" for child support purposes.

Section 9. Amends the definition of "support order" to include cash medical support.

Section 10. Amends garnishment provision to include insurance and cash medical support.

Section 11. Amends the Alaska Native family assistance program to include obligations for cash medical support.

Section 12. Provides for an indirect court rule amendment to Rule 90.3, Alaska Rules of Civil Procedure for changes made in the bill.

Section 13. Makes bill changes applicable to child support actions filed on or after the bill's effective date.

Section 14. Authorizes the Department of Revenue to proceed to adopt regulations needed under the bill.

Section 15. Provides for a conditional effect for the court rule amendment in sec. 12 only for two-thirds majority vote.

Section 16. Makes sec. 14 effective immediately.

Section 17. Provides for a July 1, 2009, effective date for all other bill sections.

JMM:ljw
09-125.ljw

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: 773-09-0026
() Publish Date:

Identifier (file name): CSSB96(HSS)-DOR-CSS-03-02-09
Title: Cash Medical Support for Minor Children
Sponsor
Requester: Governor

Dept. Affected: Revenue
RDU: Child Support Services Division
Component: Child Suppor Services Division
Component Number: 111

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation does not require any additional funding.

Prepared by: John Mallonee
Division: Child Support Services Division
Phone: 269-6801
Date/Time: 12/12/2008 / 5:00pm

Approved by: Jerry Burnett
Department of Revenue
Date: 12/15/2008

(Revised 9/10/2008 OMB)

SB 101

SENATE COMMITTEE REPORT

DATE: 3/18/09

FURTHER:

DATE TURNED IN TO OFFICE: 3/27/09

Health and Social Services Committee considered SENATE BILL NO. 101

SB 101 STUDENT QUESTIONNAIRES AND SURVEYS

"An Act relating to questionnaires and surveys administered in the public schools."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
EED	3/6			✓	1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
Joy Thomas	Thomas	✓			
Joe Paskvan	Paskvan	X			
CHAIR: Betty Davis	DAVIS	X			

Alaska State Legislature

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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 101

"An Act relating to questionnaires and surveys administered in the public schools."

Sponsor Statement

SB 101 is intended to allow for more student participation the Youth Risk Behavior Survey (YRBS) which is conducted as part of a national effort by the U.S. Centers for Disease Control and Prevention (CDC) to monitor health-risk behaviors of the nation's high school students. These behaviors, in turn, result in the most significant causes of both mortality and morbidity during youth and adulthood. The behaviors monitored by the Alaska YRBS include traffic safety; weapons and violence; suicide; tobacco use; alcohol and other drug use; sexual behavior; and diet, nutrition and exercise.

Prior to new language in SB 101 written parental consent was required to administer the YRBS. Under SB 101 only written refusal, or written non-consent to participate is required of parents or guardians of students. SB 101 provides that students themselves, independent of parental consent or non-consent, can elect not to answer certain questions or not to participate in the Youth Risk Behavior Survey or any questionnaire or survey. Moreover, SB 101 expands information required in the 2-week parental notice requirement to include date, sponsor, description of content, opportunity to review the questionnaire or survey, school contacts, and how to submit written permission or refusal for a student to participate. While studies have found that the vast majority of parents would consent to students participating in school questionnaires and surveys, non-response is more often due to apathy, oversight, or student omission or error in returning forms, rather than parental refusal.

The CDC determined that at least 60% of students in the selected sample must complete the YRBS for it to accurately represent student behavior across the entire state. In 2005, Alaska missed achieving an adequate response rate and was unable to use the data. As a result, lost were valuable measures of population-based information on youth which helps policy makers, educators, program planners, agencies, non-profits, and parents to better understand, fund, and track trends over time and help guide and evaluate important health and prevention programs. State and federal grant programs which rely on these surveys include tobacco prevention and control, obesity prevention, diabetes, heart disease and stroke, safe and drug free schools and other substance abuse prevention, and injury prevention, including violence and suicide prevention, HIV and STD prevention, and more.

Alaska State Legislature

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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 101, 26-LS0524\A

"An Act relating to questionnaires and surveys administered in the public schools."

Sectional Summary

Note: this sectional summary should not be considered an authoritative interpretation of the bill, as the bill itself is the best statement of its contents.

Section 1. Amends AS 14.03.110(a) to require a school district to obtain written permission to administer a questionnaire or survey, anonymous or not, with the exception of the Youth Risk Behavior Survey, as provided in Section 4 in new subsection AS 14.03.110(g).

Section 2. Repeals and reenacts AS 14.03.110(d) to require a school district provide to a student's parent or legal guardian written notice of a questionnaire or survey with detailed information as to the date, contents, sponsor, contacts at the school district, opportunity to review the questionnaire or survey, description of how to submit written permission or denial of permission to participate, including an anonymous or specific questionnaire or survey.

Section 3. Amends AS 14.03.110(e) to allow a student to participate but to refuse to "answer specific questions." Subsection (e) also requires that a parent or legal guardian may refuse to allow the student to participate in a specific questionnaire or survey "by submitting to the teacher or school principal a written denial of permission for the student's participation."

Section 4. Adds a new subsection AS 14.03.110(g) which provides that if a school district administers the Youth Risk Behavior Survey provided by the United States Centers for Disease Control and Prevention, written permission of the student's parent or legal guardian is not required, but the school district shall provide parents notice of the survey and the opportunity to submit to the teacher or school principal a written denial of permission to take the survey.

Note: Subsections AS 14.03.110(b) and (c) remain unchanged as to annual permission and two weeks notice for anonymous surveys under (b), and written permission and two weeks notice for surveys which are not anonymous under (c).

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: SB 101
Bill Version:
() Publish Date:

Identifier (file name): SB101-EED-ESS-3-06-09
Dept. Affected: EED
Title "An Act relating to questionaires and surveys adminstered in the public schools."
RDU Teaching & Learning Support
Component School & Student Achievement
Sponsor Sen. Davis
Requester Senate Education Committee
Component Number 2796

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

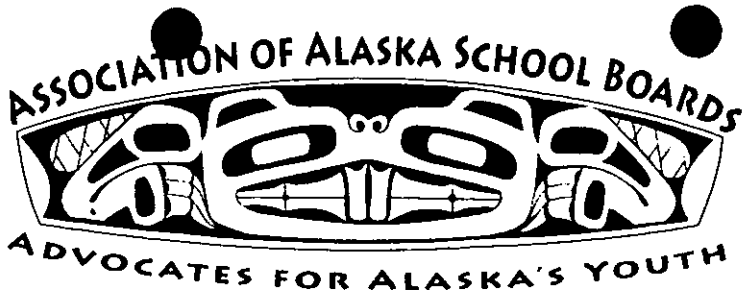
Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

There is no fiscal impact on the Department of Education and Early Development.

Prepared by: Paul Prussing, Deputy Director
Phone 465-8721
Division Teaching & Learning Support
Date/Time 3/6/09 12:00 AM
Approved by: Larry LeDoux
Date 3/6/2009
Commissioner

(Revised 9/10/2008 OMB)



Position Statement on SB 101
Relating to Questionnaires and Surveys in Public Schools

AASB member districts need school-by-school data to increase student achievement and accurately assess the effectiveness of current programs. Since passage of HB 70 in 1999, schools have been unable to obtain an adequate sample of student information to provide reliable information. AASB supports modifying the requirements for parental or legal guardian permission for a student to participate in a questionnaire or survey administered in a public school.

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Karleen Jackson
Commissioner
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STATE OF ALASKA
DEPARTMENT OF
HEALTH AND SOCIAL SERVICES

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Fact Sheet

COMMISSIONER'S OFFICE

FOR IMMEDIATE RELEASE: Nov. 19, 2007

Fact Sheet: 2007 Youth Risk Behavior Survey (YRBS)

What is the Youth Risk Behavior Survey (YRBS)?
The Youth Risk Behavior Survey (YRBS) is part of an epidemiological surveillance system that was established in 1990 by the Centers for Disease Control and Prevention (CDC). It was developed to monitor health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. These behaviors, often established during childhood and early adolescence, include:

- Tobacco use;
- Unhealthy dietary behaviors;
- Inadequate physical activity;
- Alcohol and other drug use;
- Sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; and
- Behaviors that contribute to unintentional injuries and violence.

What are the purposes of the YRBS?

- Determine the prevalence of health risk behaviors;
- Assess whether health risk behaviors increase, decrease, or stay the same over time;
- Provide comparable national, state and local data;
- Provide comparable data among subpopulations of youth; and
- Monitor progress toward achieving the Healthy People 2010 objectives and other program indicators.

How long has Alaska participated in the YRBS?
The YRBS high school survey was first implemented at the national level in 1990. Since that time CDC has sponsored national surveys from 1991 to the present on an every-other-year basis. Alaska first participated in the YRBS in 1995 and obtained representative statewide data. Due to external factors, the YRBS was not administered in 1997. It was administered in 1999; however the Anchorage School District did not participate. Without Anchorage the data were not representative of the state as a whole. The survey was administered in 2001, but unfortunately low student response rates rendered the data unusable. A major obstacle in 2001 was the constraint of the active parental consent law that had just gone into effect. In 2003 the survey was administered statewide with active parental consent and representative data were obtained, making this

the first statewide YRBS representative sample since 1995. The survey was again administered in 2005, however the response rate fell just below the target and the data was not used. In 2007, the survey was administered and achieved an adequate response rate, yielding important survey results.

What is the difference between active and passive consent?
Alaska's active parental consent law, AS 14.03.110, prohibits public schools from administering surveys or questionnaires that ask about personal or family affairs, or anything else that is not a matter of public record or readily observable in public, without first getting written permission from all participating students' parents or legal guardians. This law holds regardless of whether the surveys are anonymous and voluntary. Alaska is one of only a few states in the nation that has a school survey law requiring active parental consent for surveys of this type. Most states employ passive parental consent when administering such anonymous surveys. Passive parental consent involves notifying and informing the parents about the survey and assuming that students will participate unless the parent provides a written refusal to opt out of the survey.

How was the YRBS conducted?
A two-stage sample design was used to select the actual students for participation. The first stage consisted of selecting schools. Schools were selected with probability proportional to the size of their enrollment. Once a school was selected, classes were selected as the second stage. Eligible classes were those where a student would be enrolled in one and only one class at a time. For example second period or required English. This gave each student an equal opportunity of being selected. At any time a school district, an individual school, a student's parents, or a specific student had the opportunity to decline participation.

At the classroom level, teachers were given a script to read to students that established guidelines for student privacy and anonymity and the importance of the survey. Each student was given an unmarked envelope in which to seal his or her survey before turning it in. These survey envelopes remained sealed until received at a central state collection site. The Centers for Disease Control and Prevention and a CDC contractor analyzed the state survey data.

A national YRBS also was conducted in 2007, however, the results will not be available until early summer 2008. As a result, 2005 National YRBS results are being used for comparison purposes.

Who participated in the survey?
Forty one high schools from 19 districts were scientifically selected to be included in the survey. Thirty-eight (88 percent) schools participated and 1,318 (68 percent) students completed the survey resulting in an overall response rate of 60 percent. The CDC has determined that the overall response rate must be 60 percent or greater in order for the data to represent the high school population of the state. Therefore, these survey results represent 34,399 students grades 9 through 12 in public high schools (excluding private, alternative, boarding and correctional schools).

How are the data used?
The results of the YRBS are used to detect changes in risk behaviors over time and provide an important piece of program planning and evaluation, curriculum development and decision-making regarding the use of available resources. The information from the YRBS can be used to help schools and communities identify strengths and weaknesses in current programs and services. Additionally the results can be used by schools and communities when applying for grant funding to initiate or maintain programs that serve youth.

Who supported the YRBS in Alaska?
The YRBS in Alaska is a cooperative effort between the state departments of Health and Social Services and Education and Early Development. The survey is also endorsed by the following groups and boards:

- Association of Alaska School Boards
- Alaska Action for Healthy Kids
- All Alaska Pediatric Partnership
- American Heart Association, Pacific/Mountain Affiliate
- American Lung Association of Alaska
- American Cancer Society, Alaska
- Alaska Health Education Consortium
- Alaska Tobacco Control Alliance
- Alaska Native Tribal Health Consortium

Contact: Greg Wilkinson, HSS, (907) 269-7285, Cell (907) 382-7032
Ann Potempa, HSS, (907) 269-7957, Cell (907) 240-9158
Eric Fry, EED, (907) 465-2851

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Healthy Alaska

Youth Risk Behavior Survey (YRBS) Nationally and in Alaska

January 2007

Inside This Issue:

- YRBS - Nationally
- YRBS - How Can This Short Survey Collect Vital Behavioral Information We Need?
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- An Overwhelming Opportunity
- SE Alaska Regional Conference on Fetal Alcohol Spectrum Disorders (FASD)
- Brain Booster

January 25-27, 2007
Centennial Hall
Juneau, Alaska

Registration Deadline: January 16, 2007. Any questions regarding registration contact Robbi Wolfing at 907-723-7556 or fasdconference@yahoo.com

Question:

Make this equation correct without changing the numbers: 8 - 8 = 91

YRBS -Nationally

The Youth Risk Behavior Survey (YRBS) is the largest and most respected source of data on the youth risk behaviors that contribute to the leading causes of mortality, morbidity, and social problems in the US. The YRBS was created by the Division of Adolescent School Health, Center for Disease Control, and representatives from more than 800 local, state, and federal health agencies in 1990. The YRBS measures behaviors that fall into the following 6 categories: Behaviors that result in unintentional injuries and violence, tobacco use, alcohol and other drug use, sexual behaviors that result in HIV infection, other STDs, and unintended pregnancies, dietary behaviors, physical activity.

YRBS- How Can This Short Survey Collect the Vital Behavioral Information We Need?

Amazingly, nationally 71% of all deaths for persons 10-24 years of age are due to only 4 causes: motor vehicle crashes, other unintentional injuries, homicide, and suicide. In addition, 800,000-900,000 teenaged girls become pregnant each year and an estimated 3 million STDs occur among persons ages 10-19. A limited number of behaviors usually established during youth contribute substantially to these causes of mortality and morbidity. These behaviors include: carrying a weapon, physical fighting, attempting suicide, drinking or using drugs while operating a motor vehicle, lack of seatbelt use while riding in a motor vehicle, lack of helmet use while riding a bicycle, and unprotected sexual intercourse that results in HIV infection, other STDs, or unintended pregnancies.

The Youth Risk Behavior Survey also surveys youth on the leading causes of adult morbidity and mortality as many individuals initiate the risk behaviors that lead to problems as adults in their adolescence. Among adults in the US aged 25 and older, 63% of deaths are due to only 2 causes: cardiovascular disease and cancer. A limited number of causes contribute to these health problems. These behaviors include: use of tobacco, unhealthy dietary behaviors, and physical inactivity.

YRBS - How it Works

The YRBS is administered in a collection of randomly drawn sample schools from nearly every state every other year. The survey is administered to high school aged students in a single class period and is completely anonymous. Some school districts choose to survey all of their high school students to better understand and measure risk behaviors in their communities. Strict precautions are in place to absolutely insure student confidentiality and participation in the survey is completely voluntary. Students answer the multiple choice questions about their current and past risk behaviors, which are collected and sent to the state for processing. State results are then shared federally with CDC.

YRBS - The Value

The YRBS results have tremendous value at the national, state, and local level. Results allow health and educational professionals to track the prevalence of youth risk behaviors over time, to compare their state to other states or to the nation, and even to empower local communities to measure themselves compared to the rest of the state. Understanding the extent to which youth practice health risk behaviors is critical for developing programs that address risk behaviors practiced in their jurisdiction and for measuring progress toward program goals. YRBS results also help with focusing school health education teacher training and instructional programs, supporting health-related legislation, and seeking funding for school health programs.

Alaska's YRBS

Alaska managed to collect enough student responses to the YRBS to get usable data twice since it began administering the survey in 1995. CDC determined that at least 60% of students in the selected sample must complete the survey for it to accurately represent student behavior across the entire state. Alaska was able to get 60% or more responses in 1995 and in 2003. In 2005, Alaska missed achieving an adequate response rate and was unable to use the data. Every effort is being made for a successful survey in 2007.

Here is a sample of Alaska 2003 YRBS data:

- 11.8% of high school boys reported carrying a weapon to school in the last 30 days
- 38.7% of high school students reported drinking alcohol in the last 30 days
- 47.5% of high school students reported having ever used marijuana
- 1 in 4 high school students reporting driving in a vehicle with a driver who drank alcohol in the last 30 days
- 1 in 5 high school girls reported seriously considering suicide in the last 12 months

For more information visit http://www.hss.state.ak.us/dph/chronic/school/pubs/YRBSreport2003.pdf.

DEAR PAT,

I am a health teacher who recently heard that Alaska has a law that requires parental consent for youth health surveys at school. I occasionally utilize classroom surveys with my students and now am concerned if I am following protocol. Is this true, and if so, what should I do? Signed, Alarmed in ABC School

Dear Alarmed in ABC School,

Alaska has had a law, AS 14.03.110, since 1999 that prohibits schools from administering surveys or questionnaires at public schools that inquire into personal or family affairs, or anything else that is not a matter of public record or readily observable in public (regardless of whether or not the surveys are anonymous and voluntary) without first getting written permission from all participating students' parents or legal guardians. This type of requirement is known as active parental consent.

According to the Centers for Disease Control Alaska is one of two or three states in the nation that has a school survey law requiring active parental consent for surveys that are anonymous and voluntary. Most states employ passive parental consent when administering such surveys. Under this system, written notice is sent out to parents informing them of the upcoming survey and the types of questions it will ask, and then permission to participate is assumed unless parents or students indicate otherwise. With passive parental consent all students and parents can decline to participate at any point in the process.

Classroom teachers need to be aware of this law as it applies to small informal surveys teachers may want to include in their instruction as well as to national surveys like the YRBS. Many teachers are surprised to learn of this law and its requirements, and are forced to revisit some of their current instructional assignments and practices to avoid violations. Teachers should check with their school administrators for further guidance.

Addressing active consent is a controversial topic. Advantages to active parental consent are greater parental involvement and less risk of students being included in surveys without parental approval. Disadvantages of active parental consent include the drastically increased costs and labor involved in conducting student surveys, the high failure rates for getting enough student responses to get usable data for larger surveys, the potential for leading to inaccurate/misrepresentative data, the research suggesting that the vast majority of parents consent to their students participating in such surveys, and that most parental failures to provide written permission are driven by apathy, oversight, or student error, not by refusal.

As a health teacher you can do several things to support collections of important health data for local, state and national use. First you can communicate with your site administrator to see if consent for surveys is built into your school's annual parental enrollment packet. Second, you can incorporate lessons on the YRBS into your curriculum, highlighting its findings and its importance. Student health projects could focus on raising community awareness and support for the YRBS and other youth risk behavior surveys. Finally, some students could choose to research Alaska's law around surveys in schools and its current effects on Alaska's youth risk behavior data collection efforts.

***Much of the information in this edition comes from CDC's 2005 Handbook for Conducting YRBS Surveys.

Brain Booster

Answer:

Look at the equation upside down. 16 – 8 = 8

Fundamentals of HIV Prevention Counseling Training

February 12 & 13, 2007
Anchorage, Alaska

The training is designed for HIV test counselors, substance abuse counselors, mental health clinicians, and other responsible for HIV prevention counseling. If you have any questions please contact Carl Aronson at (907) 269-8055.

*****SUBSCRIBE*****

To subscribe directly to our newsletter, visit us at www.eed.state.ak.us/tls/schoolhealth/subscribe.htm

*****FEEDBACK*****

We are looking for feedback! If there are any changes you would like to see made and/or suggestions for content of the newsletter, please send them to Sarah Schaal at sarah_schaal@eed.state.ak.us

School Health Partners:

www.eed.state.ak.us/tls/schoolhealth/

www.hss.state.ak.us/dph/chronic/school/default.htm

Planned Parenthood®
of the Great Northwest

March 9, 2009

The Honorable Bettye Davis
Alaska State Senate
State Capitol, Rm 30
Juneau, AK 99801-1182

Dear Senator Davis:

On behalf of Planned Parenthood of the Great Northwest (PPGNW), I'm writing in support of Senate Bill 101, "*An Act relating to questionnaires and surveys administered in the public schools.*"

Planned Parenthood relies on the results of the school-based Alaska Youth Behavior Risk Survey to determine where our efforts should be in terms of education and STI prevention programs. For accurate survey results it's critical to get as many survey responses as possible. Planned Parenthood recognizes that the current regulations of active parental consent for anonymous surveys decrease the response rate significantly.

Senate Bill 101 will increase the accuracy of the vital information Planned Parenthood and many other organizations rely on to serve Alaska's young people. Thank you for addressing this issue.

Sincerely,

Clover Simon
Vice President of Alaska
Planned Parenthood of the Great Northwest
(907) 770-9705
clover.simon@ppgnw.org

SB 101

ALASKA PUBLIC HEALTH ASSOCIATION

Committed To Advancing Alaska's Public Health Since 1978

ALPHA RESOLUTION 7-2008

Support for Passive Parental Consent for the Youth Risk Behavior Survey

Sponsor: **Jayne Andreen**

Whereas the Youth Risk Behavior Survey (YRBS) is part of an epidemiological surveillance system that was established in 1988 by the Centers for Disease Control and Prevention (CDC) to help monitor the prevalence of behaviors that put young people at risk for the most significant health and social problems that can occur during adolescence and adulthood.

Whereas the survey examines six categories of adolescent behavior including: 1) behaviors that result in unintentional and intentional injuries; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviors that can result in HIV infection, other sexually transmitted diseases (STD's) and unintended pregnancies; 5) dietary behaviors; and 6) physical activity.[1]

Whereas Alaska's YRBS is a joint project between the Dept. of Education & Early Development and the Dept. of Health and Social Services and was established in Alaska in 1995.[2]

Whereas survey results are used at the national, state, and local level such as measuring progress towards the national Healthy People 2010 and the Healthy Alaskans 2010 health objectives.

Whereas, understanding the health risk behaviors of youth is critical for developing programs that address risk behaviors practiced and for measuring progress toward program goals.

Whereas Alaska's YRBS has been unable to collect reliable data consistently with the challenge of administering the survey under the active parental consent law AS 14.03.110, which requires written permission from all participating students' parents or legal guardians. [2]

Whereas employing active parental consent drastically increases costs and labor involved in conducting student surveys, and results in high failure rates for getting enough student responses to get usable data for larger surveys, and the potential for leading to inaccurate/misrepresentative data.[3]

Whereas Alaska is one of only three states in the nation that has a school survey law requiring active parental consent for surveys of this type.[3]

Whereas most states employ passive parental consent when administering such surveys which involves notifying and informing the parents about the survey and assuming that students will participate unless the parent provides a written refusal to opt out of the survey. [3]

Whereas it is believed that the majority of parents consent to their students participating in such surveys and that most parental failures to provide active parental consent (written permission to participate) are driven by apathy, oversight, or student error, not by refusal. [4]

Whereas the survey is anonymous and voluntary.

Therefore be it resolved that the Alaska Public Health Association supports the content and the implementation of the Youth Risk Behavior Survey in Alaska with parental notification and passive parental consent

And be it further resolved that the Alaska Public Health Association supports changing the requirement for participation in the survey from active parental consent to passive parental consent.

References:

[1] Centers for Disease Control and Prevention. Retrieved November 2, 2008 from http://www.cdc.gov/HealthyYouth/yrbs/brief.htm

[2] State of Alaska, Department of Health and Social Services. Retrieved November 2, 2008 from http://www.hss.state.ak.us/dph/chronic/school/YRBS.htm

[3] Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health. (2006) *Parental Permission and the Youth Risk Behavior Survey*. 2006

[4] Ellickson P, Hawes JA. An assessment of active versus passive methods for obtaining parental consent. Evaluation Review 1989;13(1):45–55.

Sen. Bettye Davis

From: Gretchen Clarke [bhantelope@gci.net]
Sent: Sunday, March 22, 2009 9:48 AM
To: Sen. Bettye Davis; Sen. Joe Paskvan; Sen. Johnny Ellis; Sen. Joe Thomas; Sen. Fred Dyson
Subject: Support SB 101

Senators,

I urge you to support SB 101 (Davis) changes the parental permission for Youth Risk Behavior Survey (YRBS) to opt out procedure rather than the current opt in.
YRBS provides critical information regarding the health and behaviors of our young people. It is an anonymous survey and is the 'gold standard' for schools. The information collected by YRBS is crucial for schools and others who work with youth as it provides information that supports grant applications and other sources of youth support funding. However, in order for YRBS to be a useful tool for collecting information, a large number of youth need to take this survey so progress can be noted. Most parents do not object to their children taking part in YRBS. They are just busy and don't get the permission forms returned which leads to school districts spending additional resources to track down permission forms, all in effort to get enough student participation in the survey to get statistically valid results. Please support the change to parental passive consent; parents opposed to their children participating will still be able to refuse participation.
Thank you for your consideration,
Gretchen Clarke
Sitka, AK

SB 105

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

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State Capitol, Suite 30
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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill No. 105

"An Act relating to continuing the secondary public education of a homeless student; relating to the purpose of certain laws as they relate to children; relating to tuition waivers, loans, and medical assistance for a child placed in out-of-home care by the state; relating to foster care; relating to children in need of aid; relating to foster care transition to independent living; and relating to juvenile programs and institutions."

Sponsor Statement

SB 105 provides much needed additional educational, medical, financial, and housing assistance to foster care or "out-of-home" care children and students as they transition through and out of the Alaska state foster care system. An estimated 40% of the 2,000 Alaska foster care youth become homeless after being released from care. Many others wind up in poverty or are incarcerated at higher levels than their peers. SB 105 codifies and increases assistance beyond certain provisions of the federal McKinney-Vento Act, which was reauthorized as Title X, Part C, of the No Child Left Behind Act in January 2002. The McKinney-Vento Act is the primary piece of federal legislation dealing with the education of children and youth experiencing homelessness in U.S. public schools. Fourteen or more states have enacted foster care/educational legislation modeled after some provisions of the McKinney-Vento Act.

Children in foster care struggle academically and suffer more poverty, low self-esteem, emotional trauma, social stigma, and higher mobility than others. They are more likely to drop out of school, repeat grades, and be placed in special education. A 2004 study of Chicago Public School youth found that fifteen-year-old students in out-of-home care were half as likely as other students to have graduated from high school five years later, with 55% having dropped out and 10% having been incarcerated. Only 54% of young adults who age out of care have completed high school. Youth in foster care attending public schools score 16 to 20 percentile points below youth in the general population in statewide standardized tests. And Youth in foster care on average read at only at a 7th grade level after completing 10th or 11th grade. (Casey Family Programs, White Paper, Educating Children in Foster Care, McKinney-Vento and NCLB; also, ABANET.org/Child/Education).

Low educational outcomes are exacerbated by the high mobility of children in foster care. Frequent school changes are associated with an increased risk of failing a grade in school and of repeated behavior problems. By 6th grade, students who have changed schools four or more times have lost approximately 1 year of educational growth. A Casey Foundation study of 1,087 foster care alumni found that youth who

had one fewer placement change per year were almost twice as likely to graduate from high school before leaving care. The Legal Center for Foster Care and Education reported that children and youth in out-of-home care experience, on average, 1 or 2 foster care placement changes per year, citing U.S. Dept. of Health & Human Services Administration for Children and Families. One third of children in foster care stay in care for less than 5 months, and another 17% remain in care for one year or less.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 7, 2009

SUBJECT: Sectional Summary (CSSB 105(EDC);
Work Order No. 26-LS0556\E)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Provides for the continuation of a public education in a student's school of origin for a homeless student under federal specifications. Provides exceptions for a move outside of a school district or for insufficient funding by the legislature. Modifies federal definition of homelessness to include students who are placed in out-of-home care by the state.

Section 2. Provides for a waiver of unmet need for tuition, fees, and room and board expenses at a state-supported educational institution for a person who was placed in out-of-home care at age 16 or older and who meets specified eligibility requirements. The waiver is subject to appropriation.

Section 3. Defines out-of-home care for purposes of student loans and waivers.

Section 4. Changes "foster care" to "out-of-home care" under the procurement code.

Section 5. Amends the state's purpose and policy related to children to include education and intellectual development.

Section 6. Amends the legislative intent related to children to include providing a public education as provided under section 1.

Section 7. Replaces the term "foster homes" with "out-of-home care" for purposes of establishing medical assistance eligibility for certain persons and adds a category of eligibility for persons under 21 years of age who were in out-of-home care for a specified period of time on or after the person's 16th birthday.

Section 8. Defines "out-of-home care" for purposes of medical assistance eligibility.

Section 9. Authorizes the extension of court orders for a child who is in state custody to age 21.

Section 10. Establishes mandatory monthly visits by social workers employed by the department to make monthly home visits, as described, to all children in the custody of the department.

Section 11. Amends the definition of "child" for purposes of the child in need of aid statutes.

Section 12. Defines "out-of-home care" for purposes of the child in need of aid statutes.

Sections 13 - 15. Changes "foster care" to "out-of-home care" for purposes of the transition to the independent living program.

Section 16. Defines "program" to mean "out-of-home care" transition program.

Section 17. Establishes a monetary stipend to be paid to persons who are eligible for the out-of-home care transition program.

Section 18 Defines "out-of-home care" for purposes of the transition program.

JMM:plm
09-259.plm

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: SB105
Bill Version:
() Publish Date:

Identifier (file name): SB105-UA-Sysbra-3-23-09
Dept. Affected: University of Alaska
Title: Tuition Waiver for a child who was in foster care
RDU: University of Alaska
Component: Sysbra
Sponsor: Senators Davis and Ellis
Requester: Education Committee
Component Number:

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual		266.2	279.5	293.5	308.2	323.6	339.7
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**266.2**	**279.5**	**293.5**	**308.2**	**323.6**	**339.7**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF		266.2	279.5	293.5	308.2	323.6	339.7
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**266.2**	**279.5**	**293.5**	**308.2**	**323.6**	**339.7**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB105 extends the current age limit for youth eligible to participate from 23 to 29. The impact of the age limit increase is difficult to predict. Older students could be more apt to take advantage of the opportunity for a higher education than their younger counterparts. It is estimated that each fiscal year 111 youth fit the initial eligibility requirements for this program and may be eligible to receive benefits under this program. If only 20% (22) of these youth enroll at the UA, this would equate to $266,200 per year. A 5% inflation increase is assumed for future fiscal years.

Prepared by: Alesia Kruckenberg
Phone 907-450-8426
Division: University of Alaska
Date/Time 03/24/09 2:00PM
Approved by: Michelle Rizk
Date 03/24/09 2:00PM
Agency: University of Alaska

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB105

ANALYSIS CONTINUATION

For each student taking advantage of the Foster Youth Tuition Waiver Program, the cost in FY10 will be $12,100. This covers tuition and mandatory fees of $5,040 and room and board of $7,060. Under the current agreement with the Department of Health and Social Services, Office of Children's Services (OCS), the University of Alaska annually makes available ten Foster Youth Tuition Waiver Scholarships and the OCS provides additional financial support, up to $5,000 per academic year/per student for approved education related expenses such as; fees, books, supplies, room/board. Under this program youth are eligible until they turn 23 years of age.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB105**
() Publish Date:

Identifier (file name): **SB105-DHSS-CSM-03-05-09**
Dept. Affected: Health & Social Services
Title: Foster Care/CINA/Education of Homeless
RDU: Children's Services
Component: Children's Services Management
Sponsor: Davis
Requester: Senate EDC
Component Number: 2666

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual	204.2		0.0	0.0	0.0	0.0	0.0
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**204.2**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	73.5						
1003 GF Match	130.7						
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**204.2**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The intent of SB 105 is to address the educational, medical, financial, and housing challenges that face youth as they transition out of foster care and to support those care providers that are willing to help them during that period of transition.

The Office of Children's Services Online Resource for the Children of Alaska (ORCA) data base is mandated by the federal government and must be continuously updated to reflect changes in both state and federal law and policy. The following provides the estimated cost of ORCA updates that will be required to implement this bill.

(continued on page 2)

Prepared by: Tammy Sandoval, Director — Phone 465-3191
Division: Office of Children's Services — Date/Time 3/3/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner — Date 3/5/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

BILL NO. SB105

2009 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Requirement	Functional LOE (hours)	Development LOE (hours)	Total LOE (hours)	Cost
Update Services page for new services.	120	80	200	$22,000.00
Update Education page with post-secondary educational institutions.	80	60	140	$15,400.00
Update OHP for unlicensed independent living service categories and service types.	120	80	200	$22,000.00
Update OHP for licensed service categories and service types over 18.	120	100	220	$24,200.00
Update Ref Value for age change from 18 to 21	80	60	140	$15,400.00
Update Eligibility page calculations for new age requirement	180	160	340	$37,400.00
Update Medicaid Eligibility page calculations for new page	180	160	340	$37,400.00
Visitation Report	40	36	76	$8,360.000
Batch updates for OHP and Eligibility	40	160	200	$22,000.00
Days:	**960/8 = 120 days**	**896/8 = 112 days**	**1856/8 = 232 total days**	**Total Estimate $204,160.00**

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB105**
() Publish Date:

Identifier (file name): **SB105-DHSS-FCBR-03-05-09**
Title: Foster Care/CINA/Education of Homeless
Sponsor: Davis
Requester: Senate EDC

Dept. Affected: Health & Social Services
RDU: Children's Services
Component: Foster Care Base Rate
Component Number: 2236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	725.0		445.2	445.2	445.2	445.2	445.2
Miscellaneous							
TOTAL OPERATING	**725.0**	**0.0**	**445.2**	**445.2**	**445.2**	**445.2**	**445.2**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0		55.6	73.9	73.9	73.9	73.9
1003 GF Match	725.0		389.6	371.3	371.3	371.3	371.3
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**725.0**	**0.0**	**445.2**	**445.2**	**445.2**	**445.2**	**445.2**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The intent of SB 105 is to address the educational, medical, financial, and housing challenges that face youth as they transition out of foster care and to support those care providers that are willing to help them during that period of transition.

Sec. 11 amends AS 47.10.990 to change the definition of child to include under age 21 years if that person is living in out-of-home care as defined in AS 47.14.400.

(continued on page 2)

Prepared by: Tammy Sandoval, Director — Phone 465-3191
Division: Office of Children's Services — Date/Time 3/3/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner — Date 3/5/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB105

ANALYSIS CONTINUATION

Assumptions applied to this fiscal note:

Foster care reimbursement payments will be made available to care for children who remain in the custody of the state, who are age 18 through 20;

Approximately 15% (17 children) of the 110 that turn age 18 annually will chose to stay in foster care until age 19; 10% (10) to age 20; 5% to 21 (6); totaling 33 children. This is based simply on program experience and the assumption that most children will want to leave foster care at age 18, but that others who have stable homes will decide to stay with their foster families and that most of these children will attend post secondary education programs.

In addition to the 33 children who may wish to participate in the program in its initial year, approximately 12 of those special needs children who are 18 years of age, 6 at age 19, and 6 at age 20 will remain in care for 2010, bringing the total for 2010 to 57 children. This is based on the current numbers of children who age out with special needs. We estimate that 18 children with special needs age out annually, with 6 of them already staying in foster care until age 20, leaving 12 that may chose to stay in care.

For years 2011 - 2015, the number of participants has been reduced to 35, where it may stabilize because OCS speculates those children reaching the age of 19 or 20 will more likely opt to chose the monetary stipend in this bill.

Calculations are based on 360 days at an average base foster care base rate of $35.33 a day: $35.33 x 30 = $1,060 a month. This calculation is used to equally distribute funding estimates, and makes very little difference to the resulting totals.

Currently, federal reimbursement for the extension of the foster program is not available. However, the Adoption and Guardianship Fostering Connections to Success and Increasing Adoptions Act of 2008 includes the option to extend the assistance age through 20. This fiscal note assumes that option will be implemented when available October 1, 2010, therefore is available for the final three quarters of state fiscal year 2011 forward only.

SFY	# of Children	Age	Annual Cost Per Child	Total Est.	FFP	GF
2010	57	18,19, 20	$12,719	$724,972	$0	$724,972
2011	35	18,19,20	$12,719	$445,158	$55,631	$389,527
2012	35	18,19,20	$12,719	$445,158	$73,862	$371,296
2013	35	18,19,20	$12,719	$445,158	$73,862	$371,296
2014	35	18,19,20	$12,719	$445,158	$73,862	$371,296
2015	35	18,19,20	$12,719	$445,158	$73,862	$371,296

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB105
() Publish Date:

Identifier (file name): SB105-DHSS-FP-03-05-09
Dept. Affected: Health & Social Services
Title: Foster Care/CINA/Education of Homeless
RDU: Children's Services
Component: Family Preservation
Sponsor: Davis
Requester: Senate EDC
Component Number: 1628

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	1,971.4		953.9	953.9	953.9	953.9	953.9
Miscellaneous							
TOTAL OPERATING	**1,971.4**	**0.0**	**953.9**	**953.9**	**953.9**	**953.9**	**953.9**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE	(Thousands of Dollars)						
1002 Federal Receipts			119.2	158.3	158.3	158.3	158.3
1003 GF Match			834.7	795.6	795.6	795.6	795.6
1004 GF	1,971.4						
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**1,971.4**	**0.0**	**953.9**	**953.9**	**953.9**	**953.9**	**953.9**

Estimate of any current year (FY2009) cost:

POSITIONS							
Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The intent of SB 105 is to address the educational, medical, financial, and housing challenges that face youth as they transition out of foster care and to support those care providers that are willing to help them during that period of transition.

Sec. 14 amends AS 47.18 by adding a new section which will allow a monetary stipend, equal to the applicable foster care reimbursement rate, to individuals who are leaving foster care for a 1 year period only.

(contunued on page 2)

Prepared by: Tammy Sandoval, Director — Phone 465-3191
Division: Office of Children's Services — Date/Time 3/3/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner — Date 3/5/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB105

ANALYSIS CONTINUATION

Assumptions applied to this fiscal note:

The monetary stipends will be made available to children leaving out of home care, who are age 18 through 20, and does not need to be requested immediately upon leaving care;

70% of the 220 children currently participating in the Independent Living Program (IL) will become eligible for monetary stipends in FY2010 (ages 18, 19, and 20) – equating to about 155 FTEs (full time equivalents), resulting in higher program costs the first year the stipends are available. FTEs help provide a more stable count as it is assumed that recipients will migrate on and off the program and not all will receive a full year's stipends;

After the first year of stipends, it is assumed that about 1/3 of the IL population will be eligible for and request monetary stipends annually equaling 75 FTEs, and that number will remain somewhat static;

Calculations are based on 360 days at an average base foster care base rate of $35.33 a day: $35.33 x 30 = $1,060 a month.

Currently, federal reimbursement for the extension of the IL program is not available. However, the Adoption and Guardianship Fostering Connections to Success and Increasing Adoptions Act of 2008 includes the option to extend the assistance age through 20 under certain conditions. This fiscal note assumes those conditions will be established in regulation and when met, IV-E reimbursement will apply. This option is available October 1, 2010, therefore is available for the final three quarters of state fiscal year 2011.

	FTEs	Cost Per Month	Total Cost	Estimated FFP	GF
SFY 2010	155	$1,060	$1,971,414	$0	$1,971,414
SFY2011	75	$1,060	$953,910	$119,207	$834,703
SFY2012	75	$1,060	$953,910	$158,273	$795,637
SFY2013	75	$1,060	$953,910	$158,273	$795,637
SFY2014	75	$1,060	$953,910	$158,273	$795,637
SFY2015	75	$1,060	$953,910	$158,273	$795,637

Covenant
House
Alaska
Crisis Center · Community Services Center · Transitional Living

Representative Les Gara and Senator Bettye Davis
State Capitol
Juneau, AK 99801

February 23, 2009

Dear Representative Gara and Senator Davis,

Thank you for introducing legislation to address the needs of foster care youth, both while they are in the state's custody and when they "age-out" of the current system. Providing resources and support to our foster care children decreases the need for long-term public assistance and criminal justice resources. Responding to research that clearly identifies proven strategies for assisting our youth to independent adulthood is not only compassionate, it is fiscally sound policy.

Between 35% and 50% of foster care youth become homeless after being released from care. Covenant House Alaska (CHA) serves the homeless and at-risk youth of our state through four main programs (50% of CHA youth have been involved in the foster care system). Our Crisis Center provides shelter, food, clothing, primary health care and support resources to homeless youth. Our Community Services Center is a drop-in center that provides case management, employment assistance, educational tutoring, counseling and substance abuse referrals and life skills training. Two different programs, Rights of Passage and Passage House help youth transition to independent living and self-sufficiency. Youth can participate in either program for 18 months with up to 12 months of additional aftercare.

Through these programs, CHA is certain that increased job training, educational opportunities, rental assistance and social worker visits will benefit children in foster care. Similarly, offering consistency whenever possible through maintaining one school for children despite changes in foster care placement is essential. CHA appreciates the multi-faceted approach HB 126 and SB 105 offers.

Thank you for sponsoring this legislation and providing a voice to youth in foster care.

Sincerely,

Deirdre A. Cronin
Executive Director

Educational Stability for Youth in Foster Care

The McKinney-Vento Act[1] applies to many children in DFCS custody and provides those children with rights that promote educational stability.

What is the McKinney-Vento Act?

- McKinney-Vento is a federal law that promotes stability, access, and academic success for homeless youth. McKinney-Vento also provides assistance for homeless youth with enrollment in a new school, transportation to school, and other educational and supplemental services. It promotes educational stability by allowing homeless youth to remain in their school of origin even if homelessness has caused them to move outside the school district. School of origin is defined as the school a student attended before becoming homeless or the school where the student was last enrolled.

Are children in foster care homeless?

- In order to be eligible for the benefits and services provided for by the McKinney-Vento Act, a student must meet the criteria for homelessness. Some children in foster care meet the criteria and are therefore considered homeless under the Act.
- The McKinney-Vento Act defines homeless children and youth as "(A) individuals who lack a fixed, regular and adequate nighttime residence…; and (B) includes – (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations; *are living in emergency or transitional shelters; are abandoned in hospitals*; *or are awaiting foster care placement*…."[2] Thus, some children in DFCS custody are considered homeless for the purpose of the McKinney-Vento Act, specifically children living in shelters, abandoned in hospitals, and children awaiting foster care placement
- Using McKinney-Vento to secure rights for children in foster care helps to minimize educational disruption. The child is able to remain in the same school, continue with the current academic curriculum, and is less likely to fall behind academically.

Are children covered by McKinney-Vento after they move into a foster home?

- Once the provisions of McKinney-Vento have been met, an eligible child remains eligible for services for the remainder of that school year even if s/he moves into a foster home.
- When the next school year begins, if the child continues to live in a foster home, s/he will no longer qualify under McKinney-Vento and at that time may have to transfer to a school in the district where s/he is residing.

What about the documents schools require to enroll a child in school?

- McKinney-Vento requires schools to immediately enroll homeless children in school even without records normally required for enrollment, such as previous academic records, medical records including immunization records, proof of guardianship, and proof of residency.
- The enrolling school must contact the last school attended to obtain relevant records to facilitate enrollment and the school should refer the child to the school liaison for assistance in obtaining immunization records.

What if the child has moved out of district and the old school refuses to allow the child to continue to attend?

- All decisions about where a homeless child shall be allowed to go to school must be made according to the child's best interests. In determining best interests of the child, the local educational agency shall "to the extent feasible, keep a homeless child or youth in the school of origin, except when doing so is contrary to the wishes of the child's or youth's parent or guardian."[3]

Created by:
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- ❖ Whenever there is a disagreement between a school and a parent, guardian, or youth, the school must:
  - Immediately enroll the student in the school the parent, guardian, or youth chooses;
  - Keep the student at that school until the disagreement is settled;
  - Explain, in writing, its decision and the right to have the disagreement settled; AND
  - Send the parent, guardian or youth to the Georgia Liaison/Coordinator of Education for Homeless Children and Youth to settle the disagreement quickly. Please see the contact information below.

What if it is best to transfer the child to a new school in the district where the foster parents or relative placement live?

- ❖ Homeless children and youth have the right to stay in the school they went to before they lost their housing, to stay at whatever school they were enrolled in last, or to attend the local school where they are now living.

Is there any help with transportation?

- ❖ If McKinney-Vento applies to the child, then the school district must provide or arrange transportation for the student to stay at the school of origin, even if the student moves to a different city, county, or school district.
  - If a student is living in the same school district as the school of origin, then that school district has to provide transportation. If the student moves across district lines, then both districts have to work together to provide transportation.

What type of transportation will the school provide?

- ❖ Schools can provide transportation in different ways, including:
  - Re-routing school buses and making sure buses go to shelters, group homes and other places where students live;
  - Providing passes for public buses and subways, including passes for caretakers when needed;
  - Using the transportation systems social services use;
  - Using approved van or taxi services;
  - Reimbursing parents, guardians or youth for gas;
  - Working with service providers and public assistance agencies to make transportation plans or provide transportation;
  - Getting local businesses or other agencies to help with transportation costs; and

Where can I get more information?

- ❖ The National Law Center on Homelessness & Poverty, www.nlchp.org.
- ❖ Georgia's Education for Homeless Children and Youth Coordinator is Mr. David Davidson. He can be reached at phone 404-651-7555 or e-mail ddavidso@doe.k12.ga.us.
- ❖ The Georgia Law Center for the Homeless, www.galawcenter.org , phone: 404-681-0680.

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[1] The McKinney -Vento Act codified as amended at 42 U.S.C.A. §11432 through §11434a(2)(2004).
[2] 42 U.S.C.A.§11434a(2)(B)(2004)(emphasis added).
[3] 42 U.S.C.A. §11432(3)(B)(i)(2004).

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origin, as determined in paragraph (3)(A), in accordance with the following, as applicable:

(I) If the homeless child or youth continues to live in the area served by the local educational agency in which the school of origin is located, the child's or youth's transportation to and from the school of origin shall be provided or arranged by the local educational agency in which the school of origin is located.

(II) If the homeless child's or youth's living arrangements in the area served by the local educational agency of origin terminate and the child or youth, though continuing his or her education in the school of origin, begins living in an area served by another local educational agency, the local educational agency of origin and the local educational agency in which the homeless child or youth is living shall agree upon a method to apportion the responsibility and costs for providing the child with transportation to and from the school of origin. If the local educational agencies are unable to agree upon such method, the responsibility and costs for transportation shall be shared equally.

(2) COMPLIANCE-

(A) IN GENERAL- Each plan adopted under this subsection shall also describe how the State will ensure that local educational agencies in the State will comply with the requirements of paragraphs (3) through (7).

(B) COORDINATION- Such plan shall indicate what technical assistance the State will furnish to local educational agencies and how compliance efforts will be coordinated with the local educational agency liaisons designated under paragraph (1)(J)(ii).

(3) LOCAL EDUCATIONAL AGENCY REQUIREMENTS-

(A) IN GENERAL- The local educational agency serving each child or youth to be assisted under this subtitle shall, according to the child's or youth's best interest--

(i) continue the child's or youth's education in the school of origin for the duration of homelessness--

(I) in any case in which a family becomes homeless between academic years or during an academic year; or

(II) for the remainder of the academic year, if the child or youth becomes permanently housed during an academic year; or

(ii) enroll the child or youth in any public school that nonhomeless students who live in the attendance area in which the child or youth is actually living are eligible to attend.

(B) BEST INTEREST- In determining the best interest of the child or youth under subparagraph (A), the local educational agency shall--

(i) to the extent feasible, keep a homeless child or youth in the school of origin, except when doing so is contrary to the wishes of the child's or youth's parent or guardian;

(ii) provide a written explanation, including a statement regarding the right to appeal under subparagraph (E), to the homeless child's or youth's parent or guardian, if the local

educational agency sends such child or youth to a school other than the school of origin or a school requested by the parent or guardian; and

(iii) in the case of an unaccompanied youth, ensure that the homeless liaison designated under paragraph (1)(J)(ii) assists in placement or enrollment decisions under this subparagraph, considers the views of such unaccompanied youth, and provides notice to such youth of the right to appeal under subparagraph (E).

(C) ENROLLMENT- (i) The school selected in accordance with this paragraph shall immediately enroll the homeless child or youth, even if the child or youth is unable to produce records normally required for enrollment, such as previous academic records, medical records, proof of residency, or other documentation.

(ii) The enrolling school shall immediately contact the school last attended by the child or youth to obtain relevant academic and other records.

(iii) If the child or youth needs to obtain immunizations, or immunization or medical records, the enrolling school shall immediately refer the parent or guardian of the child or youth to the local educational agency liaison designated under paragraph (1)(J)(ii), who shall assist in obtaining necessary immunizations, or immunization or medical records, in accordance with subparagraph (D).

(D) RECORDS- Any record ordinarily kept by the school, including immunization or medical records, academic records, birth certificates, guardianship records, and evaluations for special services or programs, regarding each homeless child or youth shall be maintained--

(i) so that the records are available, in a timely fashion, when a child or youth enters a new school or school district; and

(ii) in a manner consistent with section 444 of the General Education Provisions Act (20 U.S.C. 1232g).

(E) ENROLLMENT DISPUTES- If a dispute arises over school selection or enrollment in a school--

(i) the child or youth shall be immediately admitted to the school in which enrollment is sought, pending resolution of the dispute;

(ii) the parent or guardian of the child or youth shall be provided with a written explanation of the school's decision regarding school selection or enrollment, including the rights of the parent, guardian, or youth to appeal the decision;

(iii) the child, youth, parent, or guardian shall be referred to the local educational agency liaison designated under paragraph (1)(J)(ii), who shall carry out the dispute resolution process as described in paragraph (1)(C) as expeditiously as possible after receiving notice of the dispute; and

(iv) in the case of an unaccompanied youth, the homeless liaison shall ensure that the youth is immediately enrolled in school pending resolution of the dispute.

(F) PLACEMENT CHOICE- The choice regarding placement shall be made regardless of whether the child or youth lives with the homeless parents or has been temporarily placed elsewhere.

(G) SCHOOL OF ORIGIN DEFINED- In this paragraph, the term 'school of origin' means the school that the child or youth attended when permanently housed or the school in which the child or youth was last enrolled.

(H) CONTACT INFORMATION- Nothing in this subtitle shall prohibit a local educational agency from requiring a parent or guardian of a homeless child to submit contact information.

(4) COMPARABLE SERVICES- Each homeless child or youth to be assisted under this subtitle shall be provided services comparable to services offered to other students in the school selected under paragraph (3), including the following:

(A) Transportation services.

(B) Educational services for which the child or youth meets the eligibility criteria, such as services provided under title I of the Elementary and Secondary Education Act of 1965 or similar State or local programs, educational programs for children with disabilities, and educational programs for students with limited English proficiency.

(C) Programs in vocational and technical education.

(D) Programs for gifted and talented students.

(E) School nutrition programs.

(5) COORDINATION-

(A) IN GENERAL- Each local educational agency serving homeless children and youths that receives assistance under this subtitle shall coordinate--

(i) the provision of services under this subtitle with local social services agencies and other agencies or programs providing services to homeless children and youths and their families, including services and programs funded under the Runaway and Homeless Youth Act (42 U.S.C. 5701 et seq.); and

(ii) with other local educational agencies on interdistrict issues, such as transportation or transfer of school records.

(B) HOUSING ASSISTANCE- If applicable, each State educational agency and local educational agency that receives assistance under this subtitle shall coordinate with State and local housing agencies responsible for developing the comprehensive housing affordability strategy described in section 105 of the Cranston-Gonzalez National Affordable Housing Act (42 U.S.C. 12705) to minimize educational disruption for children and youths who become homeless.

(C) COORDINATION PURPOSE- The coordination required under subparagraphs (A) and (B) shall be designed to--

(i) ensure that homeless children and youths have access and reasonable proximity to available education and related support services; and

(ii) raise the awareness of school personnel and service providers of the effects of short-term stays in a shelter and other challenges associated with homelessness.

(6) LOCAL EDUCATIONAL AGENCY LIAISON-

(A) DUTIES- Each local educational agency liaison for homeless children and youths, designated under paragraph (1)(J)(ii), shall ensure that--

YAHOO! NEWS PRINT Back to story

Foster kids find college help after 'aging out'

Associated Press

By ZINIE CHEN SAMPSON, Associated Press Writer
Fri Mar 13, 4:58 am ET

RICHMOND, Va. – Community colleges in several states are working to establish stronger support systems for former foster-care children, who are more likely to wind up homeless or in jail than earn a degree as they struggle to overcome unstable lives.

Among them is Virginia, where the Community College System's Great Expectations program uses grants and donations to provide money for tuition, transportation and living expenses. It also connects more than 120 students with mentors, career counselors and other help at seven of the state's two-year schools.

Many other states have started their own initiatives to help youths in foster care once they "age out" of the system and venture into adulthood. And it's needed: More than a quarter of foster-care youth will be incarcerated and more than 20 percent will be homeless before age 25, according to a 2007 report by public-policy group Pew Charitable Trusts.

Only 20 percent of foster-care youth nationally will seek education beyond high school, and fewer than 3 percent are expected to graduate from college.

"I never thought I'd ever get my high school diploma, and never thought I'd start college at 17, too," said Andrea Hatcher, who dropped out of high school and was shuffled among group homes and foster care in different cities after her mother lost custody of her when she was 14.

Hatcher, now 18, hopes to pursue a nursing degree now that she's completed her nursing assistant certificate at Southside Virginia Community College through the program, which started this school year. She regularly communicates with her academic adviser, who helped her navigate the education system and kept her on task.

In California, higher-education officials set up a support network for former foster children in the state's 110 community colleges, and the state's four-year systems offer similar help for housing, financial aid, academic advising and other needs. A 1996 state law called on state schools to expand services for former foster youth.

Federal legislation that took effect in 2003 helped such initiatives, said John Emerson, a postsecondary education adviser for Casey Family Programs, a foster-care advocacy group. It provided an initial $42 million, allocated to every state based on its percentage of foster-care youth, to cover up to $5,000 annually per student for college or job training.

And when Congress reauthorized the Higher Education Act last fall, it required some federally funded

programs to target students who had been in foster care, including initiatives that help low-income students pursue postsecondary education.

Giving foster-care students money for college or career-training courses opens the door but doesn't help them overcome poor academic preparation, lack of family support and homelessness, Emerson said.

"We've heard from students who have enrolled in college so they can find a place to sleep," he said. "They're using their survival skills to find a place to stay and food to eat — let alone transportation and health insurance."

Nationally, more than 800,000 children are in the foster-care system, according to the National Working Group on Foster Care and Education, a coalition of child-welfare groups.

Virginia has about 8,000 children in foster care, and about half — a higher percentage than any other state — leave the system without a permanent home, according to Great Expectations.

Many foster children must overcome their belief that everything in life is unstable because of their experiences moving from home to home, said Casey Irving, Hatcher's case worker at Southside Virginia Community College. They also must learn to trust others for guidance.

Hatcher admits her earlier attitude and behavior made things difficult.

After her mother lost custody of her and she moved in with an aunt, Hatcher said she skipped school to "party all night, and I would drink and get high and do pills every day." Her aunt eventually turned her over to the state, and such behavior got her booted from two group homes.

Two other group homes shut down, and Hatcher eventually moved into a foster home.

But with her social worker's help, Hatcher earned a high school equivalency diploma and finished her nursing assistant certificate in December. Now, she regularly checks in with Irving and others at the school.

"I always have somebody to go to — they're still there any time I need to talk to them," she said. "They'd do anything for me."

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Senator Bettye Davis

CS for Senate Bill No. 105 ( ), 26-LS0056\R

"An Act relating to continuing the secondary public education of a homeless student; relating to the purpose of certain laws as they relate to children; relating to tuition waivers, loans, and medical assistance for a child placed in out-of-home care by the state; relating to foster care; relating to children in need of aid; and relating to out-of-home care transition to independent living.

Changes in CSSB 105( ), 26-LS0056\R from SB 105, 26-LS0056\A

- Extends McKinney-Vento Act provisions for comparable education and transportation of a homeless student to "school of origin" for the "remainder of the school year, or if the student is attending school for a summer term." (Section 1).
- Removes exemption of McKinney-Vento provisions regarding "school of origin" if the "superintendent of the school district makes a written finding that a waiver of the requirement is in the student's best academic interest and the finding is mailed to the school board and to the person in charge of children's services for the Department of Health and Social Services."
- Changes "foster care" to "out-of-home care" for purposes of the transition to the independent living program under Sections 13-15.
- Increases one-year extensions of commitment to state custody in the best interest of the child beyond age 19 from a maximum age of 20 to age 21. (Section 9).
- Eliminates state educational loans and deferred payment and interest for a child who was in out-of-home care and was eligible for a tuition waiver to offset the person's tuition, fees, and room and board expenses in a state-supported educational institution.
- Limits monetary stipend upon leaving foster care to not more than one year and shall end before individual is 23 years of age. (Section 17).

105

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Wednesday, April 08, 2009 6:21 PM
To: Lynda Zaugg; Jennifer Thorsteinson
Cc: Rowland, Mindy B (GOV); Horton, Tara J (HSS); Elgee, Alison M (HSS)
Subject: RE: SB 105 Fiscal Notes

Lynda, Mindy asked me to clarify with you that only the Family Preservation fiscal note changed. We've been instructed by OMB only to re-submit fiscal notes that change and let the senate secretary/house clerk revise the fiscal note number and publish date to reflect existing notes that still pertain to a CS. In this case, we mistakenly submitted all three. We may need to get this straightened out with the senate secretary's office. I can to you more about it tomorrow if you have questions.

w.

From: Yerkes, Reuben A (GOV)
Sent: Wednesday, April 08, 2009 4:41 PM
To: Davis, Bettye J (LAA); Obermeyer, Thomas S (LAA); Zaugg, Lynda (LAA); Thorsteinson, Jennifer A (LAA)
Cc: Rowland, Mindy B (GOV); Laughlin, Wilda J (HSS); Horton, Tara J (HSS)
Subject: SB 105 Fiscal Notes

Please find three fiscal notes attached for SB 105. Let me know if I can be of further assistance.

Have a great day,

Reuben Yerkes
Governor's Legislative Office
Office of the Governor
(907)465-4021

Lynda Zaugg

From: Thomas Obermeyer
Sent: Tuesday, April 07, 2009 6:46 PM
To: Lynda Zaugg
Subject: FW: SB 105 Homeless Students

Lynda, For HSS committee member distribution. Tom

-----Original Message-----
From: Friedman_Jeff [mailto:Friedman_Jeff@asdk12.org]
Sent: Tuesday, April 07, 2009 4:23 PM
To: Sen. Bettye Davis; Thomas Obermeyer
Cc: Comeau_Carol; Siegfried_Robin; Steiner_John
Subject: SB 105 Homeless Students

Dear Senator Davis

As you know, the Anchorage School District has been supportive of this bill, but some of the recent changes raise a caution flag.

The extension of the transportation requirement through summer school is one possible problem. We do not provide transportation for summer school except for some of the Title I programs. If the homeless student wanted to attend summer school, and they were not in a Title I school, would we still be required to provide transportation? Also, not all of our schools have a summer school program. Would we be required to make the school of origin a summer school if there was a homeless student attending that school? The bill is not provide entirely clear answers to these questions.

Second, if the homeless or foster care student is living in Anchorage, but the school of origin is in Palmer, Kenai, or Nome, are we required to provide transportation? I think I know the answer to this one, but it is important that the legislative history make this clear in case it is challenged later.

Third, there are sometimes situations where it is important for the Superintendent to be allowed to issue a waiver. That was recently removed from this bill. For example, sometimes the homeless or foster care student would prefer to attend a school where his or her cousin attends rather than the school of origin. Sometimes that is in the student's best interests, and there should be a waiver process in place.

I will try to follow up on these three issues before this bill gets its next committee hearing, but I wanted to give you some advance notice of our potential concerns.

Jeff Friedman
Anchorage School Board
1534 D Street
Anchorage, AK 99501
907-742-4699 (Home)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB105(HSS)
() Publish Date:

Identifier (file name): SB105CS(HSS)-DHSS-FP-04-14-09
Dept. Affected: Health & Social Services
Title: Foster Care/CINA/Education of Homeless
RDU: Children's Services
Component: Family Preservation
Sponsor: Davis, Ellis
Requester: Senate HSS
Component Number: 1628

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	555.9		617.1	382.5	382.5	382.5	382.5
Miscellaneous							
TOTAL OPERATING	**555.9**	**0.0**	**617.1**	**382.5**	**382.5**	**382.5**	**382.5**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts			77.1	63.1	63.1	63.1	63.1
1003 GF Match			540.0	319.4	319.4	319.4	319.4
1004 GF	559.1						
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**559.1**	**0.0**	**617.1**	**382.5**	**382.5**	**382.5**	**382.5**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The intent of CS SB 105 is to address the educational, medical, financial, and housing challenges that face youth as they transition out of foster care and to support those care providers that are willing to help them during that period of transition.

The bill amends AS 47.18 by adding a new section which will allow a monetary stipend to individuals leaving out-of-home care. Fiscal analysis is not supported by data but based on assumptions from program experience. The note addresses the following assumptions:

The living expense stipend will be made available to youth between the ages of 18 and 21 (18, 19 & 20 year olds) (continued on next page)

Prepared by: Tammy Sandoval, Director
Phone 465-3191
Division: Office of Children's Services
Date/Time 4/13/09 12:00 AM

Approved by: Alison Elgee, Assistant Comissioner
Date 4/14/2009
DHSS Finance and Management Services

FISCAL NOTE

STATE OF ALASKA **BILL NO.** CSSB105(HSS)

2009 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

who have left out of home care and does not need to be requested immediately upon leaving care. The stipend will be available to youth who age out of foster care for 6 months at a maximum monthly rate of $1,060.00, and 3 months at an adjusted maximum rate of $525.00 per month. Any one stipend cannot exceed $6,120 per nine month period. Stipend availability expires at age 21 years.

An exception will be made for youth who remain in custody to age 21. The stipend will be available to youth who age out of foster care at age 21, for 6 months at a maximum monthly rate of $1,060.00 and 3 months at an adjusted maximum rate of $525.00 per month immediately after release from custody. Any one stipend cannot exceed $6,120. We anticipate that the youth who remain in custody to age 21 will fall within the 70% calculation used in this fiscal note. No additional funding has been requested for these youth as the numbers are minimal – 10 or less.

Approximately 70% of the 220 youth who currently participate in the Independent Living Program will continue their involvement in the program after being released from custody and will more likely than not apply for the living expense stipend. This note also assumes that 70% of those 155 youth likely to participate will apply during the first year the stipend is available. The remaining 30% will apply during the second year of the program.

OCS assumes that under regulation yet to be written, a scaled methodology to determine the exact amount of each stipend will be developed. To that point, the stipend will be available within the authorized funding only. It is assumed that the program is not meant to be an entitlement program but a definitive amount of limited funds distributed based on each youth's Independent Living Program participation plan.

Applying the previous assumption, this fiscal note is calculated on a daily rate based on the mean between a minimum of $300 and a maximum of $1,060 per month, or $680 per month. Federal fund participation is not available for an extension of the Independent Living Program until October 1, 2010, so therefore federal participation is adjusted to none for FY 2010 and three quarters for FY 2011.

Maximum availability of stipend:

$1,060.00	per month for 6 months	$6,360.00	annual maximum
$525.00	per month for 3 months	$1,575.00	annual maximum
	Total annual maximum	$7,935.00	

Program Participation:

FY 2010

220 average number of youth participating in Independent Living at any given time
70% assumption that 70% of those 220 youth will apply for stipends and continue participation in the IL progr
155 youth currently ages 18, 19, and 20 years will apply for stipends the first or second year of the program
70% of the 155 (109) youth will apply for stipends in the first year of the program
109 youth will participate in the program during FY 2010

FY 2011

70% assumption that 70% of those 110 youth will apply for stipends and continue in the IL program annually
75 youth who turn 18 each year and age out of foster care will apply for stipends
30% of the 155 (46) youth will apply for stipends in the second year of the program
121 youth will participate in the program during FY 2011

FY 2012 - FY 2105

110 average number of youth who turn 18 and age out of foster care annually
70% assumption that 70% of those 110 youth will apply for stipends and continue in the IL program annually
75 youth who turn 18 each year and age out of foster care will apply for stipends

Fiscal Year	FTEs Participating	Approximate Cost per 6 Months	Approximate Cost per 3 Months	Total Cost Per FTE for 9 Months	Total Program Cost	Estimated Federal Participation	Estimated General Fund
SFY 2010	109	$4,080.00	$1,020.00	$5,100.00	$555,900.00	0	$555,900.00
SFY 2011	121	$4,080.00	$1,020.00	$5,100.00	$617,100.00	$77,137.50	$539,962.50
SFY 2012	75	$4,080.00	$1,020.00	$5,100.00	$382,500.00	$63,112.50	$319,387.50
SFY 2013	75	$4,080.00	$1,020.00	$5,100.00	$382,500.00	$63,112.50	$319,387.50
SFY 2014	75	$4,080.00	$1,020.00	$5,100.00	$382,500.00	$63,112.50	$319,387.50
SFY 2015	75	$4,080.00	$1,020.00	$5,100.00	$382,500.00	$63,112.50	$319,387.50

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 11, 2009

SUBJECT: Sectional Summary (CSSB 105(HSS);
Work Order No. 26-LS0556\C)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Provides for the continuation of a public education in a student's school of origin for a homeless student under federal specifications. Provides exceptions for a move outside of a school district or for insufficient funding by the legislature. Modifies federal definition of homelessness to include students who are placed in out-of-home care by the state.

Section 2. Provides for a waiver of unmet need for tuition, fees, and room and board expenses at a state-supported educational institution for a person who was placed in out-of-home care at age 16 or older and who meets specified eligibility requirements. The waiver is subject to appropriation.

Section 3. Changes "foster care" to "out-of-home care" under the procurement code.

Section 4. Amends the state's purpose and policy related to children to include education and intellectual development.

Section 5. Amends the legislative intent related to children to include providing a public education as provided under section 1.

Section 6. Replaces the term "foster homes" with "out-of-home care" for purposes of establishing medical assistance eligibility for certain persons and adds a category of

eligibility for persons under 21 years of age who were in out-of-home care for a specified period of time on or after the person's 16th birthday.

Section 7. Defines "out-of-home care" for purposes of medical assistance eligibility.

Section 8. Authorizes the extension of court orders for a child who is in state custody to age 21.

Section 9. Establishes mandatory monthly visits by social workers employed by the department to make monthly home visits, as described, to all children in the custody of the department.

Section 10. Amends the definition of "child" for purposes of the child in need of aid statutes.

Section 11. Defines "out-of-home care" for purposes of the child in need of aid statutes.

Sections 12 - 14. Changes "foster care" to "out-of-home care" for purposes of the transition to the independent living program.

Section 15. Defines "program" to mean "out-of-home care" transition program.

Section 16. Establishes a monetary stipend to be paid to persons who are participating in the out-of-home care transition program.

Section 17 Defines "out-of-home care" for purposes of the transition program.

JMM:ljw
09-242.ljw

26-LS0556\C
Mischel
4/11/09

CS FOR SENATE BILL NO. 105(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, Ellis

4/13/09 accepted w/ mmt

A BILL

FOR AN ACT ENTITLED

"An Act relating to continuing the secondary public education of a homeless student; relating to the purpose of certain laws as they relate to children; relating to tuition waivers and medical assistance for a child placed in out-of-home care by the state; relating to foster care; relating to children in need of aid; and relating to out-of-home care transition to independent living."

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

* **Section 1.** AS 14.03 is amended by adding a new section to read:

Sec. 14.03.096. Continuing the public education of a homeless student. (a) Except as provided in (b) and (d) of this section, the governing body of a school district shall comply with the requirements for continuing the public education of a homeless student in the student's school of origin and for providing comparable education and transportation services for the remainder of the current school year or, if the student is attending school for a summer term, for the remainder of the summer

term, under 42 U.S.C. 11431 - 11435 (McKinney-Vento Homeless Education Assistance Improvement Act of 2001), as those provisions existed on February 1, 2009.

(b) The requirements in (a) of this section do not apply if the student moves to a school district other than the school district in which the student's school of origin is located.

(c) If a homeless student is transferred to a school other than the student's school of origin, the school of origin shall provide a copy of the student's records to the student's new school within seven school days after notification of the transfer. The student's new school shall allow the student to attend school while awaiting the transfer of records under this subsection.

(d) A school district is required to comply with this section only

(1) if the legislature appropriates funds for the purpose; and

(2) to the extent possible using funds appropriated for the purpose.

(e) In this section,

(1) "homeless student" has the meaning given in 42 U.S.C. 11434a for "homeless child or youth," and the phrase "awaiting foster care placement" in that definition shall be interpreted to include all students who are placed in out-of-home care and in the custody of the Department of Health and Social Services under AS 47.10.080(c) or who are committed to the custody of the Department of Health and Social Services under AS 47.12.120(b)(1) or (3);

(2) "school of origin" means the school in which the student was last enrolled.

*** Sec. 2.** AS 14.43 is amended by adding a new section to read:

Article 3A. Free Tuition for a Person Who Was in Out-of-Home Care.

Sec. 14.43.086. Free tuition and fees for a person who was in out-of-home care. (a) A person who enrolls as a student in good standing in a state-supported educational institution in the state is entitled to a waiver of tuition, fees, and room and board expenses if the person provides adequate proof that the person

(1) was in the custody of the state under AS 47.10 or AS 47.14;

(2) was placed in out-of-home care for a period of not less than six

consecutive months on or after the person became 16 years of age; and

(3) is under 29 years of age.

(b) The amount of the waiver to which a person is entitled under this section is the amount of unmet need for tuition, room, and board expenses, as determined by the institution, after deducting funding for the school year from education loans, grants, or scholarships received by a person eligible for a waiver.

(c) The proceeds of an education loan, grant, or scholarship received by a person eligible for a waiver under this section must be paid to the educational institution to offset the person's tuition, fees, and room and board expenses.

(d) A state-supported educational institution in the state is required to provide a waiver under (a) of this section only if the legislature appropriates funds for the purpose of offsetting waivers under this section. If an appropriation is not sufficient to fully offset waivers for each person entitled to a waiver under (a) of this section, the institution may offer full or partial waivers to eligible applicants as funding permits and at the discretion of the institution.

(e) In this section, "out-of-home care" has the meaning given in AS 47.14.400.

*** Sec. 3.** AS 36.30.850(b)(42) is amended to read:

(42) grants and contracts with qualified entities for services under AS 47.18.330 for the **out-of-home** [FOSTER] care transition program;

*** Sec. 4.** AS 47.05.060 is amended to read:

Sec. 47.05.060. Purpose and policy relating to children. The purpose of this title as it relates to children is to secure for each child the care and guidance, preferably in the child's own home, **as well as an adequate education,** that will serve the moral, emotional, mental, **intellectual,** and physical welfare of the child and the best interests of the community; to preserve and strengthen the child's family ties unless efforts to preserve and strengthen the ties are likely to result in physical or emotional damage to the child, removing the child from the custody of the parents only as a last resort when the child's welfare or safety or the protection of the public cannot be adequately safeguarded without removal; and, when the child is removed from the family, to secure for the child adequate custody**, education,** and care and adequate planning for permanent placement of the child.

* **Sec. 5.** AS 47.05.065 is amended to read:

Sec. 47.05.065. Legislative findings related to children. The legislature finds that

(1) parents have the following rights and responsibilities relating to the care and control of their child while the child is a minor:

(A) the responsibility to provide the child with food, clothing, shelter, education, and medical care;

(B) the right and responsibility to protect, nurture, train, and discipline the child, including the right to direct the child's medical care and the right to exercise reasonable corporal discipline;

(C) the right to determine where and with whom the child shall live;

(D) the right and responsibility to make decisions of legal or financial significance concerning the child;

(E) the right to obtain representation for the child in legal actions; and

(F) the responsibility to provide special safeguards and care, including appropriate prenatal and postnatal protection for the child;

(2) it is the policy of the state to strengthen families and to protect children from child abuse and neglect; the state recognizes that, in some cases, protection of a child may require removal of the child from the child's home; however,

(A) except in those cases involving serious risk to a child's health or safety, the Department of Health and Social Services should provide time-limited family support services to the child and the child's family in order to offer parents the opportunity to remedy parental conduct or conditions in the home that placed the child at risk of harm so that a child may return home safely and permanently; and

(B) the state also recognizes that when a child is removed from the home, visitation between the child and the child's parents or guardian and family members reduces the trauma for the child and enhances the likelihood that the child will be able to return home; therefore, whenever a child is

removed from the parental home, the Department of Health and Social Services should encourage frequent, regular, and reasonable visitation of the child with the child's parent or guardian and family members;

(3) it is the policy of the state to recognize that, when a child is a ward of the state, the child is entitled to reasonable safety, adequate care, and adequate treatment and that the Department of Health and Social Services as legal custodian and the child's guardian ad litem as guardian of the child's best interests and their agents and assignees, each should make reasonable efforts to ensure that the child is provided with reasonable safety, adequate care, and adequate treatment for the duration of time that the child is a ward of the state;

(4) it is in the best interests of a child who has been removed from the child's own home for the state to apply the following principles in resolving the situation:

(A) the child should be placed in a safe, secure, and stable environment;

(B) the child should not be moved unnecessarily;

(C) a planning process should be followed to lead to permanent placement of the child;

(D) every effort should be made to encourage psychological attachment between the adult caregiver and the child;

(E) frequent, regular, and reasonable visitation with the parent or guardian and family members should be encouraged; [AND]

(F) parents and guardians must actively participate in family support services so as to facilitate the child's being able to remain in the home; when children are removed from the home, the parents and guardians must actively participate in family support services to make return of their children to the home possible; **and**

(G) the child should continue to attend the child's school of origin as provided under AS 14.03.096;

(5) numerous studies establish that

(A) children undergo a critical attachment process before the

time they reach six years of age;

(B) a child who has not attached with an adult caregiver during this critical stage will suffer significant emotional damage that frequently leads to chronic psychological problems and antisocial behavior when the child reaches adolescence and adulthood; and

(C) it is important to provide for an expedited placement procedure to ensure that all children, especially those under the age of six years, who have been removed from their homes are placed in permanent homes expeditiously.

* **Sec. 6.** AS 47.07.020(b) is amended to read:

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in **out-of-home care** [FOSTER HOMES] or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age who are in an institution designated

as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed $1,656 a month but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under 21 years of age who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(8) persons under 21 years of age and not covered under (a) of this section [,] who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under 21 years of age not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 - 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them;

(12) disabled persons, as described in 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under applicable federal regulations or guidelines, is less than 250 percent of the official poverty line applicable to a family of that size according to the United States Department of Health and Human Services, and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is not eligible under another provision of this section shall pay a premium or other cost-sharing charges according to a sliding fee scale that is based on income as established by the department in regulations;

(13) persons under 19 years of age who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(14) pregnant women who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(15) persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII);

(16) persons under 21 years of age who were in the custody of the department under AS 47.10 or AS 47.14 and who were placed in out-of-home care for a period of not less than six consecutive months on or after reaching 16 years of age.

* **Sec. 7.** AS 47.07.020 is amended by adding a new subsection to read:

(o) In this section, "out-of-home care" has the meaning given in AS 47.14.400.

* **Sec. 8.** AS 47.10.080(c) is amended to read:

(c) If the court finds that the child is a child in need of aid, the court shall

(1) order the child committed to the department for placement in an appropriate setting for a period of time not to exceed two years or in any event not to extend past the date the child becomes 19 years of age, except that the department or the child's guardian ad litem may petition for and the court may grant in a hearing

(A) one-year extensions of commitment that do not extend beyond the child's 19th birthday if the extension is in the best interests of the child; and

(B) **one-year extensions of commitment that do not extend beyond the child's 21st birthday** [AN ADDITIONAL ONE-YEAR PERIOD OF STATE CUSTODY PAST 19 YEARS OF AGE] if the continued state custody is in the best interests of the person and the person consents to it;

(2) order the child released to a parent, adult family member, or guardian of the child or to another suitable person, and, in appropriate cases, order the parent, adult family member, guardian, or other person to provide medical or other care and treatment; if the court releases the child, it shall direct the department to supervise the care and treatment given to the child, but the court may dispense with the department's supervision if the court finds that the adult to whom the child is released will adequately care for the child without supervision; the department's supervision may not exceed two years or in any event extend past the date the child reaches 19 years of age, except that the department or the child's guardian ad litem may petition for and the court may grant in a hearing

(A) one-year extensions of supervision that do not extend beyond the child's 19th birthday if the extensions are in the best interests of the

child; and

(B) an additional one-year period of supervision past 19 years of age if the continued supervision is in the best interests of the person and the person consents to it; or

(3) order, under the grounds specified in (o) of this section or AS 47.10.088, the termination of parental rights and responsibilities of one or both parents and commit the child to the custody of the department, and the department shall report quarterly to the court on efforts being made to find a permanent placement for the child.

*** Sec. 9.** AS 47.10.080 is amended by adding a new subsection to read:

(v) A social worker employed by or under contract with the department shall, not less than monthly, conduct visits with a child committed to the custody of the department under (c) of this section. The visits must be of sufficient substance and duration to address issues pertinent to case planning and service delivery to ensure the child's safety, permanency, and well-being. The majority of the visits conducted under this subsection must be at the location of the child's current placement. Nothing in this paragraph creates a private right of action against the department or the department's contractors. In this subsection, "visit" means face-to-face contact between social worker and child.

*** Sec. 10.** AS 47.10.990(3) is amended to read:

(3) "child" means a person **who is**

(A) under 18 years of age**;**

(B) [AND A PERSON] 19 years of age if that person was under 18 years of age at the time that a proceeding under this chapter was commenced**; and**

(C) under 21 years of age if that person is living in out-of-home care;

*** Sec. 11.** AS 47.10.990 is amended by adding a new paragraph to read:

(33) "out-of-home care" has the meaning given in AS 47.14.400.

*** Sec. 12.** AS 47.18.300(a) is amended to read:

(a) The department, in coordination with local public and private agencies,

shall design, develop, and implement **an out-of-home care** [A FOSTER CARE] transition program to provide support and services to individuals who

(1) reach or have reached the age of 16 or older while in state **custody and placed in out-of-home** [FOSTER] care and have not yet reached 23 years of age; and

(2) meet other eligibility criteria established by the department under (b) of this section.

*** Sec. 13.** AS 47.18.310 is amended to read:

Sec. 47.18.310. Program design. The department, in coordination with local public and private agencies, shall design the program as a continuation of the training efforts related to independent living skills that were initiated **for a child in state custody who was placed in out-of-home care and** [WHEN THE STATE FOSTER CARE RECIPIENTS WERE] identified as being likely to remain in **out-of-home** [STATE FOSTER] care until reaching **not less than** the age of 18. The program design must require that program participants are directly involved in identifying the program activities that will prepare them for independent living.

*** Sec. 14.** AS 47.18.320(a) is amended to read:

(a) Subject to the availability of an appropriation made for the purposes of AS 47.18.300 - 47.18.390, the program may provide

(1) education and vocational training;

(2) assistance in obtaining basic education and training;

(3) career and employment services;

(4) training in basic life skills;

(5) housing and utility assistance;

(6) mentoring and counseling; and

(7) other appropriate services to complement the efforts of former state foster care recipients **or a child who was in state custody and placed in out-of-home care** to achieve self-sufficiency.

*** Sec. 15.** AS 47.18 is amended by adding a new section to read:

Sec. 47.18.335. Monetary living expense stipend. (a) The department shall provide a monthly monetary living expense stipend for a period not to exceed nine

months in an amount described in (b) of this section to an individual who

(1) has left out-of-home care at age 18 or older;

(2) is participating in services in the program; and

(3) has monthly contact with a social worker involved in the program.

(b) A stipend provided under this section shall be in an amount necessary to meet an eligible individual's living expense as determined by the department. The amount may not exceed

(1) for the first six months of eligibility, the daily rate provided to a licensed foster parent; or

(2) for a period not to exceed three additional months during the period that follows the first six months of eligibility, half of the daily rate provided to a licensed foster parent.

(c) The department shall pay the stipend provided under this section until the later of the date that the individual

(1) reaches 21 years of age; or

(2) has left out-of-home care for six months.

(d) The department may adopt regulations to implement this section.

*** Sec. 16.** AS 47.18.390(1) is amended to read:

(1) "program" means the **out-of-home** [FOSTER] care transition program authorized under AS 47.18.300 - 47.18.390;

*** Sec. 17.** AS 47.18.390(3) is repealed and reenacted to read:

(3) "out-of-home care" has the meaning given in AS 47.14.400.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 7, 2009

SUBJECT: Sectional Summary (CSSB 105(EDC);
Work Order No. 26-LS0556\E)

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Provides for the continuation of a public education in a student's school of origin for a homeless student under federal specifications. Provides exceptions for a move outside of a school district or for insufficient funding by the legislature. Modifies federal definition of homelessness to include students who are placed in out-of-home care by the state.

Section 2. Provides for a waiver of unmet need for tuition, fees, and room and board expenses at a state-supported educational institution for a person who was placed in out-of-home care at age 16 or older and who meets specified eligibility requirements. The waiver is subject to appropriation.

Section 3. Defines out-of-home care for purposes of student loans and waivers.

Section 4. Changes "foster care" to "out-of-home care" under the procurement code.

Section 5. Amends the state's purpose and policy related to children to include education and intellectual development.

Section 6. Amends the legislative intent related to children to include providing a public education as provided under section 1.

Section 7. Replaces the term "foster homes" with "out-of-home care" for purposes of establishing medical assistance eligibility for certain persons and adds a category of eligibility for persons under 21 years of age who were in out-of-home care for a specified period of time on or after the person's 16th birthday.

Section 8. Defines "out-of-home care" for purposes of medical assistance eligibility.

Section 9. Authorizes the extension of court orders for a child who is in state custody to age 21.

Section 10. Establishes mandatory monthly visits by social workers employed by the department to make monthly home visits, as described, to all children in the custody of the department.

Section 11. Amends the definition of "child" for purposes of the child in need of aid statutes.

Section 12. Defines "out-of-home care" for purposes of the child in need of aid statutes.

Sections 13 - 15. Changes "foster care" to "out-of-home care" for purposes of the transition to the independent living program.

Section 16. Defines "program" to mean "out-of-home care" transition program.

Section 17. Establishes a monetary stipend to be paid to persons who are eligible for the out-of-home care transition program.

Section 18 Defines "out-of-home care" for purposes of the transition program.

JMM:plm
09-259.plm

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB105(EDC)
() Publish Date:

Identifier (file name): SB105CS(EDC)-DHSS-CSM-04-06-09
Dept. Affected: Health & Social Services
Title: Foster Care/CINA/Education of Homeless
RDU: Children's Services
Component: Children's Services Management
Sponsor: Davis
Requester: Senate EDC
Component Number: 2666

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual	204.2		0.0	0.0	0.0	0.0	0.0
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**204.2**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	73.5						
1003 GF Match	130.7						
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**204.2**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The intent of SB 105 is to address the educational, medical, financial, and housing challenges that face youth as they transition out of foster care and to support those care providers that are willing to help them during that period of transition.

The Office of Children's Services Online Resource for the Children of Alaska (ORCA) data base is mandated by the federal government and must be continuously updated to reflect changes in both state and federal law and policy. The following provides the estimated cost of ORCA updates that will be required to implement this bill.

(continued on page 2)

Prepared by: Tammy Sandoval, Director
Phone 465-3191
Division: Office of Children's Services
Date/Time 3/3/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 4/6/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. CSSB105(EDC)

ANALYSIS CONTINUATION

Requirement	Functional LOE (hours)	Development LOE (hours)	Total LOE (hours)	Cost
Update Services page for new services.	120	80	200	$22,000.00
Update Education page with post-secondary educational institutions.	80	60	140	$15,400.00
Update OHP for unlicensed independent living service categories and service types.	120	80	200	$22,000.00
Update OHP for licensed service categories and service types over 18.	120	100	220	$24,200.00
Update Ref Value for age change from 18 to 21	80	60	140	$15,400.00
Update Eligibility page calculations for new age requirement.	180	160	340	$37,400.00
Update Medicaid Eligibility page calculations for new page	180	160	340	$37,400.00
Visitation Report	40	36	76	$8,360.000
Batch updates for OHP and Eligibility	40	160	200	$22,000.00
Days:	**960/8 = 120 days**	**896/8 = 112 days**	**1856/8 = 232 total days**	**Total Estimate $204,160.00**

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB105(EDC)
() Publish Date:

Identifier (file name): SB105CS(EDC)-DHSS-FCBR-04-06-09
Dept. Affected: Health & Social Services
Title: Foster Care/CINA/Education of Homeless
RDU: Children's Services
Component: Foster Care Base Rate
Sponsor: Davis
Requester: Senate EDC
Component Number: 2236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	725.0		445.2	445.2	445.2	445.2	445.2
Miscellaneous							
TOTAL OPERATING	**725.0**	**0.0**	**445.2**	**445.2**	**445.2**	**445.2**	**445.2**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0		55.6	73.9	73.9	73.9	73.9
1003 GF Match	725.0		389.6	371.3	371.3	371.3	371.3
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**725.0**	**0.0**	**445.2**	**445.2**	**445.2**	**445.2**	**445.2**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The intent of SB 105 is to address the educational, medical, financial, and housing challenges that face youth as they transition out of foster care and to support those care providers that are willing to help them during that period of transition.

Sec. 11 amends AS 47.10.990 to change the definition of child to include under age 21 years if that person is living in out-of-home care as defined in AS 47.14.400.

(continued on page 2)

Prepared by: Tammy Sandoval, Director
Division: Office of Children's Services
Phone: 465-3191
Date/Time: 3/3/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 4/6/2009

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. CSSB105(EDC)

ANALYSIS CONTINUATION

Assumptions applied to this fiscal note:

Foster care reimbursement payments will be made available to care for children who remain in the custody of the state, who are age 18 through 20;

Approximately 15% (17 children) of the 110 that turn age 18 annually will chose to stay in foster care until age 19; 10% (10) to age 20; 5% to 21 (6); totaling 33 children. This is based simply on program experience and the assumption that most children will want to leave foster care at age 18, but that others who have stable homes will decide to stay with their foster families and that most of these children will attend post secondary education programs.

In addition to the 33 children who may wish to participate in the program in its initial year, approximately 12 of those special needs children who are 18 years of age, 6 at age 19, and 6 at age 20 will remain in care for 2010, bringing the total for 2010 to 57 children. This is based on the current numbers of children who age out with special needs. We estimate that 18 children with special needs age out annually, with 6 of them already staying in foster care until age 20, leaving 12 that may chose to stay in care.

For years 2011 - 2015, the number of participants has been reduced to 35, where it may stabilize because OCS speculates those children reaching the age of 19 or 20 will more likely opt to chose the monetary stipend in this bill.

Calculations are based on 360 days at an average base foster care base rate of $35.33 a day: $35.33 x 30 = $1,060 a month. This calculation is used to equally distribute funding estimates, and makes very little difference to the resulting totals.

Currently, federal reimbursement for the extension of the foster program is not available. However, the Adoption and Guardianship Fostering Connections to Success and Increasing Adoptions Act of 2008 includes the option to extend the assistance age through 20. This fiscal note assumes that option will be implemented when available October 1, 2010, therefore is available for the final three quarters of state fiscal year 2011 forward only.

SFY	# of Children	Age	Annual Cost Per Child	Total Est.	FFP	GF
2010	57	18,19, 20	$12,719	$724,972	$0	$724,972
2011	35	18,19,20	$12,719	$445,158	$55,631	$389,527
2012	35	18,19,20	$12,719	$445,158	$73,862	$371,296
2013	35	18,19,20	$12,719	$445,158	$73,862	$371,296
2014	35	18,19,20	$12,719	$445,158	$73,862	$371,296
2015	35	18,19,20	$12,719	$445,158	$73,862	$371,296

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB105(EDC)
() Publish Date:

Identifier (file name): SB105CS(EDC)-DHSS-FP-4-6-09
Title: Foster Care/CINA/Education of Homeless
Sponsor: Davis, Ellis
Requester: Senate HSS

Dept. Affected: Health & Social Services
RDU: Office of Children's Services
Component: Family Preservation
Component Number: 1628

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	4,833.1		1,907.8	1,907.8	1,907.8	1,907.8	1,907.8
Miscellaneous							
TOTAL OPERATING	**4,833.1**	**0.0**	**1,907.8**	**1,907.8**	**1,907.8**	**1,907.8**	**1,907.8**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts			238.4	316.5	316.5	316.5	316.5
1003 GF Match			1,669.4	1,591.3	1,591.3	1,591.3	1,591.3
1004 GF	4,833.1						
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**4,833.1**	**0.0**	**1,907.8**	**1,907.8**	**1,907.8**	**1,907.8**	**1,907.8**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The intent of CSSB105 is to address the educational, financial and housing challenges that face youth as they transition out of foster care, and to support foster care providers who are willing to help youth during that period of transition.

CSSB 105, as it relates to the Department of Health and Social Services, Office of Children's Services, amends AS 47.10.080(c) to provide the court the authority to commit a child to placement to age 21 if in the best interest of the youth and the youth is in agreement; amends AS 47.10.990(3) by further defining a child to include youth under 21 years of age if that youth is living in out-of-home care; and expands the current Foster Care Transition Program (AS 47.18.300-390) to include children in state custody who were placed in out-of-home care and

(continued on next page)

Prepared by: Tammy Sandoval, Director — Phone 465-3191
Division: Office of Children's Services — Date/Time 4/7/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner — Date 4/8/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. CSSB105(EDC)

ANALYSIS CONTINUATION

identified as likely to remain in out-of-home care until age 18; and allows for a one-year monetary living expense stipend to eligible youth who have left out-of-home care up to age 23. This fiscal note addresses increased costs related to the one-year monetary living expense stipend to eligible youth up to age 23 who have left out-of-home care.

The OCS, lacking historical data or comparative program results, has made the following assumptions and applied them to this fiscal note:

1) The monetary stipend will be made available to youth age 18 to 23 who leave out-of-home care at any time during that age span.
2) The monetary stipend is not tied to post secondary education.
3) The number of youth who age out of foster care will remain somewhat stagnant at about 110 youth annually;
4) Assumes that 70% of youth ages 18 to 23 who are eligible to participate in the Independent Living Program (IL) will make use of the monetary stipends in FY2010. This equates to approximately 380 full time equivalents (FTEs) who will become eligible, resulting in higher program costs the first year the stipend is available. FTEs are used to account for the constant change in the population as more youth turn 18 to 23 and move on and off the program at varying rates.
5) The out years will lose children aging out of foster care and pick up new youth between ages 19 and 23 who have not yet utilized the program, still maintaining the assumption that 70% will eventually utilize the program. There is no available data or program results upon which to base these assumptions.
6) Calculations are based on 360 days at an average daily rate of $35.33; $35.33 x 30 = $1,060/month.
7) Currently, federal reimbursement for the extension of the IL program is not available. However, the Adoption and Guardianship Fostering Connections to Success and Increasing Adoptions Act of 2008 includes the option to enhance the program. This fiscal note assumes that option can be implemented when available, October 1, 2010, and therefore is available for the final three quarters of FY2011 forward, only.
8) The foster care penetration rate and the Medical Assistance Percentage Rate will remain somewhat stable over the time period of this fiscal note.

	FFP	IL FTE	MOS FC/FTE	TOTAL EXP	Federal	GF
SFY 2010	0.00%	380	$1,060	$4,833,144	$0	$4,833,144
SFY2011	12.50%	150	$1,060	$1,907,820	$238,414	$1,669,406
SFY2012	16.59%	150	$1,060	$1,907,820	$316,546	$1,591,274
SFY2013	16.59%	150	$1,060	$1,907,820	$316,546	$1,591,274
SFY2014	16.59%	150	$1,060	$1,907,820	$316,546	$1,591,274
SFY2015	16.59%	150	$1,060	$1,907,820	$316,546	$1,591,274

20 Years Covenant House Alaska
Crisis Center · Community Services Center · Transitional Living

Senator Bettye Davis
State Capitol
Juneau, AK 99801

April 13, 2009

Dear Senator Davis,

Thank you for introducing SB 105, "An Act relating to continuing the secondary public education of a homeless student...". Covenant House Alaska (CHA) provides shelter, food, healthcare and transitional living assistance to Alaska's homeless youth. CHA strongly supports SB 105.

The proposed legislation provides access to educational, housing and life skills support that is vital for young people to successfully transition to adulthood. Nearly 50% of CHA youth have been involved with the foster care system at some point in their lives. They arrive on our door step with a plastic bag full of a few belongings. Many of these youth survive for a few months after being released from care, but find at the young age of 18 they don't have the resources and life skills required to live completely independently on their own. After living traumatized lives, they are faced with a new trauma and a new set of dangers that homelessness presents.

This legislation is fundamentally about providing to our foster care youth the resources we would naturally provide to our own children. Youth still require assistance with educational, occupational and housing needs past the age of 18. This bill ensures that while we cannot completely erase the trauma endured by foster care children, we can lessen it. We can actively take steps to help them in a responsible, reasonable fashion.

Thank you for your consideration of this letter and the proposed legislation. Please contact me with any questions you may have.

Sincerely,

Deirdre A. Cronin

Deirdre A. Cronin
Executive Director

26-LS0556\CE
Mischel
4/116/09

CS FOR SENATE BILL NO. 105(HSS~~EDC~~)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES~~EDUCATION~~ COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, Ellis

4/13/09
- lofton comm
accepted
printed

A BILL

FOR AN ACT ENTITLED

"An Act relating to continuing the secondary public education of a homeless student; relating to the purpose of certain laws as they relate to children; relating to tuition waivers and medical assistance for a child placed in out-of-home care by the state; relating to foster care; relating to children in need of aid; and relating to out-of-home care transition to independent living."

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

*** Section 1.** AS 14.03 is amended by adding a new section to read:

Sec. 14.03.096. Continuing the public education of a homeless student. (a) Except as provided in (b) and (d) of this section, the governing body of a school district shall comply with the requirements for continuing the public education of a homeless student in the student's school of origin and for providing comparable education and transportation services for the remainder of the current school year or, if the student is attending school for a summer term, for the remainder of the summer

term, under 42 U.S.C. 11431 - 11435 (McKinney-Vento Homeless Education Assistance Improvement Act of 2001), as those provisions existed on February 1, 2009.

(b) The requirements in (a) of this section do not apply if the student moves to a school district other than the school district in which the student's school of origin is located.

(c) If a homeless student is transferred to a school other than the student's school of origin, the school of origin shall provide a copy of the student's records to the student's new school within seven~~7~~ school days after notification of the transfer. The student's new school shall allow the student to attend school while awaiting the transfer of records under this subsection.

(d) A school district is required to comply with this section only

(1) if the legislature appropriates funds for the purpose; and

(2) to the extent possible using funds appropriated for the purpose.

(e) In this section,

(1) "homeless student" has the meaning given in 42 U.S.C. 11434a for "homeless child or youth," and the phrase "awaiting foster care placement" in that definition shall be interpreted to include all students who are placed in out-of-home care and in the custody of the Department of Health and Social Services under AS 47.10.080(c) or who are committed to the custody of the Department of Health and Social Services under AS 47.12.120(b)(1) or (3);

(2) "school of origin" means the school in which the student was last enrolled.

*** Sec. 2.** AS 14.43 is amended by adding a new section to read:

Article 3A. Free Tuition for a Person Who Was in Out-of-Home Care.

Sec. 14.43.086. Free tuition and fees for a person who was in out-of-home care. (a) A person who enrolls as a student in good standing in a state-supported educational institution in the state is entitled to a waiver of tuition, fees, and room and board expenses if the person provides adequate proof that the person

(1) was in the custody of the state under AS 47.10 or AS 47.14;

(2) was placed in out-of-home care for a period of not less than six

consecutive months on or after the person became 16 years of age; and

(3) is under 29 years of age.

(b) The amount of the waiver to which a person is entitled under this section is the amount of unmet need for tuition, room, and board expenses, as determined by the institution~~commission~~, after deducting funding for the school year from education loans, grants, or scholarships received by a person eligible for a waiver.

(c) The proceeds of an education loan, grant, or scholarship received by a person eligible for a waiver under this section must be paid to the educational institution to offset the person's tuition, fees, and room and board expenses.

(d) A state-supported educational institution in the state is required to provide a waiver under (a) of this section only if the legislature appropriates funds for the purpose of offsetting waivers under this section. If an appropriation is not sufficient to fully offset waivers for each person entitled to a waiver under (a) of this section, the institution may offer full or partial waivers to eligible applicants as funding permits and at the discretion of the institution.

(e) In this section, ~~* **Sec. 3.** AS 14.43.160 is amended by adding a new paragraph to read:~~

~~(7)~~ "out-of-home care" has the meaning given in AS 47.14.400.

* **Sec. 34.** AS 36.30.850(b)(42) is amended to read:

(42) grants and contracts with qualified entities for services under AS 47.18.330 for the **out-of-home** [FOSTER] care transition program;

* **Sec. 4~~5~~.** AS 47.05.060 is amended to read:

Sec. 47.05.060. Purpose and policy relating to children. The purpose of this title as it relates to children is to secure for each child the care and guidance, preferably in the child's own home, **as well as an adequate education,** that will serve the moral, emotional, mental, **intellectual,** and physical welfare of the child and the best interests of the community; to preserve and strengthen the child's family ties unless efforts to preserve and strengthen the ties are likely to result in physical or emotional damage to the child, removing the child from the custody of the parents only as a last resort when the child's welfare or safety or the protection of the public cannot be adequately safeguarded without removal; and, when the child is removed from the family, to secure for the child adequate custody**, education,** and care and

adequate planning for permanent placement of the child.

* **Sec. 5.~~6.~~** AS 47.05.065 is amended to read:

Sec. 47.05.065. Legislative findings related to children. The legislature finds that

(1) parents have the following rights and responsibilities relating to the care and control of their child while the child is a minor:

(A) the responsibility to provide the child with food, clothing, shelter, education, and medical care;

(B) the right and responsibility to protect, nurture, train, and discipline the child, including the right to direct the child's medical care and the right to exercise reasonable corporal discipline;

(C) the right to determine where and with whom the child shall live;

(D) the right and responsibility to make decisions of legal or financial significance concerning the child;

(E) the right to obtain representation for the child in legal actions; and

(F) the responsibility to provide special safeguards and care, including appropriate prenatal and postnatal protection for the child;

(2) it is the policy of the state to strengthen families and to protect children from child abuse and neglect; the state recognizes that, in some cases, protection of a child may require removal of the child from the child's home; however,

(A) except in those cases involving serious risk to a child's health or safety, the Department of Health and Social Services should provide time-limited family support services to the child and the child's family in order to offer parents the opportunity to remedy parental conduct or conditions in the home that placed the child at risk of harm so that a child may return home safely and permanently; and

(B) the state also recognizes that when a child is removed from the home, visitation between the child and the child's parents or guardian and family members reduces the trauma for the child and enhances the likelihood

that the child will be able to return home; therefore, whenever a child is removed from the parental home, the Department of Health and Social Services should encourage frequent, regular, and reasonable visitation of the child with the child's parent or guardian and family members;

(3) it is the policy of the state to recognize that, when a child is a ward of the state, the child is entitled to reasonable safety, adequate care, and adequate treatment and that the Department of Health and Social Services as legal custodian and the child's guardian ad litem as guardian of the child's best interests and their agents and assignees, each should make reasonable efforts to ensure that the child is provided with reasonable safety, adequate care, and adequate treatment for the duration of time that the child is a ward of the state;

(4) it is in the best interests of a child who has been removed from the child's own home for the state to apply the following principles in resolving the situation:

(A) the child should be placed in a safe, secure, and stable environment;

(B) the child should not be moved unnecessarily;

(C) a planning process should be followed to lead to permanent placement of the child;

(D) every effort should be made to encourage psychological attachment between the adult caregiver and the child;

(E) frequent, regular, and reasonable visitation with the parent or guardian and family members should be encouraged; [AND]

(F) parents and guardians must actively participate in family support services so as to facilitate the child's being able to remain in the home; when children are removed from the home, the parents and guardians must actively participate in family support services to make return of their children to the home possible; **and**

(G) the child should continue to attend the child's school of origin as provided under AS 14.03.096;

(5) numerous studies establish that

(A) children undergo a critical attachment process before the time they reach six years of age;

(B) a child who has not attached with an adult caregiver during this critical stage will suffer significant emotional damage that frequently leads to chronic psychological problems and antisocial behavior when the child reaches adolescence and adulthood; and

(C) it is important to provide for an expedited placement procedure to ensure that all children, especially those under the age of six years, who have been removed from their homes are placed in permanent homes expeditiously.

* **Sec. 6.~~7.~~** AS 47.07.020(b) is amended to read:

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in **out-of-home care** [FOSTER HOMES] or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed $1,656 a month but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under 21 years of age who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(8) persons under 21 years of age and not covered under (a) of this section [,] who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under 21 years of age not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 - 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or

intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them;

(12) disabled persons, as described in 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under applicable federal regulations or guidelines, is less than 250 percent of the official poverty line applicable to a family of that size according to the United States Department of Health and Human Services, and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is not eligible under another provision of this section shall pay a premium or other cost-sharing charges according to a sliding fee scale that is based on income as established by the department in regulations;

(13) persons under 19 years of age who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(14) pregnant women who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(15) persons who have been diagnosed with breast or cervical cancer

and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII);

(16) persons under 21 years of age who were in the custody of the department under AS 47.10 or AS 47.14 and who were placed in out-of-home care for a period of not less than six consecutive months on or after reaching 16 years of age.

*** Sec. 7.~~8.~~** AS 47.07.020 is amended by adding a new subsection to read:

(o) In this section, "out-of-home care" has the meaning given in AS 47.14.400.

*** Sec. 8.~~9.~~** AS 47.10.080(c) is amended to read:

(c) If the court finds that the child is a child in need of aid, the court shall

(1) order the child committed to the department for placement in an appropriate setting for a period of time not to exceed two years or in any event not to extend past the date the child becomes 19 years of age, except that the department or the child's guardian ad litem may petition for and the court may grant in a hearing

(A) one-year extensions of commitment that do not extend beyond the child's 19th birthday if the extension is in the best interests of the child; and

(B) **one-year extensions of commitment that do not extend beyond the child's 21st birthday** [AN ADDITIONAL ONE-YEAR PERIOD OF STATE CUSTODY PAST 19 YEARS OF AGE] if the continued state custody is in the best interests of the person and the person consents to it;

(2) order the child released to a parent, adult family member, or guardian of the child or to another suitable person, and, in appropriate cases, order the parent, adult family member, guardian, or other person to provide medical or other care and treatment; if the court releases the child, it shall direct the department to supervise the care and treatment given to the child, but the court may dispense with the department's supervision if the court finds that the adult to whom the child is released will adequately care for the child without supervision; the department's supervision may not exceed two years or in any event extend past the date the child reaches 19 years of age, except that the department or the child's guardian ad litem may petition for and the court may grant in a hearing

(A) one-year extensions of supervision that do not extend

beyond the child's 19th birthday if the extensions are in the best interests of the child; and

(B) an additional one-year period of supervision past 19 years of age if the continued supervision is in the best interests of the person and the person consents to it; or

(3) order, under the grounds specified in (o) of this section or AS 47.10.088, the termination of parental rights and responsibilities of one or both parents and commit the child to the custody of the department, and the department shall report quarterly to the court on efforts being made to find a permanent placement for the child.

* **Sec. 9.~~10.~~** AS 47.10.080 is amended by adding a new subsection to read:

(v) A social worker employed by or under contract with the department shall, not less than monthly, conduct visits with a child committed to the custody of the department under (c) of this section. The visits must be of sufficient substance and duration to address issues pertinent to case planning and service delivery to ensure the child's safety, permanency, and well-being. The majority of the visits conducted under this subsection must be at the location of the child's current placement. Nothing in this paragraph creates a private right of action against the department or the department's contractors. In this subsection, "visit" means face-to-face contact between social worker and child.

* **Sec. 10.~~11.~~** AS 47.10.990(3) is amended to read:

(3) "child" means a person **who is**

(A) under 18 years of age**;**

(B) [AND A PERSON] 19 years of age if that person was under 18 years of age at the time that a proceeding under this chapter was commenced**; and**

(C) under 21 years of age if that person is living in out-of-home care;

* **Sec. 11.~~12.~~** AS 47.10.990 is amended by adding a new paragraph to read:

(33) "out-of-home care" has the meaning given in AS 47.14.400.

* **Sec. 12.~~13.~~** AS 47.18.300(a) is amended to read:

(a) The department, in coordination with local public and private agencies, shall design, develop, and implement **an out-of-home care** [A FOSTER CARE] transition program to provide support and services to individuals who

(1) reach or have reached the age of 16 or older while in state **custody and placed in out-of-home** [FOSTER] care and have not yet reached 23 years of age; and

(2) meet other eligibility criteria established by the department under (b) of this section.

*** Sec. 13.~~14.~~** AS 47.18.310 is amended to read:

Sec. 47.18.310. Program design. The department, in coordination with local public and private agencies, shall design the program as a continuation of the training efforts related to independent living skills that were initiated **for a child in state custody who was placed in out-of-home care and** [WHEN THE STATE FOSTER CARE RECIPIENTS WERE] identified as being likely to remain in **out-of-home** [STATE FOSTER] care until reaching **not less than** the age of 18. The program design must require that program participants are directly involved in identifying the program activities that will prepare them for independent living.

*** Sec. 14.~~15.~~** AS 47.18.320(a) is amended to read:

(a) Subject to the availability of an appropriation made for the purposes of AS 47.18.300 - 47.18.390, the program may provide

(1) education and vocational training;

(2) assistance in obtaining basic education and training;

(3) career and employment services;

(4) training in basic life skills;

(5) housing and utility assistance;

(6) mentoring and counseling; and

(7) other appropriate services to complement the efforts of former state foster care recipients **or a child who was in state custody and placed in out-of-home care** to achieve self-sufficiency.

*** Sec. 15~~16~~.** AS 47.18 is amended by adding a new section to read:

Sec. 47.18.335. Monetary living expense stipend. (a) The department shall

provide a monthly monetary living expense stipend for a period not to exceed nine months in an amount described in (b) of this section to an individual ~~eligible for services under the program~~ who

(1) has left out-of-home care at age 18 or older;

(2) is participating in services in the program; and

(3) has ~~a~~ monthly contact with a social worker involved in the program.

(b) A stipend provided under this section shall be in an amount necessary to meet an eligible individual's living expense as determined~~set~~ by the department. The amount may not exceed

(1) for the first six months of eligibility, ~~that is not more than~~ the daily rate provided to a licensed foster parent; or

(2) for a period not to exceed three additional months during the period that follows the first six months of eligibility, half of the daily rate provided to a licensed foster parent.

(c) The department shall pay the stipend provided under this section until the later of the date that the individual

(1) reaches 21 years of age; or

(2) has left out-of-home care for six months.

(d) ~~for necessary living expenses. The stipend shall continue for a period of not more than one year and shall end before the individual is 23 years of age.~~ The department may adopt regulations to implement this section.

*** Sec. 16~~17~~.** AS 47.18.390(1) is amended to read:

(1) "program" means the **out-of-home** [FOSTER] care transition program authorized under AS 47.18.300 - 47.18.390;

*** Sec. 17.~~18.~~** AS 47.18.390(3) is repealed and reenacted to read:

(3) "out-of-home care" has the meaning given in AS 47.14.400.

SB

133

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/2/09

FURTHER: (Finance)

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/27/09

Health and Social Services Committee considered SENATE BILL NO. 133

SB 133 ELECTRONIC HEALTH INFO EXCHANGE SYSTEM

"An Act creating a statewide electronic health information exchange system; and providing for an effective date."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 133 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[✓] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS/MAA	3/13	✓			1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
Joe Thomas	Thomas	✓			
Joe Parkkinen	Parkkinen	X			
CHAIR: Kelly A Davis	DAVIS	X			

4396

26-LS0489\S
Mischel
3/25/09

CS FOR SENATE BILL NO. 133( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS PASKVAN, Davis

A BILL

FOR AN ACT ENTITLED

"An Act creating a statewide electronic health information exchange system; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. It is the intent of the legislature to create a secure electronic health information exchange system that

(1) ensures that the confidentiality of individually indentifying health information of a patient is secure and protected;

(2) improves health care quality, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services;

(3) promotes wellness, disease prevention, and management of chronic illnesses by increasing the availability and transparency of information related to the health

care needs of an individual for the benefit of the individual;

(4) ensures that appropriate information needed to make medical decisions is available in a usable form at the time and in the location that the medical service is provided;

(5) produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, inappropriate care, and incomplete information;

(6) promotes a more effective marketplace, greater competition, greater systems analysis, increased choice, enhanced quality, and improved outcomes in health care services; and

(7) improves the coordination of information and the provision of health care services through an effective infrastructure for the secure and authorized exchange and use of health care information.

*** Sec. 2.** AS 18.23 is amended by adding new sections to read:

Article 4. Electronic Health Information Exchange System.

Sec. 18.23.300. Creation of health information exchange system. (a) The department shall establish and implement a statewide electronic health information exchange system and ensure the interoperability and compliance of the system with state and federal specifications and protocols for exchanging health records and data.

(b) The system established under this section must

(1) include infrastructure planning that involves

(A) the designation by the commissioner of a qualified entity or combination of qualified entities in the state that

(i) has an advisory or governing body made up of health system stakeholders that include members identified under (d) of this section;

(ii) applies for available federal and state funding for planning and implementation of the system authorized by the commissioner;

(iii) submits an annual budget for approval of the commissioner;

(iv) complies with nondiscrimination and conflict of

interest policies;

(v) meets and complies with federal and state health information policies and standards;

(vi) provides cost and cost saving data associated with the development and use of the system to the department;

(B) the development of statewide infrastructure to support the electronic health information exchange system established under this section and to connect electronic health records to the infrastructure;

(C) the development of a statewide technology plan, with the participation of identified stakeholders, to promote the implementation and sustained use by public and private health care payors and providers of electronic health records and the system established under this section in order to ensure interoperability among government-operated health information systems and other public and private health information and reporting systems;

(D) the development of policies and standards, consistent with federal and state law, to safeguard the privacy and security of health information;

(E) the development of a training and workforce development plan for implementing and serving the system;

(F) an estimate of costs of the hardware, software, services, and support needed to implement and maintain the technical infrastructure; and

(2) include implementation measures that

(A) provide for installation and training on the use of the system;

(B) set out a plan to encourage health care provider, payor, and patient use of electronic records over a sustained period of time;

(C) provide support to providers for workflow redesign, quality improvement, and care management services;

(D) provide for participation by all identified stakeholders in the planning and implementation of the system;

(E) comply with federal and state health information policies;

and

(F) provide for periodic evaluation and improvement of the system.

(c) The department may enter into contracts, seek and accept available federal and private funds and equipment, and adopt regulations necessary to carry out the purposes of this section.

(d) The designee under (b)(1)(A) of this section may be the state or a private for-profit or nonprofit entity or entities under contract with the state or a combination of the state and one or more entities under contract with the state. The advisory or governing body of the designee must include

(1) the commissioner; and

(2) eight other individuals, each of whom represents one of the following interests:

(A) hospitals and nursing home facilities;

(B) private medical care providers;

(C) community-based primary care providers;

(D) federal health care providers;

(E) Alaska tribal health organizations;

(F) health insurers;

(G) health care consumers;

(H) employers or businesses.

Sec. 18.23.305. Department; duties. In carrying out its duties under AS 18.23.300, the department shall

(1) in accordance with federal recommendations, determine the manner in which the system is developed and operated;

(2) provide oversight and technical assistance needed for planning and implementing the system;

(3) authorize and facilitate applications for available federal funding for planning and implementing the system;

(4) ensure compliance with applicable federal and state health information policies and standards;

(5) ensure compliance with federal and state law and standards that safeguard the privacy and security of health information.

Sec. 18.23.310. Confidentiality and security of information. (a) The department shall establish appropriate security standards to protect the transmission and receipt of individually identifiable information contained in the system established under AS 18.23.300. The standards must

(1) include controls over access to and collection, organization, and maintenance of records and data that protect the confidentiality of the individual who is the subject of a health record;

(2) include a secure and traceable electronic audit system for identifying access points and trails;

(3) meet the most stringent applicable federal or state privacy law governing the protection of the information contained in the system.

(b) A person may not release or publish individually indentifying health information from the system for purposes unrelated to the treatment or billing of the patient who is the subject of the information. Use or distribution of the information for a marketing purpose is strictly prohibited.

(c) The department shall establish procedures for a patient who is the subject of a health record contained in the system to

(1) opt out of the system;

(2) consent to the distribution of the patient's records contained in the system;

(3) be notified of a violation of the confidentiality provisions required under this section;

(4) on request to the department, view an audit report created under this section for the purpose of monitoring access to the patient's records.

Sec. 18.23.315. Health information exchange system report to the legislature. The department shall provide to the legislature, on or before December 31 of each year, an annual report on the progress of the health information exchange system in the state, including a specific set of recommendations for long-term participation and financial support by the state.

Sec. 18.23.320. Contract conditions. A contract entered into to carry out the purposes of AS 18.23.300 must require that the contractor meet applicable federal and state requirements for protecting health information privacy and security and nationally recognized standards for interoperability of health information technology.

Sec. 18.23.325. Definitions. In AS 18.23.300 - 18.23.325,

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

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

(3) "system" means the statewide electronic health information exchange system established under AS 18.23.300.

*** Sec. 3.** This Act takes effect July 1, 2009.

ALASKA STATE LEGISLATURE

Senator Joe Paskvan

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Senate District E – Fairbanks, AK

MEMORANDUM

DATE: **March 5, 2009**

TO: **Senator Bettye Davis, Chair**
Senate Health & Social Services Committee

FROM: **Senator Joe Paskvan**

RE: **Hearing Request for SB 133 – Electronic Health Info Exchange System**

I am requesting that Senate Bill 133 be scheduled for a hearing in the Senate Health and Social Services Committee at your earliest convenience.

This bill establishes an electronic health information exchange system within the Department of Health and Social Services. It also provides privacy protection standards in addition to those already required in Federal Law and regulation. When implemented, this system is estimated to save Alaska's healthcare system approximately $250 million annually while also improving the safety and quality of healthcare for Alaskans.

Included in this packet:

- Sponsor Statement
- A current version of SB 133 – 26-LS0489\E
- Background Information
- Letters of Support

Other backup will be forthcoming as required. Thank you.

Please contact Jake Hamburg – 465-2872 with any questions regarding SB 133.

ALASKA STATE LEGISLATURE

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Sponsor Statement

SB 133

Alaska health care providers and patients continue to rely on an outdated healthcare infrastructure, with many providers using only paper based systems, which contributes to dangerous drug interactions, missed diagnoses, costly delays, duplicate testing and administrative overhead. According to national studies, these problems contribute to approximately 5% of health care expenditures or $250 million annually in Alaska and unnecessarily degrade the quality of health care for all Alaskans.

SB 133 modernizes Alaska's healthcare IT infrastructure by developing a secure electronic Health Information Exchange (HIE) system to improve the *safety, cost effectiveness,* and *quality of healthcare* in Alaska. This standards-based electronic health network will allow individual Alaskans to have their own personal health record and to authorize their health care providers to exchange electronic medical records in a timely, secure manner.

The use of such technology requires careful and strict privacy protection measures. Current Federal and State laws already provide a number of standards protecting a patient's privacy and personal information. The privacy and security rules contained in the Health Insurance Portability and Accountability Act (HIPAA) most directly and extensively impact the HIE system. HIPAA establishes individuals' right to review and obtain a copy of their health information, requires notice of privacy practices, limits the use of records and the disclosure of information, and institutes strict security standards.

SB 133 establishes further strict standards to secure and protect the confidentiality of individually identifying health information of a patient. These standards include a secure and traceable electronic audit system to allow patients to see who has viewed their record, restrictions on how information may be used, patient consent requirements, an ability to opt out of the health information exchange system, and notification of confidentiality violations.

When complete, the Health Information Exchange System will have the capability to provide any Alaskan with a secure Personal Health Record, including authorization for their health care providers on the network to have access to electronic records required for continuity of care, such as hospitalization records, prescription information, vaccinations, allergies, imaging records, laboratory results, etc. The Network will support telemedicine services, the transfer of high resolution images for patient care, video conferencing, and Voice over Internet applications for providers.

Over 300 health organizations in Alaska are eager to participate in the electronic Health Information Exchange system.

I urge your support for SB 133.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 133
() Publish Date:

Identifier (file name): SB 133-DHSS-MAA-03-13-09
Dept. Affected: Health & Social Services
Title: Electronic Health Info Exchange System
RDU: Health Care Services
Component: Medical Assistance Administration
Sponsor: Paskvan, Davis
Requester: Senate HSS
Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	557.6		557.6	557.6	557.6	557.6	557.6
Travel	10.0		10.0	3.0	3.0	3.0	3.0
Contractual	56.4		56.4	3,356.4	3,356.4	3,356.4	3,356.4
Supplies	15.6		12.0	12.0	12.0	12.0	12.0
Equipment	30.0						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**669.6**	**0.0**	**636.0**	**3,929.0**	**3,929.0**	**3,929.0**	**3,929.0**
CAPITAL EXPENDITURES	**27,275.0**						
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	25,150.1		572.4	2,135.0	2,135.0	2,135.0	2,135.0
1003 GF Match	2,794.5		63.6	1,794.0	1,794.0	1,794.0	1,794.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**27,944.6**	**0.0**	**636.0**	**3,929.0**	**3,929.0**	**3,929.0**	**3,929.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	**6.0**		6.0	6.0	6.0	6.0	6.0
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 133 proposes to create a secure statewide electronic health information exchange system. It would mandate the department to create the system by 1) infrastructure planning that includes the designation of a qualified nonprofit entity in the state that has an advisory body made up of health system stakeholders; 2) implementating measures that include installation and training, a plan to encourage use of the system, support to providers, and compliance with federal and state health information policies.

Since this is a large and complex task to complete, the department has chosen to pursue funding in both the operating and capital budgets. The department believes that this approach enhances the overall success of the project.

Prepared by: William J. Streur, Deputy Commissioner
Phone 334-2520
Division: Health Care Services
Date/Time 3/13/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/13/2009
DHSS Finance & Management Services

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB 133

ANALYSIS CONTINUATION

The Division of Health Care Services estimates that it will need a total of 6 FTE's for the planning, infrastructure development, installation, and administration of the electronic health information exchange system.

Operating Budget :

Administrative costs

1 Project Manager, $150.0, 1 Micro Network Specialist II, $95.0, 1 Research Analyst II, $72.9, 1 Medical Assistance Administrator III, $92.4, 1 Accountant III $82.2, 1 Accounting Technician II, $65.0. All personal services costs include benefits. Assumes $9.4 per FTE annually for office space, phones, and other contractual costs. Assumes $2.6 one time costs per FTE for computers and software. Assumes $5.0 one time costs per FTE for Office equipment. Assumes $2.0 per FTE annually for supplies. Assumes $10.0 for travel for first 2 years and $3.0 for remaining years.

Maintenance

Assumes $3,000.0 per year for hosted service maintenance costs beginning in FY2012.

Assumes $300,000 annual maintenance costs for broadband support beginning in FY2012.

Capital Budget:

Planning

Assumes approximately $1,500.0 will be needed for infrastructure planning, Statewide Technical planning, policy and standard planning, training and workforce development planning, and health information policy compliance.

Implementation

Assumes $13,000.0 one time costs will be needed for contractual services to upgrade broadband support statewide for the electronic health information exchange system to be interactive, responsive, and less subject to frequent breakdowns especially in rural parts of the state. Assumes $7,000.0 one time costs will be needed for hardware and software updates for the system. Assumes $5,775.0 one time costs will be needed for Health Electronic Records repository, patient and provider potals.

Fund Source

Assumes 90% federal for FY2010 and FY2011
Assumes 54.34% federal for 2012 and beyond

Interoperable Statewide Health Information Exchange (HIE)

State Medicaid General Fund and Alaska Health Care System Cost Savings Projections

Annual Medicaid State General Funds	Net Value Percentage	Annual Net Value of HIE*	
$248,544,000	4.68%	$11,631,859	Based on standard cost benefit model
$248,544,000	3.69%	$9,171,274	Based on high-cost HIE model
$248,544,000	5.70%	$14,167,008	Based on low-cost HIE model

Annual AK Health Care Spending	Net Value Percentage	Annual Net Value of HIE*	
$5,294,000,000	4.68%	$247,759,200	Based on standard cost benefit model
$5,294,000,000	3.69%	$195,348,600	Based on high-cost HIE model
$5,294,000,000	5.70%	$301,758,000	Based on low-cost HIE model

*Full Annual Net Value realized beginning 2013

Assumptions:

Fully standardized and fully implemented statewide interoperable Health Information Exchange
State Medicaid GF budget based on Gov 09 Request for Medicaid Services Component only
State Medicaid GF budget remains flat
Annual AK Health Care Spending remains flat
Based on national cost benefit model (see Sources):
- Cost savings: 5.68% of annual health care expenditures, minus cost: 1% of annual health care expenditures
- National cost benefit model calculates projected cost savings based on projected efficiencies in laboratory testing, imaging procedures, interactions between outpatient providers and pharmacies, provider to provider connectivity, provider to public health agency connectivity, and provider-payer transactions

Sources:

Institute for Social and Economic Research, UA Research Summary No. 6, March 2006
http://www.iser.uaa.alaska.edu/Publications/researchsumm/RS6_06.pdf
Walker, J, et al, The Value of Health Care Information Exchange and Interoperability, Health Affairs, January 2005.
http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.10/DC1

Implementation Project Summary and Impact Analysis

State of Alaska Report

Subcontract No.
RTI Project No. 9825

Prepared by:

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Submitted to:

Linda Dimitropoulos, Project Director
Privacy and Security Solutions for
Interoperable Health Information Exchange

Research Triangle Institute
P. O. Box 12194
3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

December 5, 2007

RTI INTERNATIONAL

Alaska HISPC Implementation Project Summary and Impact Analysis Report

Executive Summary:

Alaska, like the rest of the United States, faces challenges in addressing increasing health care costs, improving access to medical care, and ensuring and improving quality medical care for patients. Timely access to essential medical information by providers at the point of care is critical to good outcomes for the patients. A statewide initiative is working to address these challenges by promoting the expansion of the use of electronic health records by Alaska's medical providers and by establishing a statewide electronic health information exchange delivery system to provide critical information when and where it is needed.

Alaska health care leaders and members of the Alaska Telehealth Advisory Council formed the Alaska Regional Health Information Organization to look at innovative technology solutions targeted toward lowering costs and preventing medical errors. To accomplish this goal the Alaska RHIO, with the support of the Alaska Governor's office, successfully competed for a national contract to focus on issues of security and privacy as related to health information exchange. In January 2007, the Alaska RHIO was reorganized as Alaska ChartLink.

The Health Information Security and Privacy Collaboration (HISPC) is part of a national effort to encourage wider adoption of Electronic Health Records (EHRs) and establish a Health Information Exchange (HIE) network in Alaska and throughout the United States. Participation in this national initiative gives a voice to Alaska specific issues, needs, and recommendations in the development of national policies as related to security, privacy and best business practices surrounding interoperability of health information exchange.

Phase I of the HISPC contract provided an assessment of the privacy and security climate in Alaska as it relates to health information exchange. The findings from this assessment determined a number of action steps that needed to be addressed in order for Alaskans to begin exchanging electronic health information. Key areas of action included:

- Legal solutions for enacting legislation related to medical records and the electronic exchange of health information,
- Standardized policies and procedures for use across participating organizations,
- Participation agreements for use by participating organizations and consumers, and
- Education and marketing tailored to consumers and providers encouraging use of electronic health records.

Phase II of the HISPC contract provided an opportunity for Alaska to implement selected solutions developed during Phase I and to participate in a national collaborative security and privacy think tank. In particular, the Alaska HISPC contract produced three products:

1. Five essential documents providing a standardized approach to the exchange of health information and addressing privacy and security concerns.
2. A Communications Plan and educational materials targeted toward patients, providers, and payers, that addressed the benefits of exchanging critical medical information in a secure manner that ensures patient privacy.
3. A collaborative report developed in conjunction with Guam, Iowa, New Jersey, North Carolina, North Dakota, Puerto Rico, and South Dakota addressing multi-state inter-organizational agreements for health information exchange.

Volunteers from across the state participated in the HISPC project. Over 250 Alaska citizens participated in stakeholder meetings held in both urban and rural locations. Participants included; healthcare consumers, public, private and federal providers, payers, state and municipal workers, healthcare professionals, lawyers and employers. These dedicated individuals provided valuable insights into the needs, desires and fears associated with electronic health information. The documents created through the exchanges with the citizens of Alaska provide a sound basis for the ongoing development of health information exchange in Alaska.

V. Conclusion

Phase I of the HISPC contract provided an assessment of the privacy and security climate in Alaska as it relates to health information exchange. The findings from this assessment determined a number of action steps that needed to be addressed in order for Alaskans to begin exchanging electronic health information. Key areas of action included:

- Legal solutions for enacting legislation related to medical records and the electronic exchange of health information,
- Standardized policies and procedures for use across participating organizations,
- Participation agreements for use by participating agreements and consumers, and
- Education and marketing tailored to consumers and providers encouraging use of electronic health records.

Phase II of the HISPC contract provided an opportunity for Alaska to implement selected solutions developed during Phase I and to participate in a national collaborative security and privacy think tank. In particular, the Alaska HISPC contract produced three products:

1. Six essential documents providing a standardized approach to the exchange of health information and addressing privacy and security concerns.
2. A Communications Plan and educational materials targeted toward patients, providers, and payers addressing the benefits ofe lectronic health records, personal health records, and exchanging critical medical information in a secure manner that ensures patient privacy.
3. A collaborative report developed in conjunction with Guam, Iowa, New Jersey, North Carolina, North Dakota, Puerto Rico, and South Dakota addressing multi-state inter-organizational agreements for health information exchange.

In addition to the products developed during the HISPC contract, the Alaska partners received additional benefits:

The HISPC project has helped to increase awareness of electronic health records and health information exchange in both consumers and providers throughout the state. Processes are now in place to continue this awareness campaign.

Prior to this project there was no coordinated statewide approach to addressing issues of privacy and security. Standardized policies, procedures, and participation agreements are now available for use statewide.

The collaborative process initiated by HISPC facilitated the exchange of ideas and lessons learned between many states. It was an opportunity for Alaska's Core Team to share and receive "best practice" solutions to privacy and security issues.

The HISPC project created an opportunity for Alaska to advance the HIE and EHR initiatives within Alaska and has opened the door to potential future grant opportunities.

Updating Privacy Laws to Facilitate Health Information Exchange

Consumer and provider concerns about privacy and security are inhibiting adoption of health IT. Consumers are concerned about the consequences of disclosure of sensitive health information related to dire or stigmatized diseases, such as the loss of health coverage or employment. Providers, concerned about varying interpretations of state and federal privacy laws and the liability for violations, often are reluctant to exchange data. State updates to health privacy laws can help alleviate these and other concerns. Trends identified in enacted legislation include the following.

Comprehensive Reform

Key policy decisions for states that want to update privacy laws to allow for health information exchange include structuring patient consent, addressing provider concerns and establishing accountability mechanisms.

Structuring Patient Consent

States face key questions on the issue of patient consent. Under what circumstances should patient consent be required? How should consent be structured (opt-in, opt-out)? Will patients have to choose between including all their information for exchange or none? Or will patients be able to choose specific information to share? As states set policy on consent, a number of competing issues must be balanced, including: patients' desire to control data, providers' concern about having access to all relevant information for treatment, and implementation costs for providers and health information exchanges.

Provider Concerns

Providers, understandably, want access to all relevant patient information at time of treatment. They are concerned about liability if they treat a patient based on incorrect or missing data obtained from a health information exchange. Providers also are concerned about the cost of implementing privacy rules and their effect on practice workflows.

Accountability

States need to structure regulations and penalties so that patient, provider and health information exchange needs are balanced.

Minnesota and Rhode Island passed health privacy updates as part of comprehensive health IT measures. A comparison of the privacy portion of the bills illustrates the differing paths states take as they attempt to capture the benefits of mobile health data and temper the associated risks (Table 1).

Table 1. Comparison of Privacy Provisions from Minnesota and Rhode Island

	Minnesota *Minnesota Health Records Act*	**Rhode Island** *Rhode Island Health Information Exchange Act of 2008*
Bill	2007 HB 1078	2008 HB 7409
Status	Enacted 5/25/07	Enacted 7/10/2008
Summary	Allows creation of record locator services (RLS). An RLS is an electronic index of patient identifying information that directs providers to the location of patient health records held by providers and group purchasers.	Establishes a statewide health information exchange (HIE) under state authority. Designates the Rhode Island Quality Institute as the governance body or regional health information organization (RHIO) for the HIE.
Putting Patient Data into the System	An RLS can be created without patient consent. Patients have the right to opt-out of the RLS in total or can exclude specific provider contacts from the system.	Patients must opt in for their data to be included in the HIE.
Consent for Access	Consent is required to search an RLS for the location of a patient's records except in an emergency. To facilitate the real-time exchange of data, one provider can electronically represent patient consent to another. To do so, a provider must have a signed and dated patient consent form authorizing the release. In addition, the provider releasing the record shall document: 1) the provider requesting the health records; 2) the identity of the patient; 3) the health records requested; and 4) the date the health records were requested.	Patients who opt in can choose which providers have access to their data. If a patient opts in their authorization is not required for release to: • public health authorities for specified functions; • health care providers for diagnosis or treatment in an emergency; and • the RHIO for operation and administrative oversight of the HIE.

Table 1. Comparison of Privacy Provisions from Minnesota and Rhode Island (continued)

	Minnesota *Minnesota Health Records Act*	**Rhode Island** *Rhode Island Health Information Exchange Act of 2008*
Audit Log	RLS must maintain an audit log of providers who access a patient's information. The log must contain at least the following: 1) the identity of the provider accessing the information; 2) the identity of the patient whose information was accessed by the provider; and 3) the date the information was accessed.	Patients have the following rights: (a) to obtain a copy of their health care information from the HIE; (b) to obtain a copy of the disclosure report pertaining to their health care information; (c) to be notified of a breach of the HIE security system; (d) to terminate participation in the HIE; and (e) to request to amend their information through the provider participant.
Provider Liability	(b) When requesting health records using consent, or a representation of holding a consent, a provider warrants that the request: 1) contains no information known to the provider to be false; 2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law; and 3) does not exceed any limits imposed by the patient in the consent.	Provides immunity to health care providers who rely in good faith upon information provided through the HIE in the treatment of a patient.
Penalties	An RLS is liable for inappropriate disclosures of information. Anyone who inappropriately discloses a patient's data is liable for compensatory damages caused by an unauthorized release, plus costs and reasonable attorneys' fees. Providers who violate the statute can face disciplinary action by the appropriate licensing board or agency.	The bill establishes civil and criminal penalties for violations of the statute. Attorneys' fees may be awarded by the court to the successful party in any action under this chapter.

Source: National Conference of State Legislatures, 2008.

Other Strategies

Make HIPAA the Rule

Nevada specifies that the Health Insurance Portability and Accountability Act (HIPAA) shall preempt any more stringent state laws related to the electronic exchange of health information by covered entities. The bill allows patients to not participate in electronic transmission of individually identifiable health information, with an exception for Medicaid and SCHIP patients and when required by HIPAA or state law.

> Nevada SB 536 *Section 1 1. "If a covered entity transmits electronically individually identifiable health information in compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which govern the electronic transmission of such information, the covered entity is, for purposes of the electronic transmission, exempt from any state law that contains more stringent requirements or provisions concerning the privacy or confidentiality of individually identifiable health information."*

Address Varying Interpretations of State and Federal Privacy Laws

To address differing interpretations and application of federal and state privacy laws, the Oklahoma Legislature ordered the State Board of Health to create a standard authorization form for exchange of health information. Providers who use the form and follow the board's instructions are immunized from liability under state privacy laws that may arise from the exchange of health information. Use of the form is not required. (Oklahoma SB 1420)

Data Breach Notification

California AB 1298 expands the state's data breach notification law to include unencrypted medical information and health insurance information. The bill also expands the definition of provider of health care under the state's Confidentiality of Medical Information Act to cover third-party vendors of personal health records such as Google and Microsoft. HIPAA and most state health privacy laws do not cover personal health records maintained by third-party vendors.

E-prescribing

A few states prohibit e-prescribing systems from influencing provider prescribing practices. New Hampshire passed the most comprehensive of these bills, which included the following language to prohibit use of prescription information by certain parties:

> New Hampshire HB 134 *"(e) No person who has access to electronic prescription information solely by transmitting or facilitating the transmission of prescriptions between the licensed prescriber generating the prescription and the pharmacy receiving the prescription, or any intermediary, shall retain the prescription or any information it contains for longer than is mandated by federal or state law, after which time the prescription information shall be destroyed. No such person shall sell, use, or otherwise make available the prescription information for any purpose other than transmission of prescriptions, prescription refills, and clinical information displayed to the prescriber or pharmacist."*

Promoting Health Information Exchange

States are working to advance health information exchange by promoting interoperable health IT tools and by establishing and sustaining health information exchange organizations and infrastructure. Interoperability, combined with state initiatives to create health information exchange organizations is essential to states efforts to achieve quality improvements and reduce duplicative tests. Trends identified in the enacted legislation include the following.

Interoperability

Interoperability allows different systems to share information in an understandable format. Uniform data standards are essential to achieving this capability among health IT systems. At the national level, the Healthcare Information Technology Standards Panel is establishing standards, and the Certification Commission for Healthcare Information Technology certifying products. State approaches to encourage interoperability vary. Some states adopted these standards by reference, while others designated a state agency or outside group to establish standards. To encourage use of the standards, states can require agencies to purchase only standards-based systems. States also can require specific functions for health IT systems sold within their borders.

Require Purchase of Certified Systems

Minnesota mandated interoperable electronic health records by 2015 for all hospital and health care providers. To meet the interoperability standards set by statute, providers must use an electronic health records system certified by the Certification Commission for Healthcare Information Technology or its successor. An exception is included in the legislation for specialists whose practice setting the Certification Commission for Healthcare Information Technology doesn't certify electronic health records for. (Minnesota SB 3780)

Use State Agency Purchasing Requirements

Virginia HB 2198 requires that electronic health records systems or other tools that interact with electronic patient information purchased by state agencies meet interoperability standards or be certified by a recognized certification body. The bill also requires state agencies that provide grants available to other entities for such systems ensure that the systems meet interoperability standards or be certified by a recognized certification body.

Create Standards and Require Use to Exchange Data

Utah HB 47 authorizes the Department of Health to adopt standards for electronic health information exchange. Payers and providers must use the standards adopted by the department to electronically exchange health information between health care systems. Payers and providers are not required to use the standards if they electronically exchange health information within a health care system.

Require Certain Functions

Texas SB 204 requires that electronic medical record systems sold to Texas health care providers who administer immunizations be able to interface with the state immunization registry.

Create or Designate a State-level Health Information Exchange

Many early health information exchange efforts began in the private sector, and state governments were asked to join. The current wave of health information exchanges, by contrast, is as likely to originate at the state level. Texas and Indiana created bodies to run the state-level health information exchange; and Connecticut, Vermont and Rhode Island designated existing independent nonprofit entities. Whether they create new entities or bless existing activities, statutes that define a state-level health information exchange confer formal status and authority, charge the health information exchange to promote health IT in both private and public sectors, define governance to include state agencies, and determine that they may receive and disburse funds on behalf of statewide health IT initiatives. Beyond these broad elements, various models have been adopted, reflecting existing activity in the state. Statutes that create these entities typically are comprehensive measures that, among other things, include: start-up support for a designated group, a state governance role, ongoing funding, and unique state-level responsibilities.

Appendix A compares legislation from Indiana, Texas and Vermont that creates or designates a state-level health information exchange.

Advancing Adoption and Use

States are drawing on a wide range of policy levers to expand the use of health IT. These include mandates, incentives and leveraging state purchasing power. Trends identified in the enacted legislation include the following.

Mandates

Minnesota and Massachusetts have enacted mandates for the use of health IT tools. A few other states considered such mandates but did not enact them.

Mandate Purchase

Minnesota enacted two mandates for the purchase of health IT systems. The first requires hospitals and health care providers to have interoperable electronic health records systems by 2015. (Minnesota HB 1078) The second requires that, by 2011, all providers, group purchasers, prescribers and dispensers establish and maintain e-prescribing systems. (Minnesota SB 3780)

Tie Facility Licensure to Health IT System Implementation

Massachusetts tied implementation of computerized physician order entry and electronic health records to facility licensure standards for hospitals and community health centers. The Department of Public Health is charged with adopting regulations to require implementation of computerized physician order entry by Oct. 1, 2012, and of electronic health records by Oct. 1, 2015. The systems are to be certified by the Certification Commission for Healthcare Information Technology or its successor. (Massachusetts SB 2863)

Require health IT competency for physician licensure.

(Massachusetts SB 2863) *"The board shall require, as a standard of eligibility for licensure, that applicants show a predetermined level of competency in the use of computerized physician order entry, e-prescribing, electronic health records and other forms of health information technology, as determined by the board."*

Incentives

Link Medical School Loan Repayment to Health IT Competency

Massachusetts created a workforce loan repayment assistance program for graduates of medical or nursing schools who specialize in areas where practitioners are in short supply. Among other eligibility requirements for the program is demonstration of competency with certain health IT tools. (Massachusetts SB 2863)

Offer Tax Credits

Wisconsin SB 40 creates a tax credit for providers who purchase electronic medical records. Providers can claim up to 50 percent of the cost of the system, to a maximum of $10 million per year.

Leverage State Purchasing Power

States are leveraging their role as a purchaser and provider of care to drive adoption and use of health IT.

Offer Incentive Payments for Electronic Health Records Use

New York SB 6808 allows providers who meet certain standards set by the Department of Health to receive supplemental payments for the increased cost of using electronic health records. To receive the payments, a provider must have an operating electronic health records system, and a set percentage of patients must be on Medicaid or uninsured.

Provide Targeted Reimbursement

Colorado SB 196 provides medical assistance program reimbursement for home and community services delivered via telemedicine.

Leverage State Employee Health Plan

Minnesota HB 548 creates a pilot program to provide a consumer-owned portable personal health record to members of the state employee health plan.

Appendix A. Comparison of Health Information Exchange Legislation in Three States

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
Bill	**2007 IN S 551**	**2007 TX H 1066**	**2007 VT H 229**
Status	Enacted 5/2/07	Enacted 6/15/07	Enacted 6/5/07
Project's Role within State Health IT Activities			
	Chapter 5. General Powers Sec. 1. The corporation shall encourage and facilitate the development of health informatics functions in Indiana. Sec. 2. The corporation is granted all powers necessary or appropriate to carry out the corporation's public and corporate purposes under this article. Chapter 7. Expiration Corporation will expire on June 30, 2015.	Section 182.051 (a) Created to promote the establishment of a voluntary statewide network for the communication of electronic health information and to foster a coordinated public-private initiative for the development and operation of the health information infrastructure in the state.	Amends the scope of work of the Vermont Information Technology Leaders (VITL, a non-profit organization incorporated in 2005). Section 903 (c) VITL shall develop the states health information technology plan. Designates VITL to operate the statewide health information exchange network.
Organizational Structure			
	Chapter 3. Indiana Health Informatics Corporation Sec. 2. (a) The corporation is a body politic and corporate, not a state agency but an independent instrumentality exercising essential public functions.	Sec.A182.051. Texas Health Services Authority; Purpose. ... (b) The corporation is a public nonprofit corporation and, except as otherwise provided in this chapter, has all the powers and duties incident to a nonprofit corporation under the Business Organizations Code.	VITL is a nonprofit corporation.

Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued)

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
Bill	**2007 IN S 551**	**2007 TX H 1066**	**2007 VT H 229**
Status	Enacted 5/2/07	Enacted 6/15/07	Enacted 6/5/07
Board Membership			
	Chapter 4. Corporation Board Sec. 1. The corporation shall be governed by a board. Sec. 2. (a) The board is composed of the following nine (9) members, none of whom may be a member of the general assembly: (1) The secretary of family and social services, or the secretary's designee. (2) The state health commissioner, or the state health commissioner's designee. (3) Seven (7) individuals appointed by the governor, of which at least: (A) one (1) individual must be a licensed physician who is actively engaged in the practice of medicine; and (B) one (1) individual must be engaged in the administration of a hospital licensed under IC 16-21.	Sec.A182.053.AA Composition Of Board Of Directors. (a) The corporation is governed by a board of 11 directors appointed by the governor, with the advice and consent of the senate. (b) The governor shall also appoint at least two ex officio, nonvoting members representing the Department of State Health Services. (c) The governor shall appoint as voting board members individuals who represent consumers, clinical laboratories, health benefit plans, hospitals, regional health information exchange initiatives, pharmacies, physicians, or rural health providers, or who possess expertise in any other area the governor finds necessary for the successful operation of the corporation.	Sec. 903. Health Information Technology (d) The following persons shall be members of VITL: (1) the commissioner, who shall advise the group on technology best practices and the state's information technology policies and procedures, including the need for a functionality assessment and feasibility study related to establishing an electronic health information infrastructure under this section; (2) the director of the office of Vermont health access or his or her designee; (3) the commissioner of health or his or her designee; and (4) the commissioner of banking, insurance, securities, and health care administration or his or her designee.

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Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued)

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
Bill	**2007 IN S 551**	**2007 TX H 1066**	**2007 VT H 229**
Status	Enacted 5/2/07	Enacted 6/15/07	Enacted 6/5/07
Financing			
	Chapter 5. General Powers Section 11 The corporation may request appropriations from the general assembly to: 1) carry out the corporation's duties under this article; and 2) fund the effort to develop and operate a statewide health information network. Section 12. (a) The Indiana health informatics fund is established. ...the corporation shall deposit the following in the fund: (1) All appropriations made by the general assembly to the corporation (2) All funding received from nonprofit entities under IC 5-31-6-2(4). (3)All other contributions received by the corporation from a nonprofit entity, as long as the nonprofit entity does not otherwise have an interest in the decisions of the corporation or board.	Sec. 182.107 (a) The corporation may be funded through the General Appropriations Act and may request, accept, and use gifts and grants as necessary to implement its functions. (b) The corporation may assess transaction, convenience, or subscription fees to cover costs associated with implementing its functions. All fees must be voluntary but receipt of services provided by the corporation may be conditioned on payment of fees. (c) The corporation may participate in other revenue-generating activities that are consistent with the corporation's purposes.	Sec. 903 (a)(8)(g) By July 1, 2007, shall prepare a plan for achieving self-sustainable funding, including an analysis of the costs, benefits, and effectiveness of any pilot projects. (i) VITL is authorized to seek matching funds...In addition, it may accept any and all donations, gifts and grants of money, equipment, supplies, materials, and services from the federal or any local government, or any agency thereof, and from any person, firm or corporation for any of its purposes and functions under this section and may receive and use the same, subject to the terms, conditions, and regulations governing such donations, gifts, and grants.

Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued)

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
Bill	**2007 IN S 551**	**2007 TX H 1066**	**2007 VT H 229**
Status	Enacted 5/2/07	Enacted 6/15/07	Enacted 6/5/07
Privacy and Security			
	Chapter 6. Duties Sec. 3. The corporation's plan to create the statewide health information exchange system must provide for procedures and security policies to ensure the following: (1) Compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). (2) Protection of information privacy. (3) Use of information in the statewide health information exchange system only in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L.104-191) and as required by public health agencies.	Sec. 182.104.AASecurity Compliance. The corporation shall: (1) establish appropriate security standards to protect both the transmission and the receipt of individually identifiable health information or health care data; (2) establish appropriate security standards to protect access to any individually identifiable health information or health care data collected, assembled, or maintained by the corporation; (3) establish the highest levels of security and protection for access to and control of individually identifiable health information, including mental health care data and data relating to specific disease status, that is governed by more stringent state or federal privacy laws; and	Sec. 903. Health Information Technology (f) The standards and protocols developed by VITL shall be no less stringent than the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996 and contained in 45 C.F.R., Parts 160 and 164, and any subsequent amendments. In addition, the standards and protocols shall ensure that there are clear prohibitions against the out-of-state release of individually identifiable health information for purposes unrelated to treatment, payment, and health care operations, and that such information shall under no circumstances be used for marketing purposes. The standards and protocols shall require that access to individually identifiable health information is secure and traceable by an electronic audit trail.

Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued)

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
Bill	**2007 IN S 551**	**2007 TX H 1066**	**2007 VT H 229**
Status	Enacted 5/2/07	Enacted 6/15/07	Enacted 6/5/07
Data Standards			
	Chapter 6. Duties Sec. 1. The corporation shall do the following:... (6) Promote the use of the statewide health information exchange system by doing the following: (A) Encouraging and facilitating users of the statewide health information exchange system and other interested parties in developing and adopting standards for the statewide health information exchange system. (B) Recommending policies and legislation that advance the development and efficient operation of the statewide health information exchange system.... (10) Encourage and endorse interoperability standards.	Sec.A182.103. Privacy of Information. (c) The corporation shall develop privacy, security, operational, and technical standards to assist health information networks in the state to ensure effective statewide privacy, data security, efficiency, and interoperability across networks. The network 's standards shall be guided by reference to the standards of the Certification Commission for Healthcare Information Technology or the Health Information Technology Standards Panel, or other federally approved certification standards, that exist on May 1, 2007, as to the process of implementation, acquisition, upgrade, or installation of electronic health information technology.	Sec. 903. Health Information Technology b) The health information technology plan shall: (3) promote the use of national standards for the development of an interoperable system, which shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols;... (6) incorporate the existing health care information technology initiatives in order to avoid incompatible systems and duplicative efforts; (7) integrate the information technology components of the blueprint for health established in chapter 13 of Title 18, the global clinical record, and all other Medicaid management information systems being developed by the office of Vermont health access, information technology components of the quality assurance system, the program to capitalize with loans and grants electronic medical record systems in primary care practices, and any other information technology initiatives coordinated by the secretary of administration pursuant to section 2222a of Title 3;

The New York Times

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March 1, 2009

UNBOXED

How to Make Electronic Medical Records a Reality

By STEVE LOHR

IN the world of technology, inventors are hailed as heroes. Yet it is more subtle forms of innovation that typically determine the impact of a technology in the marketplace and on society. Clever engineering, smart business models and favorable economics are the key ingredients of widespread adoption and commercial success.

History abounds with evidence. For years, much of what was known as "Yankee ingenuity" was, in fact, the American ability to pursue commercial applications of British inventions, from the Bessemer steel process to the jet engine. Even in computing, which we regard as made-in-America technology, the first stored-program computer, simple programming language and reusable code were pioneered in Britain.

But, of course, computer technology and the industry really flowered in the United States. That happened in no small part because the federal government nurtured the market with heavy investment, mainly by the Defense Department, and by choosing standards, like the Cobol programming language.

Today, Washington is about to embark on another ambitious government-guided effort to jump-start a market — in electronic health records. The program provides a textbook look at the economic and engineering challenges of technology adoption.

In its economic recovery package, the Obama administration plans to spend $19 billion to accelerate the use of computerized medical records in doctors' offices. Medical experts agree that electronic patient records, when used wisely, can help curb costs and improve care.

The proof is seen in large medical groups, with hundreds or thousands of physicians. They sift, sort and analyze the data from digital records, for example, to better manage the health of patients with costly, chronic conditions like diabetes and heart disease. These larger groups have the scale to invest in information technology, and they are often insurers as well as providers, so they benefit directly from the cost savings.

Yet these large groups are the exceptions in American health care. Three-fourths of the nation's doctors practice in small offices, with 10 doctors or fewer. For most of them, an investment in digital health records looks like a cost for which they are not reimbursed.

It is scarcely surprising, then, that only about 17 percent of the nation's physicians are using computerized patient records, according to a government-sponsored survey published last year in The New England Journal of Medicine.

"This is really not a technology problem," observed Erik Brynjolfsson, an economist at the Sloan School of Management at the Massachusetts Institute of Technology. "It's a matter of incentives and market failure."

That market failure is a principal target of the Obama administration's plan. A main feature of the legislation calls for incentive payments of more than $40,000 spread over a few years for a physician who buys and uses electronic health records. But the technology is just a tool, one that needs to be used properly to improve health care.

So the legislation states that physicians will be paid only for the "meaningful use" of digital records. The government has not yet defined that term precisely. While the long-term goal is better health for patients, that can take years to measure. Consequently, many health experts predict that the meaningful use will be a requirement to collect and report measurements that can be closely correlated with improved health. Examples would be data for blood glucose, cholesterol and blood pressure levels for diabetes patients.

The legislation, health experts say, seems thoughtfully put together, but the obstacles to success will be daunting. "What's underappreciated is the implementation challenge," said Dr. Blackford Middleton, chairman of the Center for Information Technology Leadership, a research arm of Partners Healthcare in Boston.

A crucial bridge to success, according to experts, will be how local organizations help doctors in small offices adopt and use electronic records. The new legislation calls for creation of "regional health I.T. extension centers." In a letter to the White House and Congress last month, Dr. Middleton and 50 other experts emphasized the importance of these centers and pointed to the Primary Care Information Project in New York City as a model.

The New York project's brief history, beginning two years ago with $27 million in financing, offers a glimpse of the challenges of wiring small physician practices. The New York team, headed by Dr. Farzad Mostashari, an assistant commissioner in the city's health department, started by bringing in decision-support experts in medicine to study how doctors work, so the technology would be easier to use. Team members considered writing their own software for simple, Web-based electronic health records, but abandoned that idea once they understood that patient records would have to be tightly linked to billing — a physician's financial lifeblood.

The project's 50-member staff provides centralized technical support and education for doctors and others. "There's no way small practices can effectively implement electronic health records on their own," Dr. Mostashari said. "This is not the iPhone."

The staff worked closely with its software supplier, eClinicalWorks, to tweak and tailor the system. They began rolling out the records a little more than a year ago. They are now used by more than 1,000 physicians, mainly in poorer neighborhoods, whose workplaces include two hospital outpatient clinics, 10 community health centers, 150 small group physician practices and one women's jail, serving a total of one million patients. The rollout is progressing, and the government plan promises to accelerate adoption.

"Our experience here is that it's just hard," Dr. Mostashari said. "It's not impossible."

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Deploying a Health Information Exchange for Alaskans

Paul Sherry, President
Alaska eHealth Network
March 2009

Medical Care: From Paper to Electronic

- Alaska's health care providers are now making major investments ($100M+) in moving from paper records to ***Electronic Medical Records***

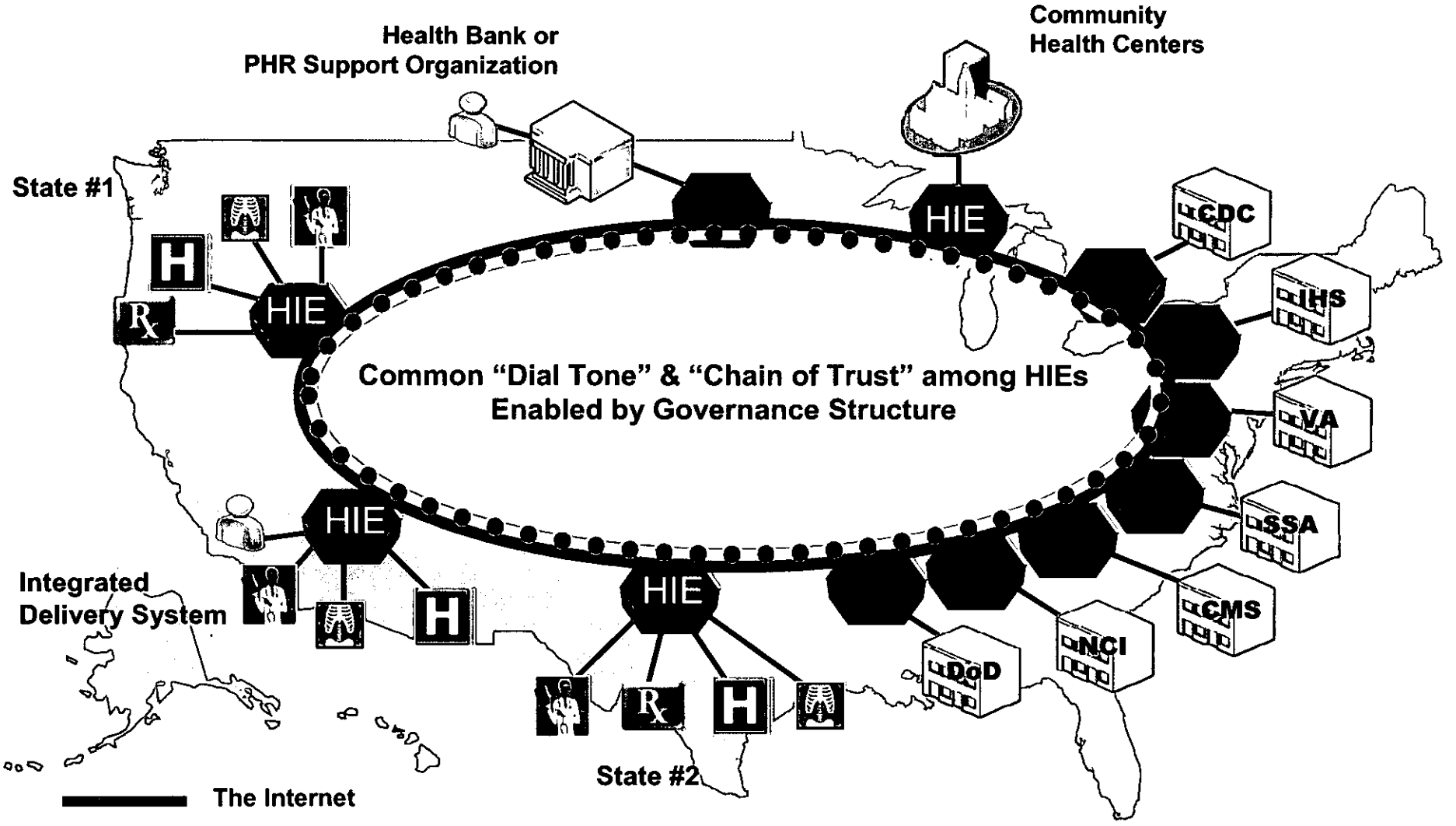
- Alaska's health care providers are aligned in support of creating a statewide ***Health Information Exchange*** network so patient records may be securely exchanged between providers for timely and safe patient care

- State of Alaska plays a ***key role as a partner*** in Alaska's developing Health Information Exchange

Health Information Exchanges: National effort: State Solutions

- Statewide and regional health information exchanges have developed over the last 10 years in other states
- "National Health Information Network" concept created in Bush administration and enhanced in Obama administration through ARRA 2009 stimulus
- Successful State Models:
  - DHIN - Delaware Health Information Network
  - CalRHIO – California, Los Angeles County
  - FHIN – Florida Health Information Network
  - Regenstrief – Indiana Eight County Network

NHIN "Network of Networks"



Health Information Exchanges: Providing timely, safer care

- Provide rapid access by authorized providers to critical patient information at the point of care

medical history	allergies
medication status	laboratory reports
immunization status	imaging reports

- Reduce redundancy in medical testing and procedures
- Improve patient safety through reducing medication reconciliation errors
- Reduce provider administrative costs for data management
- Expedited response to public health emergencies

Health Information Exchanges: Respecting Patient Privacy

- Do not require centralized patient health record repositories: health providers continue to own their records
- Facilitate connectivity with patient's Personal Health Record choices
- Respect patient decisions to opt-out of network participation
- Provide significant penalties for data breaches

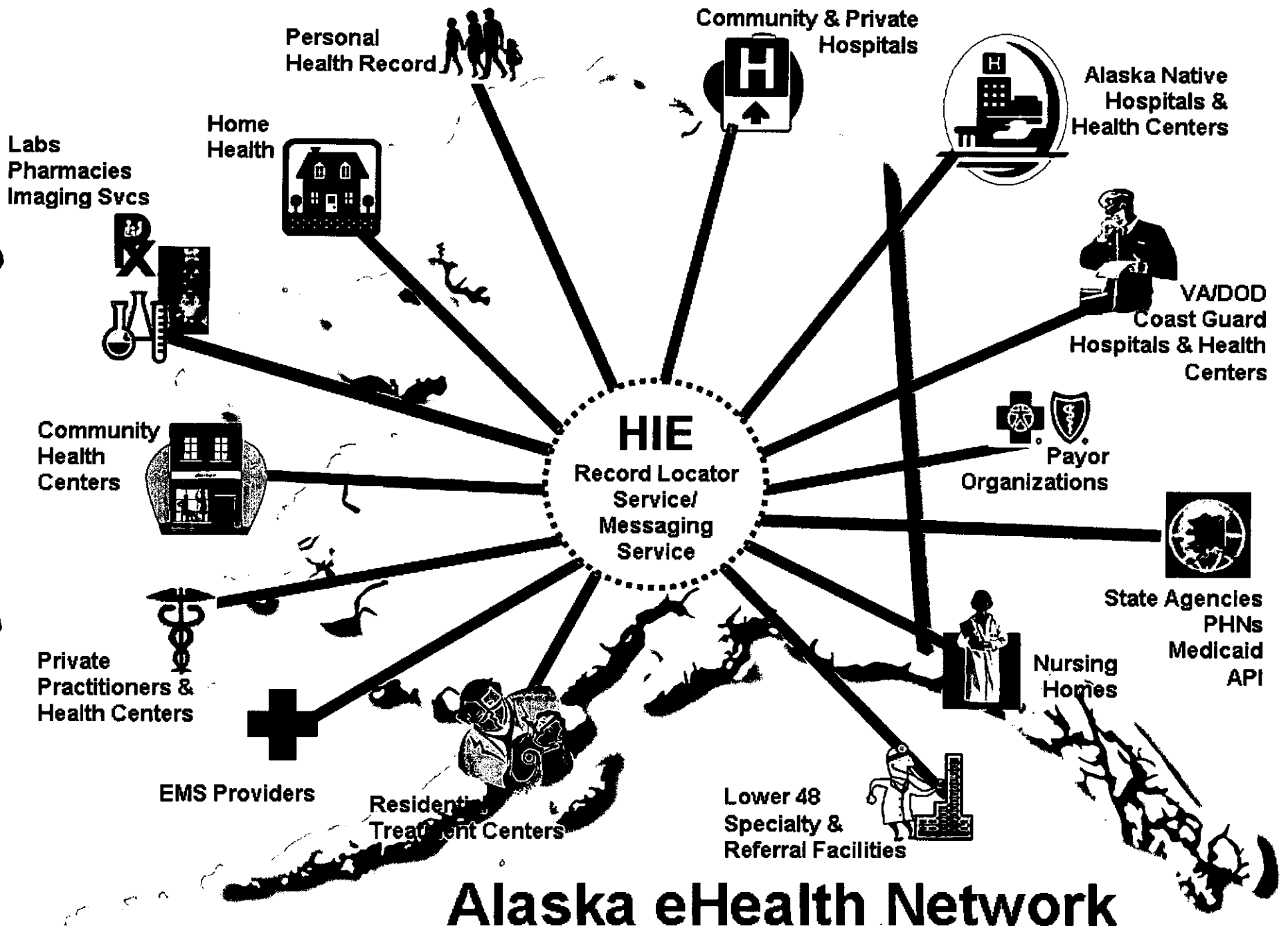
Health Information Exchanges: Saving money

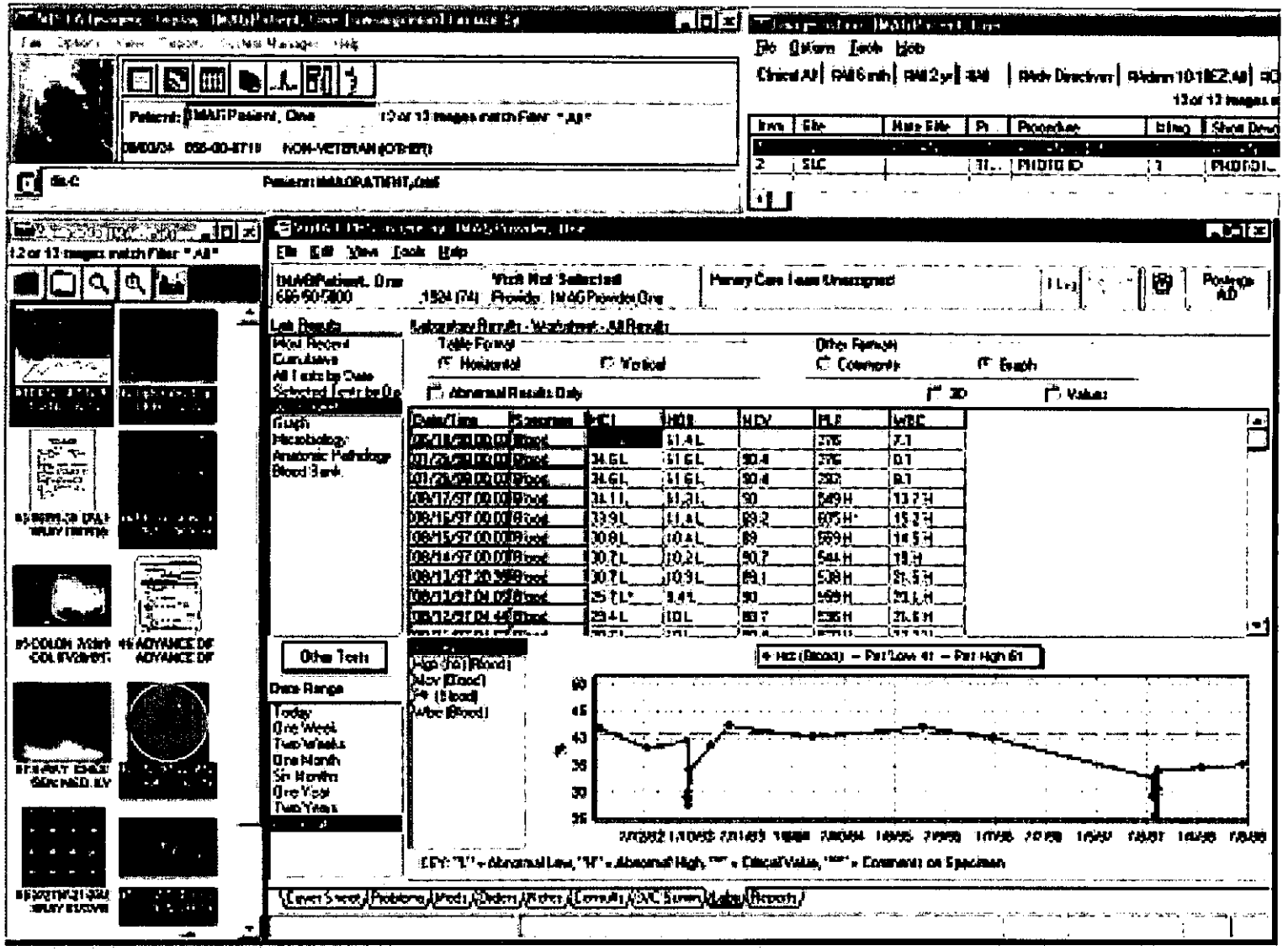
- Federal and private research projects 5% savings in annual U.S. health care expenditures from full deployment of inter-operable electronic medical records
- For Alaska's $5B health care industry, annual savings could reach $250M.
- For the State of Alaska's $250M GF Medicaid expenditures, annual savings could exceed $10M

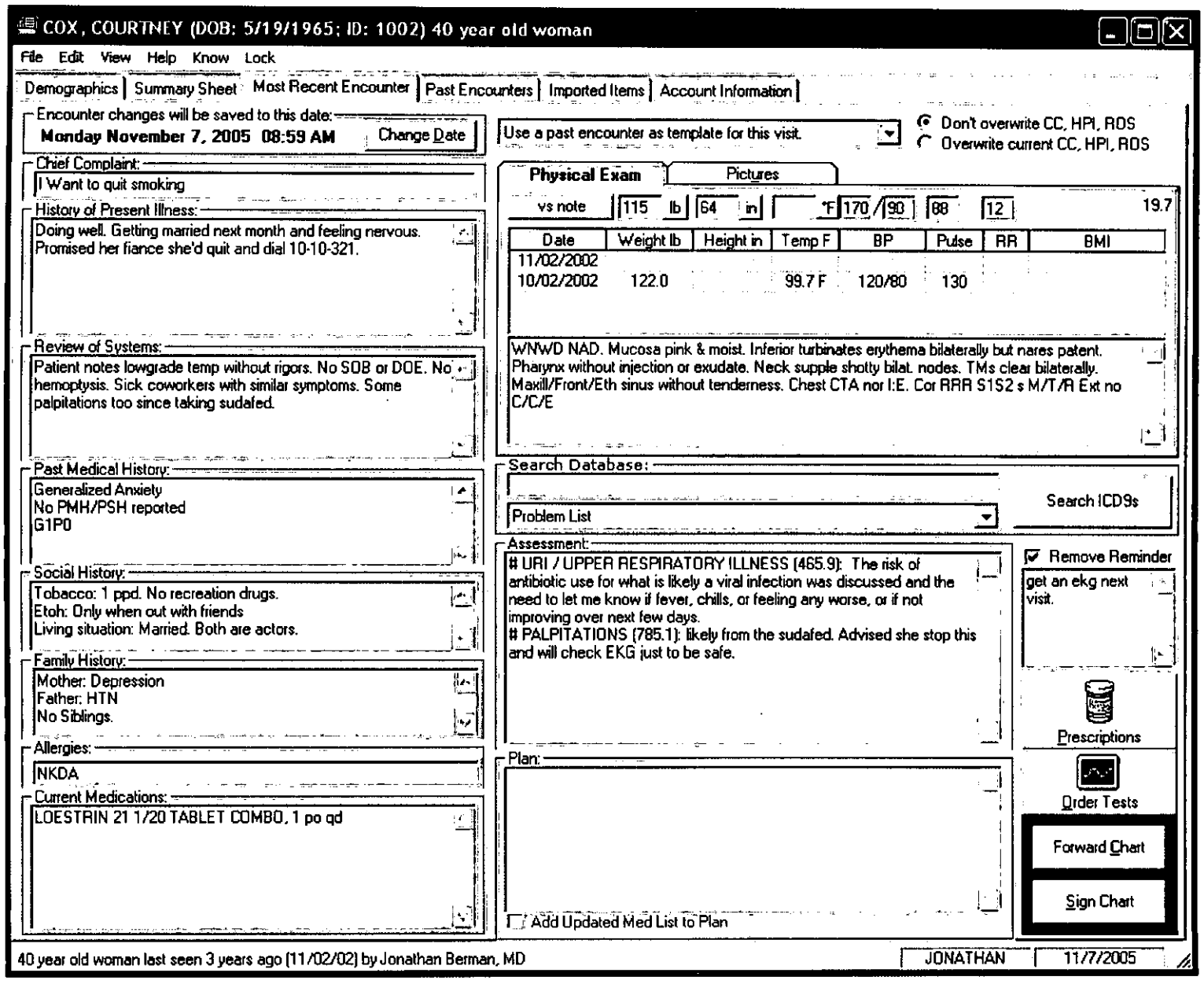
Alaska eHealth Network

- **5 year $35 million project** to deploy a secure network supporting the exchange of electronic health records between all Alaska health care providers

- **$12.0 million currently awarded** through 2008 from Federal Communications Commission, US Dept. of Health and Human Services, State of Alaska, Alaska Federal Health Care Partnership


Personal Health Record
Community & Private Hospitals
Alaska Native Hospitals & Health Centers
Home Health
Labs Pharmacies Imaging Svcs
VA/DOD Coast Guard Hospitals & Health Centers
HIE
Record Locator Service/ Messaging Service
Community Health Centers
Payor Organizations
State Agencies PHNs Medicaid API
Private Practitioners & Health Centers
Nursing Homes
EMS Providers
Residential Treatment Centers
Lower 48 Specialty & Referral Facilities
Alaska eHealth Network




COX, COURTNEY (DOB: 5/19/1965; ID: 1002) 40 year old woman
File Edit View Help Know Lock
Demographics | Summary Sheet | Most Recent Encounter | Past Encounters | Imported Items | Account Information
Encounter changes will be saved to this date:
Monday November 7, 2005 08:59 AM
Change Date
Use a past encounter as template for this visit.
Don't overwrite CC, HPI, ROS
Overwrite current CC, HPI, ROS
Chief Complaint:
I Want to quit smoking
History of Present Illness:
Doing well. Getting married next month and feeling nervous. Promised her fiance she'd quit and dial 10-10-321.
Review of Systems:
Patient notes lowgrade temp without rigors. No SOB or DOE. No hemoptysis. Sick coworkers with similar symptoms. Some palpitations too since taking sudafed.
Past Medical History:
Generalized Anxiety
No PMH/PSH reported
G1P0
Social History:
Tobacco: 1 ppd. No recreation drugs.
Etoh: Only when out with friends
Living situation: Married. Both are actors.
Family History:
Mother: Depression
Father: HTN
No Siblings.
Allergies:
NKDA
Current Medications:
LOESTRIN 21 1/20 TABLET COMBO, 1 po qd
Physical Exam
Pictures
vs note
115 lb
64 in
°F
170 / 90
88
12
19.7
Date | Weight lb | Height in | Temp F | BP | Pulse | RR | BMI
11/02/2002
10/02/2002 | 122.0 | | 99.7 F | 120/80 | 130
WNWD NAD. Mucosa pink & moist. Inferior turbinates erythema bilaterally but nares patent. Pharynx without injection or exudate. Neck supple shotty bilat. nodes. TMs clear bilaterally. Maxill/Front/Eth sinus without tenderness. Chest CTA nor I:E. Cor RRR S1S2 s M/T/R Ext no C/C/E
Search Database:
Problem List
Search ICD9s
Assessment:
URI / UPPER RESPIRATORY ILLNESS (465.9): The risk of antibiotic use for what is likely a viral infection was discussed and the need to let me know if fever, chills, or feeling any worse, or if not improving over next few days.
PALPITATIONS (785.1): likely from the sudafed. Advised she stop this and will check EKG just to be safe.
Remove Reminder
get an ekg next visit.
Prescriptions
Order Tests
Plan:
Add Updated Med List to Plan
Forward Chart
Sign Chart
40 year old woman last seen 3 years ago (11/02/02) by Jonathan Berman, MD
JONATHAN
11/7/2005

Alaska eHealth Network

- Incorporated non-profit August 2008
- Partners:
  - Alaska Native Tribal Health Consortium (designated lead partner)
  - Alaska State Hospitals and Nursing Homes Association
  - Alaska Primary Care Association
  - Premera Blue Cross/Blue Shield
  - State of Alaska DHSS
  - Alaska Federal Health Care Partnership (DOD, VA, USCG, Indian Health Service)
  - University of Alaska
  - Alaska E.H.R. Alliance (private physicians)
  - American Association of Retired Persons

Alaska eHealth Network
Board of Directors

- Alex Spector
- Jeff Davis
- Garth Hamblin
- Jay Butler, M.D.
- Jerome List, M.D.
- Tom Nighswander, M.D.
- Joel Gilbertson
- Marilyn Walsh-Kasmar
- Pat Luby
- Paul Sherry
- Rod Betit

Progress to Date: 2007-2008

- Participation in determining national privacy standards and technology interoperability standards
- Contract for technical network design awarded to GCI; determining requirements for needed broadband connectivity for Alaska health providers
- FCC grant funding is now available for health provider network technology acquisitions in 2009 and 2010

Next Steps: 2009-2010

- Complete network design and assist providers with connectivity
- Secure AeHN designation as Alaska's qualified Health Information Exchange organization
- Secure $20M+ from $19B available federal ARRA funding to acquire Health Information Exchange software

Next Steps: 2009-2010

- Secure $1.3M for FY2010 and $1.0M in FY2011 from State of Alaska for network development
  - Ensures match for federal stimulus funds
- Engage contractor/vendors to deploy Health Information "bridging" software to interconnect Alaska's various Electronic Medical Records systems
- Align the Health Information Exchange with State systems: MMIS, API, Public Health data
- Add Internet2 connectivity for telemedicine applications, teleconferencing, voice-over-internet, and consults from lower-48 academic/teaching hospitals

Sustainability: FY2011+

Establish the Alaska eHeath Network business structure to sustain network and software services through provider and payor contributions

AeHN Estimated recurring costs after FY11: $5.0M

$1.3M administration/business operations

$3.7M contractual HIE technical/software services

Estimated recurring AeHN revenues after FY11: $5.0M

- $1.5M 1500+ physicians/clinicians
- $0.5M 26 Hospitals
- $0.5M Laboratories/Pharmacies/Imaging Centers
- $1.0M State of Alaska
- $1.0M Private Insurers
- $0.5M Alaska Federal Health Care partners

SB133 Facilitates HIE development

- Positions Alaska for substantial stimulus funding
- Demonstrates state commitment to support and participate in Alaska's Health Information Exchange development
- Provides for DHSS oversight, engagement, and long-term participation plan
- Provides framework for designation of a qualified state Health Information Exchange entity
- Ensures privacy protections

Alaskan's support Health Information Exchange

- Partner organization support: hospitals, physicians, tribal health, insurers, citizens, community health centers, employers, federal health providers
- Alaska Health Care Commission short term priority area
- Strong Congressional delegation support

Summary recommendations

- A. Passage of SB133
- B. State DHSS oversight, support, and designation of HIE organization
- C. Provide stimulus match of $1.3M in FY10 and $1.0M in FY11

The outcomes:

- Timelier access to safer health care for Alaskans

- $1M annual State investment yields ~5% savings in future State expenses for Medicaid, employee health care, state-operated health care programs

Bristol Bay Area
Health Corporation
6000 Kanakanak Road
P.O. Box 130
Dillingham, AK 99576
(907) 842-5201
800-478-5201
FAX (907) 842-9354

Bristol Bay Area Health Corporation is a tribal organization representing 34 villages in Southwest Alaska:

Aleknagik
Chignik Bay
Chignik Lagoon
Chignik Lake
Clark's Point
Dillingham
Egegik
Ekuk
Ekwok
Goodnews Bay
Igiugig
Iliamna
Ivanof Bay
Kanatak
King Salmon
Knugank
Kokhanok
Koliganek
Levelock
Manokotak
Naknek
New Stuyahok
Newhalen
Nondalton
Pedro Bay
Perryville
Pilot Point
Platinum
Port Heiden
Portage Creek
South Naknek
Togiak
Twin Hills
Ugashik

To promote health with competence, a caring attitude &

March 16, 2009

To Whom It May Concern:

The Bristol Bay Area Health Corporation (BBAHC) has begun implementation of a Electronic Health Records EHR system at our Kanakanak Hospital and hopes to secure additional funding to do so with our 28 village clinics.

It is our hope that we can electronically communicate our EHR's and receives EHR's from all patients using our system and other health facilities throughout the state and elsewhere.

With our different system's we need a way to all talk to each other.
We are excited about the possibility of SB No. 133 "An Act creating a statewide electronic health information exchange systems; and providing for an effective date. By senators PASKVAN, Davis introduced on 3.2.09.

We are members of several statewide groups who are supportive of an HIE as proposed, as we have seen how well it works in the lower 48.

This should be a high priority of the state and is an area that President Obama's stimulus package supports.

Thank you for you support.

Robert J. Clark
President/CEO

BRISTOL BAY AREA HEALTH CORPORATION
P.O. Box 130
6000 Kanakanak Road
Dillingham, Alaska 99576

TOLL FREE: 1-800-478-5201 (In Alaska Only)
PHONE: 1-(907)-842-5201
FAX: 1-(907)-842-9354

PLEASE DELIVER THE FOLLOWING PAGES TO:

Name: Anna Mae — Hard Copy To Follow: Yes U No ____
Department: ____ — Phone: ____
Company: ____ — Fax: 842-5105

From: Holly Akelkok — Phone: 842-5201
Department: Administration — Fax: 842-9543

Comments: Please include this information in the hearing today at 1:30 p.m. Would you be able to send to the SHSS Committee as well as Edgmon, Hoffman & Dept Stevens? Thank you.

Date: 3-16-09 Pages: 2 Sent By: Holly Akelkok

3-16-09 11:40am

AARP

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 16, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 133 (Paskvan)—Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage your colleagues on the Senate Health and Social Services Committee to support SB 133, authored by Senator Joe Paskvan and co-sponsored by you.

AARP has been collaborating with a group of organizations and medical leaders for several years to determine how Alaska can develop electronic medical record systems in medical offices and an electronic health record exchange network to connect clinics, hospitals, labs, pharmacies, insurers, the State of Alaska and other related health and medical providers that need to have quick access to accurate records.

SB 133 will establish an electronic health information exchange system.

AARP strongly supports this effort.

We believe electronic medical records will save overall costs as well as significantly reduce medical errors. In addition, electronic medical records will also lead to the more effective use of personal health records to increase consumers' engagement in their health care. Electronic records can take advantage of technology to facilitate patient education and self-management, permit secure messaging reminders, allow patients to maintain diaries, eg., of pain, symptoms and side effects, and to obtain prescription refills, schedule medical appointments online, and track medical test results. Ideally these personal health records will be connected to the electronic medical record system.

Even if all an electronic health information exchange accomplished was a reduction in medical errors, that goal alone is worth pursuing in Alaska.

Some proponents of setting up such an exchange system believe such a network could be the biggest advance in medicine since the discovery of penicillin. A network like this in Alaska has the potential to save hundreds, if not thousands, of lives and save millions of dollars by eliminating duplicate tests, shortening hospital stays, improving care for chronically ill patients, and guaranteeing accurate prescribing.

Jennie Chin Hansen, President
William D. Novelli, Chief Executive Officer

The collaboration on this issue that we have already witnessed in Alaska gives us confidence that the system will work and work well. Some of our "best and brightest" are committed to accomplishing this for Alaska citizens and health consumers.

AARP members, more than any other age group, are consumers of health care. We believe SB 133 is in the best interests of our members as well as their families.

AARP is pleased to lend our strong support to SB 133.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

AARP

AARP Alaska
3601 C Street
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Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 6, 2009

The Honorable Joe Paskvan
Member of the Senate
Alaska State Capitol, Room 7
Juneau, AK 99801-1182

RE: SB 133 (Paskvan)—Support

Dear Senator Paskvan:

On behalf of the 97,000 members of AARP in Alaska, we are pleased to support SB 133, authored by you and co-sponsored by Senator Davis.

AARP has been collaborating with a group of organizations and medical leaders for several years to determine how Alaska can develop electronic medical record systems in medical offices and an electronic health record exchange network to connect clinics, hospitals, labs, pharmacies, insurers, the State of Alaska and other related health and medical providers that need to have quick access to accurate records.

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Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Bettye Davis
Patrick Luby

Lynda Zaugg

From: Amory Lelake
Sent: Tuesday, March 24, 2009 9:37 AM
To: Lynda Zaugg
Subject: FW: SB 133 Electronic Health Network

From: Sherry, Paul [mailto:psherry@anthc.org]
Sent: Tuesday, March 24, 2009 8:43 AM
To: Amory Lelake
Cc: Jake Hamburg; Sen. Johnny Ellis; Rep. Berta Gardner; linda.zaugg@legis.state.ak.us
Subject: RE: SB 133 Electronic Health Network

Thanks Amory. We will review her comments and provide a response to you today.

Paul Sherry

From: Amory Lelake [mailto:Amory_Lelake@legis.state.ak.us]
Sent: Tue 3/24/2009 8:30 AM
To: Sherry, Paul
Cc: Jake Hamburg; Sen. Johnny Ellis; Rep. Berta Gardner; linda.zaugg@legis.state.ak.us
Subject: FW: SB 133 Electronic Health Network

Here are the concerns our constituent Dr. Illona Farr has about electronic health records in reference to SB 133. Since the bill will be heard again on Friday, maybe we can try to set up a time to discuss her concerns.

Thanks!

Amory

From: Ilona Farr [mailto:afmc4045@gmail.com]
Sent: Monday, March 23, 2009 8:46 PM
To: Amory Lelake
Cc: afmc4045@yahoo.com
Subject: Re: SB 133 Electronic Health Network

Amory,

I just got back into town yesterday and just got your email. As a Family Practice Physician these required electronic medical records will force me to stop seeing medicare and medicaid patients because of the added time and cost associated with these records. I tried electronic medical records(EMRs) for 6 months. I went from seeing patients 5 hours a day with 3 hours of paperwork to seeing patients 3 1/2 hours a day and doing work on the computer 5 hours a day. My costs went through the roof and I started loosing long time patients because they could no longer get into see me. (that 4 MD clinic spent $240,000 on EMRs , lost lots of money and terminated the system after one year.) I went back to solo practice with hand written notes and just scan these into the computer in a word file so my patients can get a copy on disc of their word document medical file if they desire.(so I do have a form of EMR) I

have estimated the costs to my office of $65,000.00 per year for these new required medical electronic records (where I have to type or dictate into an approved system) plus add 2 more hours a day to my work schedule, forcing me to decide between family or patients.

Studies have shown that electronic medical records add 1-2 hours of work a day for each MD. Electronic medical records are beneficial in large institutions but will do nothing but be detrimental in my practice as 99% of what I do will never need to be viewed again. I recently talked to a physician from Tanana Valley Clinic. They spent 2 million dollars converting to electronic medical records, lost 1-2 million in revenues (for 35 MDs and Approx 40,000 patients) and recently had to be taken over by the hospital to keep them in business.

The technology is not there to guarantee security on internet, nor are the EMRs currently efficient for most of us in primary care. Only 17-19% of MDs do EMRs in spite of this technology being available for 20 years because it is not time or cost effective yet. There are not enough MDs in primary care seeing medicare and medicaid patients now so why force those of us who are still seeing them to stop seeing them by adding more costs to our practices when we already loose money ($100/Patient) seeing these patients now.

EMRs Will increase the costs to my patients of between $25 to $65 per visit. In this age of increasing medical care costs I see this as a needless expense for most primary care MDs in small practices which will force many into early retirement.(when there is already an MD shortage) We should not be forced into doing things that are detrimental for our practices. Let individual practices decide what is best for the individual situations (as with the unreliability of electricity in the bush records like this will be a nightmare for the healthaides.) Do you really want your records available on the internet to the 600,000 organizations that will potentially have access to them?

I hope this information helps. Please forward to Berta and others as needed.

Ilona Farr MD

On Tue, Mar 17, 2009 at 9:18 AM, Amory Lelake <Amory_Lelake@legis.state.ak.us> wrote:

Hi Ilona

My name is Amory I met you recently at the District 24 pizza party. I'm writing because today Senate Bill 133 came before Senator Ellis in the H&SS Committee: "An Act creating a statewide electronic health information exchange system; and providing for an effective date".

Senator Ellis mentioned to the committee that he had recently met with a constituent who had a number of reservations regarding the costs that such a system would create for small private practices. Senator Ellis knows you are very busy, but is hoping you could put your concerns in writing so that we can pass them on to the people involved with the bill.

Thanks!

Amory Lelake

Legislative Aide

Senator Johnny Ellis

State Capital Building, Rm 103

Juneau, Alaska 99801

DEPARTMENT OF VETERANS AFFAIRS
Alaska VA Healthcare System and Regional Office
2925 DeBarr Road
Anchorage, Alaska 99508-9998

March 4, 2009 In Reply Refer To: 463/00

Senator Joe Paskvan
State Capitol
Juneau, Alaska

Subject: Alaska e-Health Network

Dear Senator Paskvan:

I recently read with interest Senate Bill #133 that advocates creating a statewide electronic health information exchange system. The Alaska Veteran Affairs Healthcare System is a strong advocate of such a system. The VA has had an electronic medical record since the 1980's and has seen the benefits of improving quality patient care and safety, reducing healthcare costs, coordinating care and improving emergency services. Increasing the ability to exchange information with private sector providers would further enhance these benefits for Alaska veterans.

The Alaska VA Healthcare System has a strong relationship with providers throughout Alaska. Last year the Alaska VA purchased approximately $40m of healthcare services from hospitals, clinics and doctor's offices throughout the state. Allowing instantaneous exchange of vital information can do nothing but improve the quality of care for Alaskans. Reducing duplication of tests, x-rays, medications and procedures would surely drive down costs for everyone. We are excited about the possibilities of a statewide network. As such, I am a member of the Board of the Alaska e-Health Network to assure federal providers are included as a stakeholder in any system developed in our state.

The Alaska VA Healthcare System seeks the same solutions as you do. We would be glad to work with all parties to assure such a system is comprehensive in its scope.

Good Luck in your efforts.

Sincerely,

Alex Spector
Director
Alaska VA Healthcare System

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Hospitals far from paperless

By Janice Lloyd, USA TODAY

Adoption of electronic health records in hospitals lags behind previous estimates and is expected to be more costly and difficult than predicted, says a study out Wednesday in *The New England Journal of Medicine*.

Many medical experts agree that eliminating paper records would help save lives and make health care more efficient and less costly. But a survey of nearly 3,000 hospitals found only 1.5% have comprehensive electronic records in all units. An additional 7.6% have a basic system in one unit that includes physicians' or nurses' notes.

BETTER LIFE: News on what affects when the doctor can see you ...

Earlier reports estimated the portion of hospitals adopting electronic records ranged from 5% to 59%. This survey was conducted by researchers at the Harvard School of Public Health, Biostatistics Center at Massachusetts General Hospital, the Brigham and Women's Hospital, the VA Boston Healthcare System, the Institute of Health and the Department of Health Policy at George Washington University. It had a 63% response rate and is the first reliable data, the researchers say.

To rank as having comprehensive health information technology (HIT), 24 functions were required in a hospital's major clinical units. These functions range from doctors' notes to diagnostic test images to computerized provider entry for medications. Eight functions had to be present in at least one major clinical unit for the basic program. Only 12% of the hospitals had physicians' notes.

"If we want to improve health care, I think we're really going to need to see much more widespread deployment of a lot of the key functions that are at low rates," says the report's lead author, Ashish Jha of Harvard. "Certainly in those ways it seems that we have a long ways to go."

The numbers from the survey "validated what we've been hearing," says Don May of the American Hospital Association. "We've heard some have stepped up but mostly we've heard some are on the path. They're doing a little but not enough for the whole package."

Better recordkeeping part of Obama overhaul

The study's release follows on the heels of a plan by President Obama to upgrade the record-keeping system as a key part of an effort to overhaul the health care system. Obama set aside $19 billion in the economic stimulus package to help with costs and pledged to spend $50 billion over five years.

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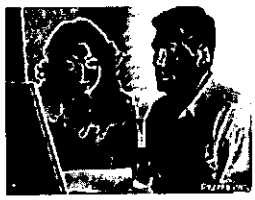
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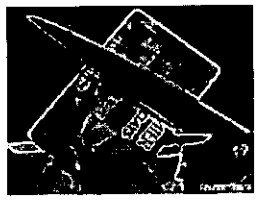
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Progress will not be easy, says David Blumenthal, director of the Institute for Health Policy and an author of the study. Blumenthal was recently named national coordinator for Health Information Technology by the U.S. Department of Health and Human Services, a post he assumes in mid-April.

"We are at a very early stage in adoption, a very low stage compared to other countries," says Blumenthal, but that suggests "an enormous upside in that respect for stimulating the adoption.

"The Congress and the administration showed enormous foresight and commitment to the goal of increasing adoption rates through the provisions of the stimulus bill," he says. "It's clear they want to see results in health care."

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

3/9/09

Senator Joe Paskvan
State Capitol
Juneau, Alaska 99801
Fax: (907) 465-4714

Re: SB 133

Dear Senator Paskvan:

Premera Blue Cross Blue Shield of Alaska is pleased to offer this letter of support for Senate Bill No.133. Benefits to Alaskans will be significant. Health information exchange networks have been successful in improving patient care and safety, reducing healthcare costs and enhancing emergency response to public health emergencies.

A non-profit organization which is independent, widely representative of the major stakeholders, and operates transparently is crucial to the success of this effort. We feel this is necessary to win and maintain the trust of Alaskans. Your bill truly meets these important criteria.

Premera feels a deep commitment to improving the health and welfare of the citizens of Alaska while creating efficiencies in the health care system. This organization is willing to work with other stakeholders to seek out best practices and solutions for a statewide healthcare network infrastructure enabling the secure exchange of health care data.

Premera supports this plan. Healthcare organizations in Alaska have a track record of working together with other health care leaders in Alaska to improve health services for our patients. We see this as a next logical step toward improving health care delivery and outcomes throughout Alaska.

Thank you, Senator Paskvan, for supporting this important legislation.

Sincerely,

Barbara B. Russell

Barbara B. Russell, CLU
Vice President, Alaska Sales
Premera Blue Cross Blue Shield of Alaska

2550 Denali Street
Suite 1404
Anchorage, AK 99503

tel 907.258.5065
fax 907.258.1619

www.premera.com

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DORSEY
DORSEY & WHITNEY LLP

CAROLYN Y. HEYMAN-LAYNE
(907) 257-7870
FAX (907) 276-4152
heyman.carolyn@dorsey.com

March 9, 2009

VIA FACSIMILE

Senator Joe Paskvan
State Capitol
Juneau, Alaska 99801
Fax: (907) 465-4714

Re: SB 133

Dear Senator Paskvan:

As a mother and a health care lawyer, I am writing in support of Senate Bill No.133. Health information exchange networks can be a great tool to improve healthcare and increase the efficiency and safety of health care services. In addition, they can assist in reducing healthcare costs and eliminating redundant services. As a mother, I want to make sure my daughter can receive the best health care with the least amount of pain or discomfort. As a health lawyer, I want to make sure clients can provide services quickly and in compliance with all laws and regulations. An independent non-profit organization representing the major stakeholders would help to facilitate these goals and is an important step towards a complete health care system. Senate Bill No. 133 is a major part of this goal.

Everyday, I encourage clients to adopt electronic health records and help them figure out the privacy and security of those records. Most clients are ready and willing to support health information exchange, if they know there will be support available and the infrastructure to make their efforts worthwhile. They also want to know that there are local laws that address and encourage the exchange of health information, so they can show patients that these efforts are backed by more than just a computer company selling a program, or a healthcare organization pushing its own agenda. This bill would be one step in the building blocks that form a health information exchange network.

Even with my daily interaction with health care providers, I did not realize how difficult coordination of records would be without an electronic health record and health information network until I had a baby. My daughter was born over a year ago, was happy and healthy, and yet we are still working out the bills and services provided during her birth. I can only imagine the difficulty that we would have had if she were not healthy and happy. By coordinating records and services electronically, and by helping families avoid redundant tests and paperwork, a health information exchange network can make it easier for parents to cope with a loved one's illness.

I strongly support this plan. Healthcare organizations in Alaska have a track record of working together with other health care leaders in Alaska to improve health services for patients – I see this happening everyday. This bill is the next logical step toward improving health care delivery and outcomes throughout Alaska.

DORSEY

Thank you, Senator Paskvan, for supporting this important legislation.

Sincerely,

DORSEY & WHITNEY LLP

Carolyn Heyman-Layne

Carolyn Y. Heyman-Layne

cc: R. Madison (via email)

ALASKA PRIMARY CARE ASSOCIATION, INC.

"... Uncompromising in the pursuit of access to primary care for all Alaskans."

March 6, 2009

Senator Joe Paskvan
State Capitol
Juneau, Alaska 99801
Fax: (907) 465-4714

Re: Alaska e-Health Network Appropriation Request

Dear Senator Paskvan:

The Alaska Primary Care Association (APCA) is pleased to offer this letter of support for Senate Bill No.133. Irrefutable research shows that health information exchange (HIE) networks are successful in improving patient care and safety, reducing healthcare costs and enhancing emergency response to public health emergencies. Thus, there is no question that benefits to Alaskans as a result of this bill will be significant.

APCA holds a deep commitment to improving the health and welfare of the citizens of Alaska while creating efficiencies in the health care system. APCA's mission, purpose and programs revolve around increasing access to primary care for all Alaskans. APCA is committed to working with other stakeholders to seek out best practices and solutions for a statewide healthcare network infrastructure enabling the secure exchange of health care data, as it will help our constituents (Alaska's community health centers and other safety net providers) in providing quality health care more effectively.

Healthcare organizations in Alaska have a track record of working together with other leaders and stakeholders here to improve health services for our patients. APCA sees this plan for the continued development of an HIE as a next logical step toward improving health care delivery and outcomes throughout Alaska.

Thank you, Senator Paskvan, for supporting this important legislation.

Sincerely,

Marilyn Walsh Kasmar, RNC, MBA
Executive Director.

Phone 907-929-2722 Fax 907-929-2734 www.alaskapca.org alaskapca@alaskapca.org
903 West Northern Lights Blvd, Suite 200 Anchorage AK 99503-2400

Alaska Ear Nose & Throat, Inc.
Jerome List, DDS, MD

3841 Piper Street
Suite T4-348
Anchorage, Alaska 99508

Tel: (907) 261-3096
Fax: (907) 261-3094

March 3, 2009

Senator Joe Paskvan
State Capitol
Juneau, Alaska 99801
Fax: (907) 465-4714

Re: Alaska e-Health Network appropriation request

Dear Senator Paskvan:

Alaska Ear Nose & Throat, Inc. is pleased to offer this letter of support for Senate Bill No.133. Benefits to Alaskans will be significant. Health information exchange networks have been successful in improving patient care and safety, reducing healthcare costs and enhancing emergency response to public health emergencies.

A non-profit organization which is independent, widely representative of the major stakeholders, and operates transparently is crucial to the success of this effort. We feel this is necessary to win and maintain the trust of Alaskans. Your bill truly meets these important criteria.

Alaska Ear Nose & Throat, Inc. feels a deep commitment to improving the health and welfare of the citizens of Alaska while creating efficiencies in the health care system. This organization is willing to work with other stakeholders to seek out best practices and solutions for a statewide healthcare network infrastructure enabling the secure exchange of health care data.

With the geography in Alaska, exchange of medical information is critical. Telemedicine has been a huge cost savings to the Native Health System not to mention numerous other benefits. We need to expand our interconnectivity to allow exchange of medical data among all Health Care Providers for all patients when appropriate & needed.

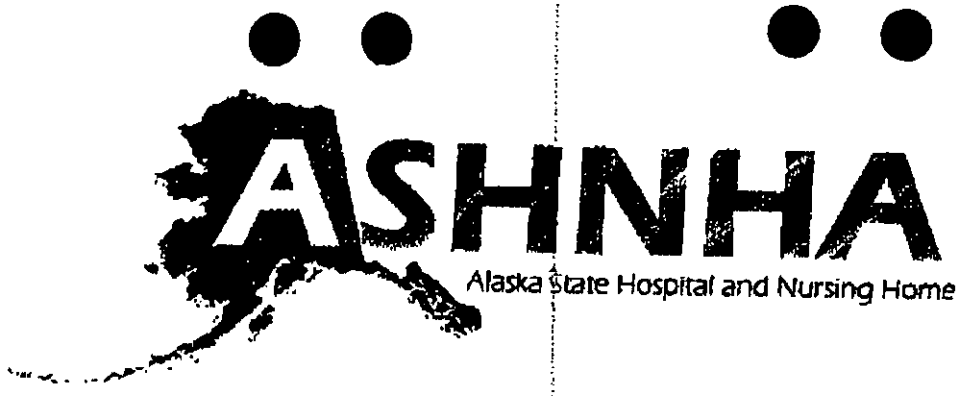
Alaska Ear Nose & Throat, Inc. supports this plan. Healthcare organizations in Alaska have a track record of working together with other health care leaders in Alaska to improve health services for our patients. We see this as a next logical step toward improving health care delivery and outcomes throughout Alaska.

Thank you, Senator Paskvan, for supporting this important legislation.

Sincerely,

Barbara Starr for

Jerome List, DDS, MD



426 Main Street
Juneau, AK 99801
907-586-1790

March 4, 2009

The Honorable Joe Paskvan
Alaska State Senator
State Capitol
Juneau, Alaska 99801

Re: SB 133 and the Alaska e-Health Network (AeHN) Budget Request

Dear Senator Paskvan:

The Alaska State Hospital & Nursing Home Association (ASHNHA) is pleased to offer this letter of support for Senate Bill No.133. ASHNHA has been – and is – a long standing and strong supporter of the efforts of the AeHN. Indeed, I have seat on the newly formed board of directors for the AeHN, in part as a reflection of the Association's keen interest in this important project, but primarily because ASHNHA's members believe that the benefits to Alaskans from the outcome of the AeHN initiative will be significant. Health information exchange (HIE) networks in other parts of the country have been successful in improving not only the quality of patient care but patient safety, as well. As a result, HIE's contribute to reducing healthcare costs while enhancing emergency response to public health emergencies.

The AeHN is an independent, non-profit organization with representative of the major stakeholders within Alaska concerned for the development and provider and patient utilization of important health information technologies (HIT). In this day of heightened concern for the speed at which digital information is spinning out across the Internet, the purposeful and transparent actions and activities of the AeHN are viewed by ASHNHA as crucial to the success of this statewide effort to bring unity of purpose to this important cost-effective, public safety program. The AeHN Board of Directors feels strongly that it must conduct its business in the full view of the public in order to win and maintain the trust of Alaskans. Your bill truly ensures these important criteria.

ASHNHA and its individual members feel a deep and demonstrative commitment to improving the health and welfare of the citizens of Alaska, while also recognizing citizen call for the creation of more efficiencies within the health care system.

Our organization is most willing to work with other healthcare related stakeholders to seek out best practices and solutions as we move forward together to create a statewide healthcare network infrastructure enabling the secure exchange of personal health care data.

ASHNHA whole heartedly supports the approach outlined in SB 133. Healthcare organizations in Alaska have a track record of working together with other health care leaders in Alaska to improve health services for our patients. We see this legislation, its goals and intents, as the next logical step toward improving health care delivery and outcomes throughout Alaska.

Thank you, Senator Paskvan, for sponsoring this important legislation.

Respectfully,

Rod Betit

Rod Betit
President and Chief Executive Officer
Alaska State Hospital & Nursing Home Association

cc: Rebecca Madison

Bristol Bay Area
Health Corporation
6000 Kanakanak Road
P.O. Box 130
Dillingham, AK 99576
(907) 842-5201
800-478-5201
FAX (907) 842-5354

Bristol Bay Area Health Corporation is a tribal organization representing 24 villages in Southwest Alaska:

- Aleknagik
- Chignik Bay
- Chignik Lagoon
- Chignik Lake
- Clark's Point
- Dillingham
- Egegik
- Ekuk
- Ekwok
- Goodnews Bay
- Igiugig
- Iliamna
- Ivanof Bay
- Kanatak
- King Salmon
- Knugank
- Kokhanok
- Koliganek
- Levelock
- Manokotak
- Naknek
- New Stuyahok
- Newhalen
- Nondalton
- Pedro Bay
- Perryville
- Pilot Point
- Platinum
- Port Heiden
- Portage Creek
- South Naknek
- Togiak
- Twin Hills
- Ugashik

To promote health with competence, a caring attitude &

March 16, 2009

To Whom It May Concern:

The Bristol Bay Area Health Corporation (BBAHC) has begun implementation of a Electronic Health Records EHR system at our Kanakanak Hospital and hopes to secure additional funding to do so with our 28 village clinics.

It is our hope that we can electronically communicate our EHR's and receives EHR's from all patients using our system and other health facilities throughout the state and elsewhere.

With our different system's we need a way to all talk to each other.
We are excited about the possibility of SB No. 133 "An Act creating a statewide electronic health information exchange systems; and providing for an effective date. By senators PASKVAN, Davis introduced on 3.2.09.

We are members of several statewide groups who are supportive of an HIE as proposed, as we have seen how well it works in the lower 48.

This should be a high priority of the state and is an area that President Obama's stimulus package supports.

Thank you for you support.

Robert J. Clark
President/CEO

ARRA Update:

Providers can receive up to $44,000 reimbursement for EHR systems. Incentives give early adopters a means to recover expenses.

Here are some tips to help you come quickly up-to-speed with the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 and the section of ARRA relating to Health Information Technology (HITECH).

"Meaningful use of EHR" is a .new concept introduced in HITECH. Incentives will require both Medicare and Medicaid eligible professionals to demonstrate meaningful use of certified EHR technology by:

- Using e-prescribing as determined to be appropriate by HHS
- Using EHR technology which provides exchange of information to improve quality of health care, such as promoting care coordination
- Reporting of clinical quality measures and other measures selected by HSS

Adoption demonstration may require attestation, submission of claims with appropriate coding, survey response, reporting on measures or other means specified by HHS. Provision is given for alternative reporting means for group practice providers.

Additional requirements may include:

- Contact information of eligible professionals who are meaningful users to be posted on the HHS web site
- To the extent possible, incentive payments will be coordinated across multiple practices for a given EP, and to avoid duplicative requirements under Medicaid
- Payment may be in a single consolidated payment or periodic installments
- Significant hardship exception may be granted up to 5 years
- Comparable incentives and adjustments are provided for professionals providing substantial services through Medicare Advantage plans

The maximum amount of the incentive is $44,000 depending on when an EHR is acquired. Note that the incentives include an "adjustment" of the full reimbursement for Medicare patients after 2015. This sanction would occur after the targeted goal for all Americans to have an EHR by 2014. The payment structure includes:

Payment Year	**Amount of Incentive or Adjustment subject to per physician cap of 75% of Medicare allowable charges in any year**
First year if implemented in 2011 or 2012	$18,000
First year if implemented before 2013	$15,000
Second year	$12,000
Third year	$8,000
Fourth year	$4,000
Fifth year	$2,000
Succeeding payment years	$0
If practice is in a health professional shortage area	Above amount increases by 10%
IF EHR is adopted after 2014	$0
IF not using EHR by 2015	99% of reimbursement
If not using EHR by 2016	98% of reimbursement
If not using EHR by 2017 and beyond	97% of reimbursement
If <75% use EHR by 2018	1% less than preceding year but not less than 95%

	reimbursement

ARRA provides for payments to those States that have approved Medicaid plans and implement programs to encourage adoption and use of certified EHR technology. Program payments cannot be more than 85% of the average allowable costs for certified EHR technology, capped at $25,000 for first year and $10,000 for subsequent years, reduced by 2/3 for pediatricians. Eligible professionals include physicians, dentists, certified nurse mid-wives and nurse practitioners, who are not provider-based with at least a 30% Medicaid patient load, pediatricians who are not provider-based with at least a 20% Medicaid patient load, and physician assistants practicing in a federal qualified health center or rural health clinic with at least 30% load of patients classified as "needy," which is broader than Medicaid beneficiaries requirements.

Lynda Zaugg

From: Amory Lelake
Sent: Wednesday, March 25, 2009 10:32 AM
To: Lynda Zaugg
Cc: Jake Hamburg; Sen. Johnny Ellis
Subject: FW: SB 133 Electronic Health Network
Attachments: ARRA Update.doc

Hi Lynda,

Just wanted to make sure you had Mr. Sherry's response to Dr. Farr's email and the attached ARRA.

From: Sherry, Paul [mailto:psherry@anthc.org]
Sent: Tuesday, March 24, 2009 11:13 AM
To: Amory Lelake
Cc: Jake Hamburg; Sen. Johnny Ellis; Rep. Berta Gardner;
Subject: RE: SB 133 Electronic Health Network

Hi Amory and all:

Thank you for sharing the comments you received from Dr. Farr, and the opportunity to address them.

The main point is that SB133 does not require any physician or other health care provider to use electronic medical records (EMR). The legislation focuses on the development of a secure network so that providers who do elect to use them can exchange patient records when they are referred or seen by new providers.

The network plans to provide information to physician offices in whatever format the office is capable of receiving including faxing, printing, or regular mail.

While some other states have enacted legislation requiring medical providers to use electronic records, this legislation does not take that step, nor are we recommending that the State do so.

Dr. Farr is not alone in having difficulties with the transition from paper to medical records. Early adopters nation-wide experienced a myriad of problems, including high implementation costs and software systems that were not easy-to-use. As the EMR industry matures, the cost is gradually coming down and the solutions are improving. For example, there are now several versions of "EMR-lite" that require substantially less investment and are more user-friendly.

Federal legislation requires physicians to have some form of EMR by the year 2014 or accept decreased Medicare payments for services. Our e-Health Network plans to provide assistance to physicians and other providers to find software, e-prescribing systems, training, and other tools to make this transition easier. We are working closely with the Alaska EHR Alliance, a physician-based group that has this activity as their main focus.

The American Recovery and Reinvestment Act (ARRA) provides new incentives for physician investments in electronic medical records. An individual physician can receive up to $44,000 for such an

investment. Those providers who were early adopters will benefit first from this funding, which becomes available in 2010. The attachment provides more information on this federal provision.

Both our network director Rebecca Madison and I live in Fairbanks and have recently received feedback from providers at the Tanana Valley Clinic. While they have gone through a painful learning curve, most say they would never go back to paper, that their charting time has been reduced by half, and that they are waiting for our network to be deployed so that they can connect with others around the state.

Hopefully these observations address the concerns brought forward by Senator Ellis at the hearing. If additional information is required regarding the deployment of EMR's or the national research that has clearly demonstrated their efficacy and cost-reductions, we would be pleased to provide such to you.

Thank you again.

Paul Sherry, President
Alaska e-Health Network

From: Amory Lelake [mailto:Amory_Lelake@legis.state.ak.us]
Sent: Tue 3/24/2009 8:30 AM
To: Sherry, Paul
Cc: Jake Hamburg; Sen. Johnny Ellis; Rep. Berta Gardner; linda.zaugg@legis.state.ak.us
Subject: FW: SB 133 Electronic Health Network

Here are the concerns our constituent Dr. Illona Farr has about electronic health records in reference to SB 133. Since the bill will be heard again on Friday, maybe we can try to set up a time to discuss her concerns.

Thanks!

Amory

From: Ilona Farr [mailto:afmc4045@gmail.com]
Sent: Monday, March 23, 2009 8:46 PM
To: Amory Lelake
Cc: afmc4045@yahoo.com
Subject: Re: SB 133 Electronic Health Network

Amory,

I just got back into town yesterday and just got your email. As a Family Practice Physician these required electronic medical records will force me to stop seeing medicare and medicaid patients because of the added time and cost associated with these records. I tried electronic medical records(EMRs) for 6 months. I went from seeing patients 5 hours a day with 3 hours of paperwork to seeing patients 3 1/2 hours a day and doing work on the computer 5 hours a day. My costs went through the roof and I started loosing long time patients because they could no longer get into see me. (that 4 MD clinic spent $240,000 on EMRs , lost lots of money and terminated the system after one year.) I went back to solo practice with hand written notes and just scan these into the computer in a word file so my patients can

get a copy on disc of their word document medical file if they desire.(so I do have a form of EMR) I have estimated the costs to my office of $65,000.00 per year for these new required medical electronic records (where I have to type or dictate into an approved system) plus add 2 more hours a day to my work schedule, forcing me to decide between family or patients.

Studies have shown that electronic medical records add 1-2 hours of work a day for each MD. Electronic medical records are beneficial in large institutions but will do nothing but be detrimental in my practice as 99% of what I do will never need to be viewed again. I recently talked to a physician from Tanana Valley Clinic. They spent 2 million dollars converting to electronic medical records, lost 1-2 million in revenues (for 35 MDs and Approx 40,000 patients) and recently had to be taken over by the hospital to keep them in business.

The technology is not there to guarantee security on internet, nor are the EMRs currently efficient for most of us in primary care. Only 17-19% of MDs do EMRs in spite of this technology being available for 20 years because it is not time or cost effective yet. There are not enough MDs in primary care seeing medicare and medicaid patients now so why force those of us who are still seeing them to stop seeing them by adding more costs to our practices when we already loose money ($100/Patient) seeing these patients now.

EMRs Will increase the costs to my patients of between $25 to $65 per visit. In this age of increasing medical care costs I see this as a needless expense for most primary care MDs in small practices which will force many into early retirement.(when there is already an MD shortage) We should not be forced into doing things that are detrimental for our practices. Let individual practices decide what is best for the individual situations (as with the unreliability of electricity in the bush records like this will be a nightmare for the healthaides.) Do you really want your records available on the internet to the 600,000 organizations that will potentially have access to them?

I hope this information helps. Please forward to Berta and others as needed.

Ilona Farr MD

On Tue, Mar 17, 2009 at 9:18 AM, Amory Lelake <Amory_Lelake@legis.state.ak.us> wrote:

Hi Ilona

My name is Amory I met you recently at the District 24 pizza party. I'm writing because today Senate Bill 133 came before Senator Ellis in the H&SS Committee: "An Act creating a statewide electronic health information exchange system; and providing for an effective date".

Senator Ellis mentioned to the committee that he had recently met with a constituent who had a number of reservations regarding the costs that such a system would create for small private practices. Senator Ellis knows you are very busy, but is hoping you could put your concerns in writing so that we can pass them on to the people involved with the bill.

Thanks!

Amory Lelake

Legislative Aide

Senator Johnny Ellis

State Capital Building, Rm 103

Juneau, Alaska 99801

HITECH (ARRA 2009) Stimulus Provisions and Notes:

QUALIFIED STATE-DESIGNATED ENTITY:
To be qualified a State-designated entity must

- be designated by the state
- be a not-for-profit entity with broad stakeholder representation on its governing board
- demonstrate that its principal goal is to use IT to improve health care quality and efficiency through HIE
- adopt nondiscrimination and conflict of interest policies to include participation of stakeholders

IMMEDIATE FUNDING:
Immediate funding is available through a number of agencies within the U.S. Department of Health and Human Services (HHS). These include the Office of the National Coordinator for Health Information Technology (ONC), Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and the Indian Health Service. Funding is expected to start flowing within 2009 for:

- HIT architecture that supports nationwide electronic exchange and use of health information in a secure, private, and accurate manner
- Development and adoption of certified EHRs for providers not eligible for other support
- Training on and dissemination of best practices to integrate HIT, including EHR, into a provider's delivery of care
- Infrastructure and tools for telemedicine
- Promotion of interoperability of clinical data repositories or registries
- Promotion of technologies that enhance protection of health information
- Improvement and expansion of uses of HIT by public health department

One area of immediate funding will be in the area of HIT implementation assistance. Two resources are provided for:

Health Information Technology Extension Program: ONC, in consultation with other Federal agencies and National Institute of Standards and Technology (NIST), establish a HIT extension program to help providers adopt, implement, and effectively use certified EHR technology that allows for the electronic exchange and use of health information

Health Information Technology Research Center: Secretary of HHS creates this center to provide technical assistance and develop or recognize best practices to support and accelerate efforts to use HIT

- HIT Regional Extension Centers: housed within U.S.-based nonprofit institutions or organizations to gain broad participation, active dissemination of knowledge, participation in HIE, and integration of HIT and EHR into initial and ongoing training of health professionals
- Focus on regional assistance to public or not-for-profit hospitals or critical access hospitals; federally qualified health centers, entities located in rural and other underserved areas, primary care individuals and small group practices

STATE GRANTS & LOANS:
Through ONC, HITECH requires the establishment of a program to facilitate and expand electronic movement and use of health information among organizations according to nationally recognized standards through planning and implementation grants to States.

Activities expected to be performed with use of this money include:

- Participation in authorized and secure nationwide electronic use and exchange of health information
- Identify State or local resources and complement Federal programs

- Provide technical assistance
- Promote strategies to adopt and utilize HIT in medically underserved communities
- Assist patients in utilizing HIT
- Encourage clinicians to work with HIT Regional Extension Centers
- Support public health agencies' use of electronic health information
- Promote use of EHRs for quality improvement, including through quality measures reporting

Grants require a match of at least $1 for each $10 of Federal funds in 2011, $1 for each $7 of Federal funds in 2012, and $1 for each $3 of Federal funds for 2013 and following years. Prior to 2011, Secretary may determine whether any state match is required.

HITECH also provides the ability for ONC to award competitive grants and loans to States or Indian tribes:

- For establishment of programs for loans to providers to purchase certified EHR technology
- Enhance utilization of certified EHR technology
- Train personnel in use of EHR technology
- Improve the secure electronic exchange of health information

In using such grant and loan funds, providers must agree to:

- Submit reports on quality measures
- Demonstrate that certified EHR technology is used to exchange health information in a manner that improves quality of health care, such as promoting care coordination
- Comply with other requirements as the entity or Secretary may require
- Include a plan on how providers involved intend to maintain and support the certified EHR technology over time

So while the largest amount of funding through the incentive program (to be discussed next) rewards use, there still are ways to support acquisition.

Provisions of the competitive grant and loan program include that there be matching funds at the rate of $1 for each $5 of Federal funding, the interest rate charged must not exceed market rate, and the principal and interest payment must start within first year of award and be fully amortized not later than 10 years. First awards may be made by January 1, 2010.

Overall Package (Billions)

SPENDING	$ 506.0
• Health care	
– Assist states with Medicaid:	86.6
– Subsidize COBRA:	24.7
– Grants, loans, infrastructure, & incentives to modernize HIT:	19.0
– NIH facilities & research:	10.0
– Prevention/wellness:	1.0
	141.3
• Infrastructure	91.7
– Including to expand broadband	
• Education	87.3
• Aid to poor & unemployed	67.0
• Energy	41.2
• Direct cash payments	14.2
• Housing	9.5
• State block grants	8.8
• Science	5.6
• Law enforcement	4.0
• Homeland security	2.8
• Other	32.6

TAXES	$ 281.0
• New tax credit	$ 116.0
• Alternative minimum tax	70.0
• Renewable energy incentives	20.0
• Child tax credit	15.0
• College credit	14.0
• Home-buyer credit	6.6
• Bonus depreciation	5.0
• Earned income tax credit	4.7
• Auto sales	1.7
• Repeal bank credit	-7.0
• Other tax provisions	35.0

Sources: Associated Press, LA Times, Tribune

Alaska eHealth Network
Health Information Exchange Infrastructure Requirements
(in thousands)

	FY2007	FY2008	FY2009	FY2010	FY2011	Funding Source
Privacy/Security Assessment and Policy Development	$300	$300				*Office of the National Coordinator for Health IT* - grant to assess Alaska Privacy and Security laws, to develop policies and procedures for the secure/private exchange of health information, and to work with an 8 state collaborative to develop inter-organizational privacy agreements.
Network/Hardware						
Technical Network Design			$260			*FCC* – contract to assess and design a statewide healthcare network for secure data exchange.
			$50			*State FY09* – required FCC match
Technical Network Development			$10,000			*FCC* – contract to implement a statewide healthcare data exchange network.
			$450			*State FY09* – required FCC match
			$500			*AFHCP* – required FCC match
Software						
Health Information Exchange Software/Implementation				$13,000	$7,000	Stimulus – proposed funding based on the draft American Recovery and Reinvestment Act of 2009.
				$1,300	$1,000	*State FY10, FY11* – appropriation request from state to match FCC and stimulus funds.
				$500		*Rasmuson* - pending
TOTAL Annual Non-Recurring	**$300**	**$300**	**$11,260**	**$14,800**	**$8,000**	Annual non-recurring requirements to provide Alaska with infrastructure for the secure exchange of healthcare information.
TOTAL Project Non-Recurring	**$34,660**					**Total non-recurring project requirements**

Yellow – State FY09

Green – State FY10 and FY11

3/13/2009

Alaska eHealth Network (AeHN)
Interoperable Statewide Health Information Exchange (HIE)

State Medicaid General Fund and Alaska Health Care System Cost Savings Projections

Annual Medicaid State General Funds	Net Value Percentage	Annual Net Value of HIE*	
$248,544,000	4.68%	$11,631,859	based on standard cost benefit model
$248,544,000	3.69%	$9,171,274	based on high-cost HIE model
$248,544,000	5.70%	$14,167,008	based on low-cost HIE model
Annual AK Health Care Spending			
$5,294,000,000	4.68%	$247,759,200	based on standard cost benefit model
$5,294,000,000	3.69%	$195,348,600	based on high-cost HIE model
$5,294,000,000	5.70%	$301,758,000	based on low-cost HIE model

* Full Annual Net Value realized beginning 2013

Assumptions:
Fully standardized and fully implemented statewide interoperable Health Information Exchange
State Medicaid GF budget based on Gov 09 Request for Medicaid Services Component only
State Medicaid GF budget remains flat
Annual AK Health Care Spending remains flat
Based on national cost benefit model (see Sources):
- Cost savings: 5.68% of annual health care expenditures, minus cost: 1% of annual health care expenditures
- National cost benefit model calculates projected cost savings based on projected efficiencies in laboratory testing, imaging procedures, interactions between outpatient providers and pharmacies, provider to provider connectivity, provider to public health agency connectivity, and provider-payer transactions

Sources:
Institute for Social and Economic Research, UA Research Summary No. 6, March 2006
http://www.iser.uaa.alaska.edu/Publications/researchsumm/RS6_06.pdf
Walker, J, et al, The Value of Health Care Information Exchange and Interoperability, Health Affairs, January 2005.
http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.10/DC1

Alaska eHealth Network (AeHN)
Interoperable Statewide Health Information Exchange (HIE)

Business Projection Based on Fee for Service

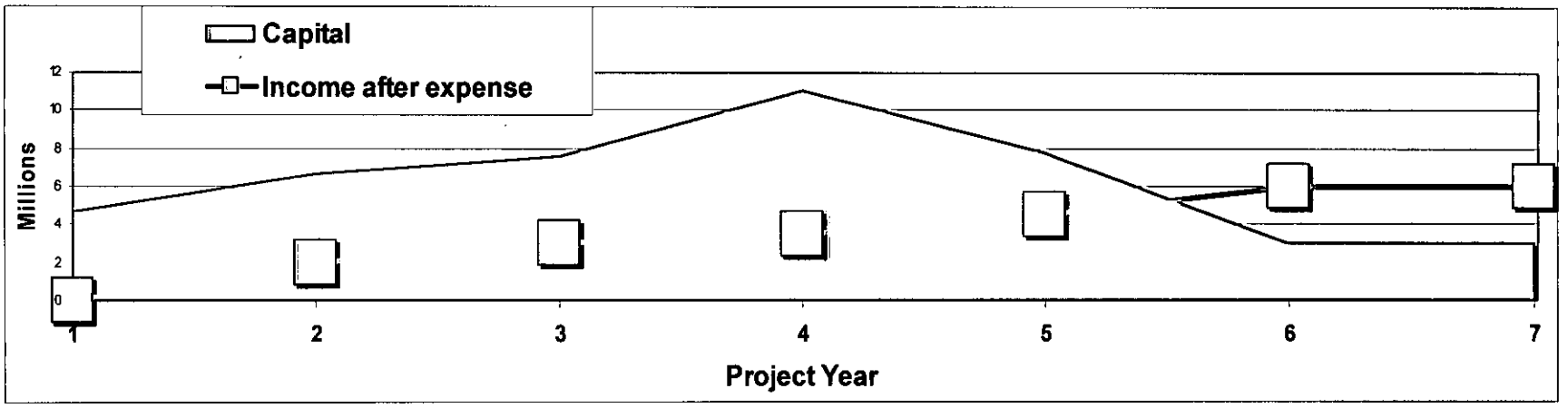
A review of more than 100 HIE projects in other states was conducted to guide the development of AeHN. Special lessons were drawn from intensive study of sustainable models in states with needs and goals similar to those of Alaska. The members of the business development team also identified the benefits and critical success factors of similar projects in other states.

A financial partnership has been created to fund development and implementation of AeHN. Capital support in varying levels is being sought from foundations, investors, state and federal agencies, tribal entities, consumer organizations, businesses, members of the AeHN Board of Directors (hospitals, employers, insurance companies, and the State Health Commission), physicians, and other caregivers.

Subscription fees and user charges will be assessed to sustain long-term operations. An 18-month rollout is planned, although early success in fundraising and availability of technology alternatives (e.g., outsourcing) could shorten the timeframe.

In summary, AeHN is designed to improve efficiency and effectiveness of healthcare in Alaska. Patient-controlled information will be accessible when and where it is needed most—complementing Alaska's national leadership in access with comparable accomplishments in cost and quality.

This graph provides an overview of the extensive business plan developed by partners of AeHN. It is expected that the project will break even in Year 5.



Paul Sherry
President
Work: (907) 729-1900
Cell: (907) 230-5572
psherry@anthc.org

February 23, 2009

Senator Lyman Hoffman, Co-Chair
Senator Bert Stedman, Co-Chair
Senate Finance Committee
State Capitol
Juneau, Alaska 99801

Re: Alaska e-Health Network appropriation request

Dear Senators Hoffman and Stedman:

On behalf of the Alaska eHealth Network, we are requesting that the State of Alaska include an appropriation of $1.3 million in FY2010 as state match for $13 million in federal stimulus funds to continue the build out of a health information exchange for Alaska.

The objective of the Alaska eHealth Network is to unify separate electronic health care networks that are being developed throughout the state and supply rural health providers with connectivity to referral providers both in Alaska and in the lower 48 states. This coordinated network will facilitate the exchange of critical health information between health providers. It will also support telemedicine services, the transfer of high resolution images for patient care, as well as videoconferencing and Voice-over-Internet applications.

Overall, an Alaska health information exchange network will improve patient's access to care, reduce unnecessary testing and procedures, improve patient safety, reduce health agency administrative costs, and enhance rapid response to public health emergencies.

In 2006 the Alaska Telehealth Advisory Council funded an effort to evaluate and recommend solutions for the electronic health information exchange for Alaska health care providers. Primary partners of this effort, now called the Alaska eHealth Network (AeHN), include the Alaska Federal Health Care Partnership, the Alaska Primary Care Association, the Alaska Native Tribal Health Consortium, the Alaska State Hospital and Nursing Homes Association, the Alaska Mental Health Trust Authority, Premera Blue Cross/Blue Shield, the University of Alaska, AARP Alaska, the State Department of Health and Social Services, and the EHR Alliance.

A business plan developed by the partners anticipates a total project cost of $35M for development of a health information exchange for Alaska over the next five years. The plan addresses the connectivity of Alaska's separate health care networks and the exchange of health information across Alaska's health care community. The plan calls for the generation of revenue through facility and provider user fees and

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a personal health record subscription fee. Break-even point for this extensive coordination of Alaska's health care information systems will occur in Year 6.

In August 2008, the Alaska eHealth Network partners elected to form a 501(c)(3) corporation. A list of the initial board members is enclosed. ANTHC has been designated by the partners to act as interim project manager for development of the Alaska eHealth Network.

The Alaska eHealth Network has as its mission: *To improve the safety, cost effectiveness, and quality of healthcare in Alaska through the promotion and facilitation of widespread implementation and use of secure and confidential electronic clinical information systems, including electronic health records, medical decision support, clinical data exchange capabilities and reimbursement mechanisms.*

To date we have secured $11.5 million in support of this initiative, primarily from federal sources (the Federal Communications Commission and the Alaska Federal Health Care Partnership. In FY2009 we received an appropriation of $500,000 in this year's capital budget. This funding has allowed the Alaska eHealth Network to proceed with planning and design of a statewide health information exchange initiative.

For FY2010 we are requesting that the State of Alaska include an appropriation of $1.3M for the state share of costs for the Alaska e-Health Network. We will be requesting an additional $1M in FY2011. We anticipate this funding will provide the match for the federal stimulus and will allow us to complete the infrastructure build out for health information exchange without any additional capital requests for FY2012 and beyond.

Please contact me at 907-230-5572 or at psherry@anthc.org if you have questions or require additional information. You may also contact project director Rebecca Madison at 907-729-3934 or at rebccam@akrivertracks.com.

Sincerely,

Paul Sherry
President
Alaska eHealth Network

Cc: Governor Sarah Palin

"Technology's Wonders" coming to a doctor's office near you ...if we act quickly.

Published 2/24/2009 in the *Fairbanks Daily News Miner* and *Juneau Empire*

By Rebecca Madison, Director, Alaska eHealth Network
[(907) 729-3934 ramadison@anthc.org]

In his inaugural speech, President Obama pledged to "wield technology's wonders to raise health care's quality and lower its costs." The recently enacted American Recovery and Reinvestment Act of 2009 includes $12 billion to bring these wonders from the world of rhetoric to the world of reality, right here in Alaska. The good news is, we are "shovel ready!"

This funding aims to accelerate the adoption of Health Information Technology systems—like the one already in the works in Alaska—while creating high-tech jobs in the process. Timing couldn't be better for Alaskans to obtain some of this funding, but competition in the national arena will be intense. We must act quickly.

The fact is, we have already made exciting progress toward this goal. This month, the non-profit Alaska eHealth Network (AeHN) begins work with GCI to design the information infrastructure to interconnect electronic health records throughout Alaska. When complete, this Network will boost the safety, speed, and quality of our healthcare data while protecting privacy and reducing costs. Once in place, it will ***save Alaskans $250 million dollars annually,*** as much as 5% of our total healthcare costs!

What are electronic health records? Simply put, an electronic health record is a computerized record that replaces the paper record for patients like you and me. As any doctor will tell you, accurate patient information is the lifeblood of effective treatment.

When needed, electronic health records can access a health information exchange—the heart of the system--which connects them from your doctor's office to another office or hospital, making your vital records instantly available to cooperating healthcare providers you designate, wherever they are. Your lab results, allergies, medical history and other essential health data are at your healthcare providers' fingertips, with information about treatments, medications, and potential side effects, for quick, effective treatment.

This feature will especially benefit rural Alaskans, whose primary care may be in a village, but may require transfer to a larger healthcare facility in a larger community. In fact, any of us who travels and suffers illness or injury away from home will be much better off with an electronic health record system in place and available to us wherever we go.

A key advantage of the Network will be patient safety. Ask Ben Tisdale, a 71-year-old Alaskan who is now blind. While undergoing treatment for heart disease, Ben was mistakenly given a dangerous combination of medicines that destroyed his optic nerves.

Had interconnected electronic health records been in place, with their medicine alerts, Ben would still have his sight today.

Another advantage is less paperwork for everyone—no more filling out the same long forms each time you visit a health provider. Once it's done, it's done. Less paperwork means less cost and fewer delays for all of us.

To ensure privacy, your records will be stored in your medical provider's secure computer system. You can access your own files, but no one else can access them unless you give permission. If you do give approval, your records can be ***viewed by*** another healthcare provider. In addition, you can check at any time to see who has "viewed" your records.

Not interested in participating? No worries. Inclusion in the Network will be entirely voluntary. No one is required to participate.

Working with the partners represented by the Alaska eHealth Network, Alaska's Legislature and forward-thinking funders such as the Rasmuson Foundation deserve enormous thanks for the support they have provided to the strategic plan for interoperable electronic health records for all Alaskans.

But Alaska still needs $15 million dollars to finish this Network. The economic stimulus package will provide money to Alaska for this work, provided there is a qualifying state match of $1 dollar of State funds to $10 of federal funds. ***To receive federal funds, the State of Alaska must approve legislation that commits Alaska to building the infrastructure necessary for health information exchange.***

We strongly urge our legislators and Governor Palin to begin taking action today to ensure these health technology stimulus funds reach Alaska. For our health, and for our finances, it is the right thing to do, and the right time to do it. Let's get this shovel in the ground and get to work.

Doctors need to ditch the paper records and get on computers

Published: January 10, 2008 *Anchorage Daily News,* " Opinion"

It's shocking, when you think about it: While your bank, your employer and much of your life depend on computers to function, your doctor is most likely stuck in the dark ages of communication. "If we were the banking industry, we'd be dead in the water a long time ago," says Anchorage physician Tom Nighswander. "We are way, way behind."

The shelves and shelves of paper charts you see in many medical offices are evidence of that. Records that should be stored on a computer are taking up whole rooms and require staff to keep them sorted.

The lack of updated technology hurts the quality of care and contributes to high costs.

Say you get an EKG test at one Anchorage hospital, then a week later you show up at another hospital's emergency room with chest pains. The second hospital may not be able to get the results of the first EKG to see if there are changes to your heart, says Dr. Nighswander.

That's just unacceptable.

Two groups in Alaska are working to make electronic medical records the standard here.

The Alaska Native Tribal Health Consortium is managing, on behalf of the entire state, a $10.5 million, three-year grant. Funded by the Federal Communications Commission, the project will set up a high-speed, secure computer network for exchanging health information.

But there's a catch: The state must provide some matching money, and none of the FCC grant money can be used to manage the program.

Another group, the Alaska Electronic Health Record Alliance, is working to get individual doctors on electronic record systems, which could then connect to the medical information network. The technology would make doctors' offices work more efficiently and accurately.

The alliance is seeking grants to help health care providers switch over their record systems, says Dr. Jerome List, a doctor who has used electronic records for about 15 years.

It costs about $20,000 for small, two- to three-doctor offices to convert. That's too much for many small practices, Dr. List says, though electronic record-keeping is expected to reduce costs in the long run.

One big incentive for getting medical offices online is eliminating prescription errors.

Wrong prescriptions and wrong doses are a big problem. Handwriting is often the culprit. If a doctor types the prescription and faxes it to the pharmacy, many potential errors are eliminated.

A patient's record, if online, might show whether that patient had been pharmacy-hopping, getting more drugs than he should have. And computer programs exist that will not let a doctor make a mistake in dosing.

The Veterans Administration is ahead of the rest of the country in creating electronic patient records that can be called up wherever the vet is, national experts say.

AARP Alaska supports the Alaska e-medicine efforts because the changeover will allow patients to be more engaged in managing their health care. They'll get message reminders, and can maintain diaries of symptoms and side effects, schedule medical appointments online and track their own test results.

There are caveats. Whatever system evolves, patients must be able to control who has access to it. For example, a person who tested HIV-positive might not want his employer or insurer to know that.

But the concerns can be resolved.

This effort now needs a big push from the state. State health officials should get behind it and encourage the Legislature to contribute the necessary funding.

BOTTOM LINE: Here's a proven way to cut medical costs and improve the quality of care.

Personal Health Records — Take Greater Control of Your Health!

An important element of the Alaska e-Health Network is that each Alaskan can access your own health and medical history via a secure, Personal Health Record (PHR). You control permissions for what is shared and with whom and you will know who else has seen your record. The PHR combines medical information from your various providers, and makes it available in a readable format for you to review and monitor. You can use tools to chart your own health, compare test results over time and take greater control over your own health.

What Alaskans Can Do To Help

Let your physicians, employers, legislative representatives, and insurers know that you want electronic access to your medical records and that you support the Alaska e-Health Network, providing exchange of health information to improve healthcare quality and reduce costs in Alaska. A show of support from the public will fuel these needed changes to our outdated healthcare system and result in positive benefits for all Alaskans. Call or write the AeHN office today to get involved.

More Information

www.ak-ehealth.com

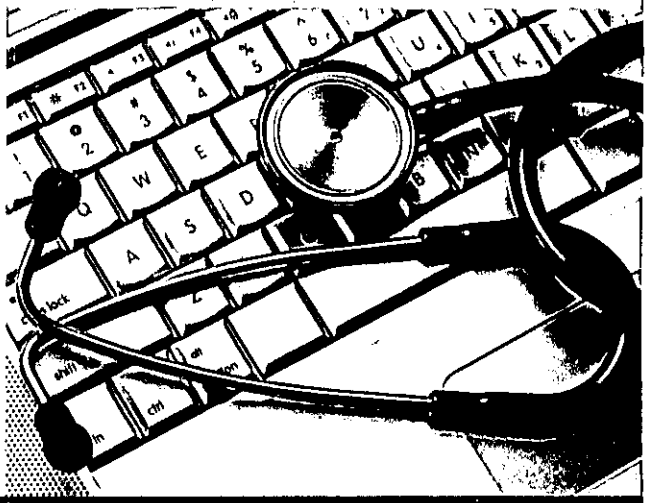
Founding Members

AARP Alaska
Alaska EHR Alliance
Alaska Federal Health Care Partnership
Alaska Native Tribal Health Consortium
Alaska Primary Care Association
Alaska State Hospital and Nursing Home Association
Alaska Veterans Administration Health Care System
Premera Blue Cross/Blue Shield of Alaska
State of Alaska Division of Health and Social Services

PMB 1143, 2440 E. Tudor Rd. | Anchorage, AK 99507
Phone: (907) 729-3934 | www.ak-ehealth.com

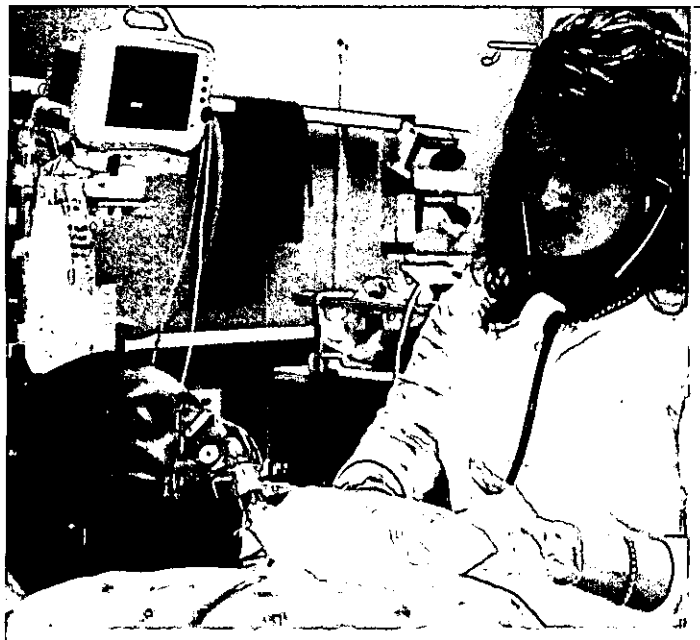
Your Health is on the Line.

Online, that is!



How an Electronic Health Records Exchange Network will improve your health and Alaska's healthcare system.

SPEED • QUALITY • PRIVACY • SECURITY
SAFETY • EFFICIENCY



Imagine You're Sick

It's a weekend. You end up at the local emergency room. Because your medical records are electronic, your ER doctor accesses them quickly via a new, statewide, electronic health record exchange network.

When this scenario becomes real, and the Alaska eHealth Network provides an exchange for health information, here are just some of the benefits you can expect:

Improved Speed & Quality of Care: With an Electronic Health Record (EHR) that is securely connected to other EHRs, doctors are allowed immediate access to your essential medical information to treat you quickly. Drugs, lab results, allergies, medical history — all are included. Potential drug interactions are identified.

Improved Safety: Since critical information is available in real time at the point of care, the risk of a medical error is greatly decreased. And, since past test results are included, expensive duplicate testing is avoided.

Increased Efficiencies: Decreased paperwork and immediate access to records, labs and other test results increase the efficiencies for delivering health care services while lowering medical costs for all involved, including you, the patient. *National studies demonstrate a 5% reduction in health care expenses when electronic records exchange is available.*

Greater Convenience: No more need to repeat your medical and personal history, contact data, or insurance and billing information! You give it once; it's in your electronic record.

Privacy and Security Safeguards: Safeguards are required and provided to ensure your privacy and the secure exchange of your medical information. Your records are identified and confirmed through a careful criteria-matching process. Contrast that with the unwieldy paper records still in use in many facilities, with outdated and error-prone faxed exchange of information.

Electronic Health Record Exchange: Alaska's Plan

What's at Stake

"I am a victim of not having electronic health records. I am legally blind because they put me on medication for my heart and four months later, the medicine killed the optic nerve in my eye. They made a mistake by giving me a medication that interacted with one of my existing medications. Had EHRs, with their medicine alerts, been available, I would have my sight today. I hope Alaska will adopt interoperable electronic health records soon, so this won't happen to anyone else."

– Alaskan Ben Tisdale, 71 years old

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Ben's wish will become real in the near future! The electronic exchange of health information is becoming reality in many parts of the U.S., Alaska included. Many Alaska hospitals, labs and some clinics are utilizing their own Electronic Health Records, while many other systems are under development. Alaska has a plan to exchange health information electronically to increase quality and decrease costs.

The Alaska eHealth Network (AeHN) has received partial funding to develop a statewide, electronic health network to safely and securely exchange health information between authorized healthcare providers and patients. Collaborative efforts are also underway to help providers adopt EHRs. If network development funding becomes available as planned, electronic health information exchange will be available to all Alaskans by 2011.

AeHN Alaska eHealth Network℠
Secure Access to Your Health Record

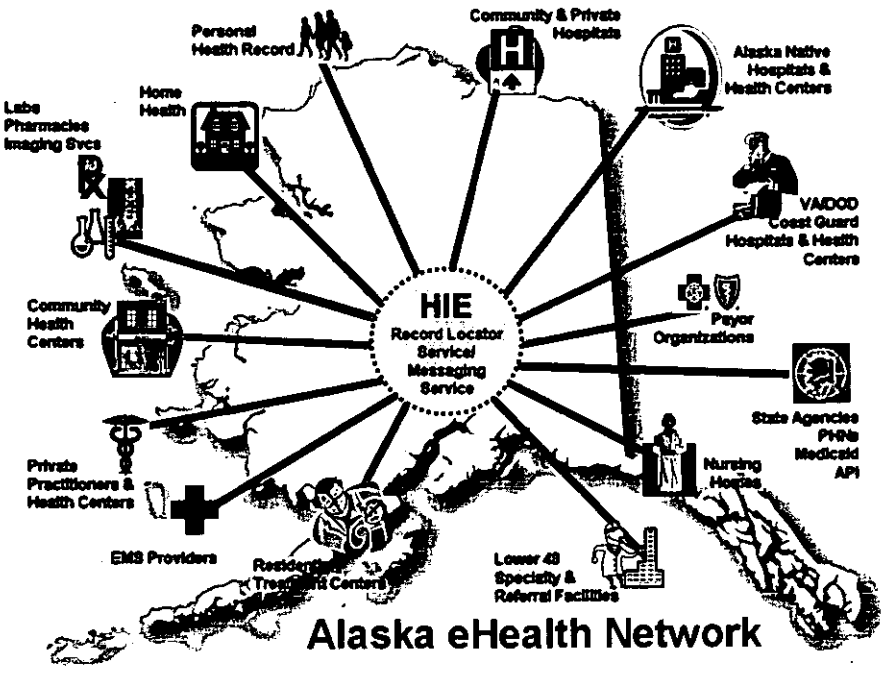
FACT SHEET

Overview The Alaska eHealth Network (AeHN) is a carefully planned solution to our national health care problem of high spending and low returns on healthcare. AeHN was established as a 501(c)(3) in 2008 to create a statewide, standards- based electronic health network which will allow individual Alaskans to have their own personal health record and to authorize their health care providers to exchange electronic medical records in a timely, secure manner.

Mission To improve the safety, cost effectiveness, and quality of healthcare in Alaska through the promotion and facilitation of widespread implementation and use of secure and confidential electronic clinical information systems, including electronic health records and clinical data exchange capabilities.

Partners The Alaska e-Health Network to date has been a collaborative partnership effort of the Alaska Federal Health Care Partnership (including the Veterans Administration, the Department of Defense, the Indian Health Service, and the U.S. Coast Guard), the Alaska Primary Care Association, the Alaska Native Tribal Health Consortium, the Alaska State Hospital and Nursing Homes Association, the Alaska Mental Health Trust Authority, Premera Blue Cross/Blue Shield, the University of Alaska, AARP Alaska, the State Department of Health and Social Services, and the Alaska EHR Alliance (private physicians).

Services When complete, the Alaska e-Health Network will have the capability to provide any Alaskan with a secure Personal Health Record, including authorization for their health care providers on the network to have access to electronic records required for continuity of care, such as hospitalization records, prescription information, vaccinations, allergies, imaging records, laboratory results, etc. The Network will support telemedicine services, the transfer of high resolution images for patient care, video conferencing, and Voice over Internet applications for providers.



Sustainability

AeHN partners are determined to ensure the long-term viability and success of the network when completed. Several models have been considered, including provider/user fees and payor contributions. Networks with the highest degree of success have secured long-term support from their state governments (e.g. Arizona, California, New York, Delaware). The annual operating cost of the Alaska e-Health Network, when fully deployed and used by the majority of state residents, is estimated at $6 million, or approximately $10 per year per resident.

Alaska's Need for Coordinated Health Information Exchange

Alaska health providers are going electronic: Many Alaskan health care agencies and providers have begun the expensive and gradual transformation of their medical record systems from paper to electronic (commonly referred to as Electronic Health Records or EHRs). Alaska medical providers are expected to invest well over $100 million in these systems over the next five years. But EHRs alone do not solve the health care problem. It takes all the EHRs sharing data through a statewide network to create change in health care.

Alaska health providers need a private, secure 'network of networks": The parallel development of a private statewide Alaska e-Health Network will unify and secure these separate electronic health record networks, connecting health providers and consumers to critical medical information for timely and quality patient care. Such Health Information Exchange (HIE) networks are being developed in many lower 48 states and regions with support from the U.S. Department of Health and Human Services and the Federal Communications Commission.

Where they have been developed successfully, the benefits of HIE networks include;

- improved patient access to medical care,
- reduction in duplicate and unnecessary testing and procedures,
- improved patient safety,
- reduced health agency administrative costs,
- greater patient and provider satisfaction, and
- enhanced rapid response to public health emergencies.

National studies demonstrate annual cost savings from the use of Electronic Health Records and HIE networks at approximately 5% of health care expenditures; this equates to an annual savings of $250 million based on Alaska's $5 billion health care expenditures, or an annual savings of $10-14 million based on the State of Alaska's $250 million Medicaid program.

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AeHN Alaska eHealth Network™

Volume 1 Winter 2008

EXCHANGE

— NEWS OF ELECTRONIC HEALTH TECHNOLOGY FROM ALASKA AND BEYOND —

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Premera Blue Cross Blue Shield
of Alaska

Joel Gilbertson
Regional Director
Providence Health System

Garth Hamblin
CFO
Bartlett Regional Hospital

Marilyn Kasmar
Executive Director
Alaska Primary Care Association

J. Patrick Luby
Advocacy Director
AARP Alaska

Jerome. List, M.D.
Alaska EHR Alliance
Alaska Ear, Nose, and Throat, Inc

Tom Nighswander, M.D., MPH
Asst. Regional Dean
WWAMI Program

Alex Spector
Director
Alaska VA Health Care System
and Regional Office

STAFF

Rebecca Madison
Director

Alaska eHealth Network

Welcome to the Exchange.

This is our first newsletter dedicated to health information exchange and the advancement of electronic health records in Alaska. We are excited to be bringing you information on the Alaska eHealth Network and other eHealth projects throughout Alaska. The Alaska eHealth Network (AeHN) is a non-profit membership organization formed to advance solutions for health information exchange across disparate health systems throughout the State. Our mission is to improve the safety, cost effectiveness, and quality of healthcare in Alaska through the promotion and facilitation of widespread implementation and use of secure and confidential electronic clinical information systems.

The Board of Directors for AeHN understands that the true value of EHRs comes from connecting them together to share health care data among all providers. The Board's vision is to promote widespread access to a statewide health information exchange system that improves quality, safety, outcomes and efficiency in healthcare by making vital data available to patients, providers and payers when and where they need it.

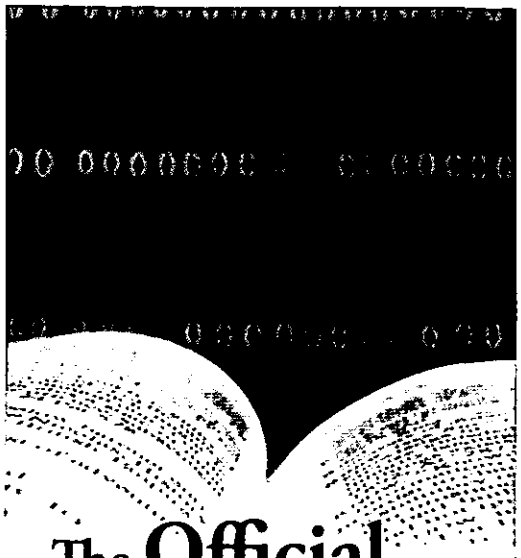
Sustainability is key to the success of this project. The Board is currently developing a sustainability plan to support health information exchange (HIE) well into the next century. It is crucial that the State of Alaska take an active role in HIE. Efforts are underway to engage legislators, consumers and providers in discussions to ensure that adequate funds are made available.

We plan to send out this newsletter quarterly. One of the regular features will include stories about eHealth projects around our State. We encourage you to share your success stories and look forward to hearing from you so that our newsletter, the Exchange, lives up to its name.

Sincerely,

Paul Sherry

Paul Sherry, Interim President,
Board of Directors



The Official Definition of EHR, HIE & PHR! Really!

The National Alliance for Health Information Technology has issued the final word(s) on what these letters really mean!

HIE: The electronic movement of health-related information among organizations according to nationally recognized standards.

EHR: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

PHR: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

So, now you know!

Alaska eHealth Projects

Health Information Security and Privacy Collaboration (HISPC)

Alaska has received $300,000 to participate in the development of model language for inter-organization and participation agreements for use when exchanging health information across multiple agencies and providers. Over 200 providers and consumers from around Alaska participated in discussions to identify security and privacy issues related to data sharing. Input from the statewide meetings has been instrumental in informing nationwide policy efforts.

To receive copies of these agreements and sample policies contact Rebecca Madison at (907) 729-3924 or rebeccam@akrivertracks.com.

New EHR Survey of Alaska Providers planned for December

A new, statewide survey of Alaska's healthcare providers will seek to determine current usage of EHRs, and interest by non-users in their adoption," announced Jerome List, M.D., President of the Board of Directors for the non-profit Alaska EHR Alliance. Formed in 2005, to assist Alaska's non-public sector providers in the adoption of EHRs, the Alliance is made up of physicians, medical organizations, insurers and consumers. "The information gathered from the survey is critical to our plan to select and recommend 1-3 EHR vendors for Alaska's providers," Dr. List said. Information from the survey will be used to help guide the EHR selection process, and to identify interested providers to invite to participate in its oversight and in a future pilot program.

In addition to selecting the recommended EHRs, they plan to seek funding to help lower the initial costs of adoption and help with the necessary employee training and office redesign. The Alliance supports the development of a statewide network by AeHN to assure EHRs can be exchanged and accessed quickly and safely by authorized providers. For more information, contact Linda Boochever at (907) 337-6218, or lbooch@gci.net.

U.S. eHealth News

President-Elect Obama Strongly Supports Health IT

When President-Elect Obama takes office in January, he will have three major priorities: the economy, the war, and healthcare reform. In campaign speeches, Obama has stressed the importance of a federal investment in "electronic health information technologies" to reduce errors and "save lives and money." His plan calls for $50 billion over five years to promote adoption of secure, interoperable electronic health records. Obama's plan or a similar version is likely to move forward in Congress in 2009 due to broad bipartisan support.

2009 ePrescribing CMS Incentive Program

In January 2009, CMS is implementing an e-prescribing incentive program for physicians, which will increase Medicare payment by 2% for those who use e-prescribing technology. CMS envisions that this initiative will encourage providers to invest in technology.

Featured eHealth Solution

EMR Metamorphosis in Juneau Clinic

By Richard Welling, MD

Ever wonder what a caterpillar might feel like if it went through all the effort to wrap itself in a cocoon and after waiting the prescribed period as indicated by the manufacturer — spread its wings, only to find it was a moth? Sure, it can fly, and the view is all right, but the problem is in the expectation. The transition to an electronic medical record (EMR) can be a little like that... here's my brief take on our clinic's recent "metamorphosis."

In 2005, our 7-partner family practice clinic decided that it was time to make the quantum leap to an EMR. We spent the next several months reading articles, calling practitioners who had made the change, and eventually hired a consultant to guide us through the process. But in the end, no matter how much homework you do, the good, the bad, and the ugly of an EMR is hard to appreciate until you spread your wings and buy — or rather, fly.

The Good. Much of what an EMR vendor says will be true. Your laptop computer is lighter than your heaviest chart, and with it, you can open everyone else's chart. When a patient needs a referral, you can print out a summary and fax it to the waiting specialist. Hardware is getting better. Your transcription bill will fall substantially, prescriptions are sent to the pharmacy without being printed out and are always legible. Allergy alerts will make you feel smart. Your computer isn't prone to under billing and can improve revenue with better coding, supported by your documentation. If your system interfaces with labs or hospitals out of town, electronic faxes can limit your paper costs by placing results directly in your EMR "in box." Lab results and patient vitals can be easily graphed over time for educational purposes. When you don't know the answer, your favorite Internet reference site is only a few clicks away. Clearly being a moth has some advantages over a caterpillar.

The Bad. Time. Our experience has been that with an EMR we are spending twice the time making half the note. Retrieving labs and x-rays generally take longer than turning a tab in a paper chart. Some of this can improve by using computers with faster processors, like desktops instead of laptops. Without an interface, lab work and hospital paper work will not necessarily arrive electronically, requiring conversion from fax to paper, and then scanning back to digital.

The Ugly. Money. Let's be honest, being a caterpillar had its moments. Pen and paper is relatively cheap in comparison to a tablet PC. And then there are proprietary software costs that vary wildly without obvious justification. In the first year with an EMR, our clinic's net revenue decreased substantially. In addition, our practice had to hire a full time technical staff member to manage our routine problems, and still flies in the occasional specialist when things get really, well, ugly. Expect at least two years to pass before breaking even on your system.

In the end, we are flying. And going back to crawling as a caterpillar isn't really an option; but, it would have been nice not to have been expecting a butterfly.

Consumer Point of View

For This Alaskan, Adopting EHRs is Personal

Alaskan retired businessman, Ben Tisdale, has a personal interest in EHRs. He is legally blind due to a medication error that could have been avoided had his physicians used electronic health records. EHRs have a medication alert system built into the software that will notify physicians of contraindications of medications when they prescribe them. "An error was made giving me a medication that interacted with one of my existing medications. Had EHRs, with their medicine alerts, been available, I would have my sight today. I hope Alaska will adopt electronic health records soon, so this won't happen to anyone else," Ben said. Ben feels so strongly about the importance of EHRs that he serves as a board member for the Alaska EHR Alliance.

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Phone: (907) 729-3934 | www.ak-ehealth.com

This is your space.

Please let us know about your health IT efforts, advice, opinions, or what you'd like to see in the newsletter. We hope it will become a forum for the exchange of ideas and news, thus the name- the Exchange! To participate, just go to the AeHN website: **www.ak-ehealth.com.**

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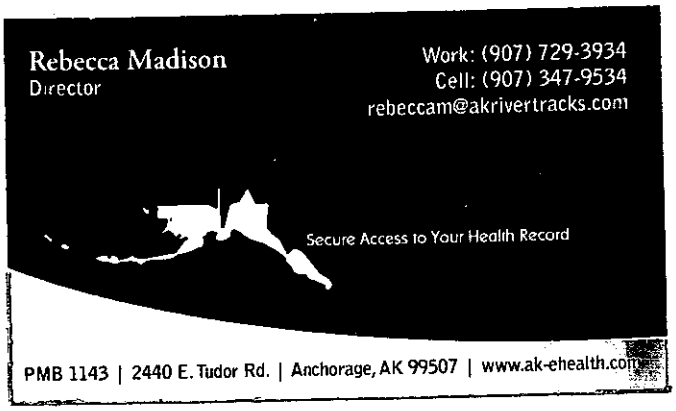
Rebecca Madison
Director
Work: (907) 729-3934
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Secure Access to Your Health Record
PMB 1143 | 2440 E. Tudor Rd. | Anchorage, AK 99507 | www.ak-ehealth.com

SB 139

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

MEMORANDUM

DATE: April 1, 2009

TO: Senator Joe Paskvan
Senator Bettye Davis, Chair Senate Health & Social Services Committee
Senator Donald Olson

FROM: Commissioner Bill Hogan

SUBJECT: Questions regarding SB 139

Administration response to questions posed by Senator Paskvan during the 3/25/2009 Senate HSS hearing on SB 139

Question 1. I understand the administration does not support this bill. Does the administration recognize the need for attracting health care workers, or is the administration rejecting recognition of the need?

Response:
Yes, the administration recognizes the need for recruiting and retaining health care workers. The Alaska Dept. of Health and Social Services (DHSS) provided statements during the 3/25/2009 Senate HSS hearing that the department has prepared documents and conducted projects that recognize health care workforce shortages and strategies to resolve these shortages. Specifically, the department referenced the Physician Supply Task Force Report that was prepared in 2006, which was staffed by DHSS and funded by the University of Alaska. This report includes documentation of need for additional physicians as well as recommended strategies, such as loan repayment (p. 55), for addressing these shortages.

In addition, DHSS is working with the Alaska Mental Health Trust Authority and the University of Alaska to address shortages in the social services workforce (including behavioral health, developmental disabilities, senior services, etc.). In addition, DHSS, along with the Alaska Dental Action Coalition, is undertaking various needs assessments and developing strategies to address the oral health workforce shortages. DHSS has also participated in an analysis of health care workforce recruitment efforts across Alaska. DHSS has participated in researching and documenting strategies that are effective in attracting and retaining health care professionals, such as loan repayment and direct incentives (http://hss.state.ak.us/dph/Healthplanning/publications).

Finally, DHSS prepares health professional shortage area (HPSA) applications on behalf of communities/boroughs and submits them to U.S. Department of Health and Human Services Health Resources and Services Administration. Designation of a borough as a health professional

shortage area allows providers in that area to apply for National Health Service Corps loan repayment.

Question 2. Does the administration oppose the bill because it wants to reject certain fields as covered under the bills? Is there the recognition that some fields should be supported, and is there some lesser number of positions the administration would support? Or is it that, despite any recognition of need, the administration opposes spending the money?

Response: The administration's opposition to SB139 is not related to rejection of certain professional fields covered under the bill. The concerns of the administration are related to the fiscal note and the funding that would be required to place 90 professionals.

The department assumed 90 positions when developing the fiscal note in order to make a substantial impact on the workforce shortages. SB 139 cites the level of funding provided to each type of professional. The bill does not identify the number of professionals to be funded each year. Thus, the bill allows for placement of fewer than 90 professionals per year if the annual funding for the loan repayment and employment incentive program were made at a lesser total amount.

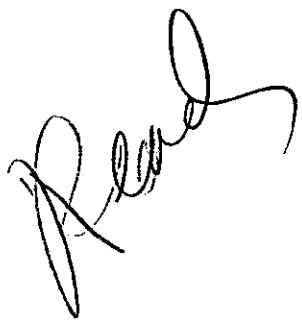
At this point, the administration cannot commit to supporting a loan repayment program, even for a reduced number of loans. Because of current economic conditions, the administration has recently introduced two other bills, SB 140 and HB 172, that would allow the Department of Revenue to enter into a bond purchase agreement and take other measures necessary to avoid a disruption in education loan services provided by the Alaska Student Loan Corporation. These measures are necessary to ensure the viability of the ASLC, and take precedence over creating additional obligations.

Lynda Zaugg

From: Kendri Cesar
Sent: Thursday, March 26, 2009 1:15 PM
To: Lynda Zaugg
Subject: Wednesday

Is fine! Sen. Davis told Rod Betit that she would like to work with us on amendments to the bill, so is there sometime tomorrow when I could speak with you and/or Sen. Davis about what she has in mind? Thanks,

Kendri Cesar, Committee Aide
Office of Senator Donald C. Olson
Capitol Building, Rm. 514
Juneau, Alaska 99801
(907) 465-3877



Lynda Zaugg

From: Kendri Cesar
Sent: Monday, April 06, 2009 10:54 AM
To: Lynda Zaugg
Subject: SB 139 Expected Testifier

Hi Lynda,

Just wanted to let you know that Rod Betit of the Alaska State Hospital and Nursing Home Association will be present today to testify. Shelley Hughes of the Alaska Primary Care Association will also be present to answer questions, and she will be in contact with you shortly if she has not already gotten a hold of you. Those are the only expected testifiers from our side, although I believe that Jay Butler from the DHSS will be present again today. Thanks,

Kendri Cesar, Committee Aide
Office of Senator Donald C. Olson
Capitol Building, Rm. 514
Juneau, Alaska 99801
(907) 465-3877

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Monday, April 06, 2009 12:47 PM
To: Lynda Zaugg; Kendri Cesar
Cc: Butler, Jay (HSS-CDC)
Subject: SB 139 testimony today

This is to let you know that Dr. Jay Butler, Alaska Chief Medical Officer, will be on line to testify for HSS on SB 139, incentives for medical providers. Let me know if you have questions.
w.

Wilda Laughlin, DHSS Legislative Liaison
Juneau: 907-465-1613
Cell: 907-723-3802

QUESTIONS for DHSS re: SB 139 *Incentives for Certain Medical Providers*

IS WORKFORCE SHORTAGE A PROBLEM?

- Would you consider the current workforce shortage and the trend ahead a concern?
- Is the shortage in Alaska getting better or worse? In other words, will we have increasing problems with access if the trend continues?

ADEQUACY OF DEPARTMENT'S EFFORT?

- If we're not training them (such as for dentists and pharmacists) or training enough of them (such as for nurses and physicians) then the only alternative is to recruit from elsewhere.
    - What is the Department doing now to recruit more of these health practitioners and if it's doing anything, is it making enough of a difference?

DIFFERENCE BETWEEN "FILLING VACANCIES" and "THE IDEAL SYSTEM"?

- If we fill these current vacancies, will this give us the "ideal" number of healthcare practitioners Alaska truly needs, or does that just fill in the current holes?

COST OF DOING NOTHING?

- In general, how are revenues impacted because someone is not on the job, and thus submitting the billings?
- I understand that a Medivac from a remote community can cost $90,000. When there is not enough staffing in Community Health Centers or tribal clinics, would you expect there to be more Medivacs as a result?

PRACTITIONERS WORKING IN RURAL AREAS, and/or WITH NEEDY POPULATIONS?

- What is a reasonable way for Alaska to get more health professionals to work in rural & remote locations, and/or with needy populations like Medicaid, Medicare and the uninsured?

COMPARISON TO OTHER STATES?

- Are we doing more or less than other states to recruit health care professionals?
- Many other states are using loan repayment and incentive programs to attract healthcare professionals to work in their states. Why isn't Alaska doing that?

WHAT IS WRONG WITH BILL AS PROPOSED?

- SB 139 will allow us to begin filling healthcare practitioner vacancies now, and will allow us to specifiy whether these recruits work in rural and remote areas, &/or with priority populations such as those on Medicaid, Medicare, and the uninsured.
    - What is wrong with either that idea or the bill as proposed?

GOVERNOR OBJECTS TO COST?

- I understand that the Department doesn't support this bill because of the Governor's concern about the fiscal note, even though it is quite modest considering that it would provide for an estimated 90 practitioners over 3 years.
    - What is wrong with the amount specified – does the Department have an alternative amount or an alternative plan to help address the immediate shortage problem?

Alaska Native
Tribal Health Consortium

Administration · 4000 Ambassador Drive · Anchorage, Alaska 99508 · Phone: (907) 729-1900 · Fax: (907) 729-1901 · www.anthc.org

POSITION PAPER

CONTACT: Valerie Davidson, Senior Director
Legal and Intergovernmental Affairs
Through Pat Jackson, State Liaison for Alaska Native Health
523-0363 – pajackson@anthc.org

DATE: March 24, 2009

RE: SB 139 - "An Act establishing a loan repayment program and employment incentive program for certain health care professionals employed in the state; and providing for an effective date."

POSITION: Support

The Alaska Native Tribal Health Consortium (ANTHC) strong supports SB 139 – Incentives for Certain Medical Providers.

ANTHC is a tribally controlled, non-profit, statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. It is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. ANMC has 139 physicians, 37 dentists and 500 nurses on staff, along with many more employees working in health-related professions. We have the same workforce challenges our partner health organizations in Alaska face, competing with employers in the Lower 48 to recruit and retain a quality workforce.

Ideally we would "grow our own" health professionals in numbers that would meet our workforce needs. We have made progress over the years—the tribal health system offers internships and scholarships that bring some of our best and brightest to the medical field. More Alaska Natives are choosing Medical and Dental careers; a University of Alaska Anchorage program, Recruitment and Retention of Alaska Natives into Nursing, is graduating more Alaska Native nurses; many of our Community Health Aides have built on their basic training opportunities to prepare for advancing careers; and the Dental Health Aide Program is graduating students who fill a need for dental health services and patient education. But we are increasingly challenged in our efforts to recruit health professionals.

We understand Alaska is only one of six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and that national studies on workforce recruitment and retention have found that loan repayment and incentives are among the most effective way to help alleviate workforce shortages. ANTHC urges your favorable consideration and passage of SB 139 to help us turn the corner on Alaska's health care workforce.

The Health Care Professions Loan Repayment & Incentive Program

As Proposed by SB 139 *Incentives for Certain Medical Providers*

Problem:

Having a sustainable and competent health care practitioner workforce is vital to the health of Alaskans. However, Alaska is at a serious disadvantage as it competes in the national health care labor market. In other states, "support-for-service programs" (SFSPs) have shown substantial and longstanding success as a cost-effective public strategy to address workforce shortages (e.g., loan repayment and direct incentive). A key problem is that Alaska does not have a robust SFSP while 44 other states have one or more SFSPs.

Solution:

The establishment of the Health Care Professions Loan Repayment and Incentive Program (HCPLRIP) will make Alaskan health care employment competitive and attractive enough for practitioners to work in Alaska, particularly in hard-to-fill localities. State funds will be used to insure that Alaskans that have the greatest difficulty in obtaining care due to limited financial resources, cultural barriers, and geography will have access to professional health care services.

Program Description

1) **Oversight Entity**
   - Health Planning & Systems Development, Department of Health & Social Services will serve as the Oversight Entity.
   - DHSS Commissioner will appoint a HCPLRIP Council to make recommendations regarding the program administration.
   - HCPLRIP Council recommendations are to be given serious consideration by the Commissioner. The HCPLRIP Council will serve as the primary communication between providers and program administrators.
2) **Fiscal Agent**
   - Alaska Commission on Post-Secondary Education (ACPE) will serve as Fiscal Agent for loan repayments. ACPE will make loan payments directly to eligible lenders.
   - DHSS will serve as Fiscal Agent for incentive payments. DHSS will make incentive payments directly to practitioners.
3) **Practitioner Eligibility**
   - DHSS Commissioner will annually prioritize the 10 eligible practitioner types:
     - Tier-1: Dentists, Pharmacists, Physicians (MD and DO)
     - Tier-2: Dental Hygienists, Nurse Practitioners, Nurses (RN), Physical Therapists, Physician Assistants, Psychologists, Social Workers (LCSW)
   - A practitioner's clinical duties must constitute at least 50% of duties to be eligible.
   - A part-time practitioner may participate and be eligible for pro-rated payments.
   - Preference may be given to current Alaskan residents.
   - A practitioner may be an employee for an employer or a sole practitioner in private practice.
4) **Site Eligibility**
   - DHSS Commissioner will rank eligibility of sites annually and can determine any area and/or population in Alaska as a "shortage priority." These may include, but are not limited to, federally defined Health Professional Shortage Areas.

- Preference will be given to sites that provide care to individuals regardless of their ability to pay, including persons who are uninsured or have Medicare &/or Medicaid.

5) **Payment Detail**

Placement Type	Regular	Hard-to-Fill
Tier 1:	up to $35,000/year	up to $47,000/year
Tier 2:	up to $20,000/year	up to $27,000/year

- Payment details are same for 2 component types: loan repayment and incentives.
- Duration of award is for a 3-year period of service.
- Payments will be made every quarter following a completed full quarter of service.
- A program practitioner in good standing may re-apply for a 2nd period of service.
- Lifetime participation cap is 6 years regardless of component type.

6) **Program Evaluation**

- The Oversight Entity will conduct annual survey of program practitioners, exit interviews, and tracking of alumni.
- The Oversight Entity will develop measures to make workforce projections, according to practitioner type category and may assess sustainability, cost-benefit issues, and rural and remote benefits of program.
- The Oversight Entity will develop evaluation policy and procedures.
- The HCPLRIP Council will adopt an evaluation plan within 12 months of initial program funding and amend annually.
- HCPLRIP will assess adequacy and distribution of the Alaska health care workforce for all program eligible-practitioner types annually.
- The Commissioner will report to the Legislature every 3 years whether payments are adequate to meet program goals. The Oversight Entity will have specified discretion based on HCPLRIP Council's review of report to adjust payment rates.

7) Funding

- An in-cash match may be required and will be paid annually by eligible sites to DHSS. The level of required match will be determined by the DHSS Commissioner and will be adjusted according to the ability of the eligible site to contribute. The contribution may be set between 0% and 100%
- Program funds will not be used to offset current or expected provider supports.
- Funding will be provided to allow DHSS to (1) conduct program management; (2) monitor placements & practice environments; (3) resolve placement issues; and (4) assess the statewide health care workforce regarding the program practitioner types.
- Proposed funding for FY10 is $7.5 million which will fund an estimated 90 participants, approximately 9 practitioners for each practitioner type category.

Question and Answer SB 139

1) What is the goal of this legislation?

Increase the recruitment and retention of health care providers to work in Alaska by assessing needs and providing related support-for-service programs that address shortages and distributions.

2) How were the 10 occupations selected?

The occupations were selected using a combination of professional experiences amongst the working group, Alaska specific data (2007 Alaska health Workforce Vacancy Study and the Alaska Health Care Data Book, 2007) and looking at the occupations used in other support-for-service programs around the country.

3) Do other states have a loan repayment program in place?

There are 81 loan repayment programs in 44 states. In addition, 21 of those states have more than one program. A key problem is that Alaska does not have a robust support-for-service program while most other states do, in fact many have several and some of them are expanding. In sum, Alaska is at a substantive disadvantage as it necessarily competes in the national healthcare labor market.

4) Is the Department of Health and Social Services supportive of this legislation?

DHSS has not yet taken a position on this legislation.

5) Who is the program aimed at?

The program is aimed at healthcare practitioners who have completed their education and are ready to practice their specialties.

6) Is a loan repayment program effective?

National studies have determined both loan repayment and direct incentive programs to be two of the most effective of the several support-for-service strategies in terms of both recruitment and retention.

7) Is the amount of money available sufficient to attract providers?

Yes. For example, a 2007 study by the American Dental Education Association found that 75% of dental school graduates have a debt of over $100,000. This program would provide a repayment of between $105,000 and $141,000 (over three years) for dentists to come to Alaska to practice.

8) Alaska has a nursing school, isn't that good enough?

No. The University of Alaska School of Nursing graduates approximately 200 nurses each year. However, the demand for nurses, according to the 2007 Alaska Health Workforce Vacancy Study exceeds 300 per year.

9) Alaska has the WWAMI program for doctors and we just doubled the number of slots two years ago. Isn't that enough?

No. Alaska has 20 slots at the University of Washington School of Medicine, which is up from the 10 slots Alaska had prior to 2007. Of the original 10 slots, there were about 7 that came to Alaska to practice. Alaska needs more than 7 doctors a year to keep up with the demands of an aging population.

10) This seems like a large fiscal note in times of declining revenues. Can Alaska afford this?

Can Alaska afford not to? This legislation would cover 90 positions for the entire three years of the program. Further, filling some of these job vacancies can have extraordinary economic impact on a local rural economy. For instance, one rural physician helps to support 23 other jobs and generates $899,000 in wages, salaries & benefits. It is up to the Legislature to decide if this is a priority and if providing health care fits into their overall goals for 2009.

11) If there is not enough money to fund all 90 positions, do the Tier I positions get funded before the Tier II positions?

No. It is the intent of the legislation to fund both Tier I and Tier II positions equally with any money that is appropriated to the program from the Legislature.

12) Does the 'employer match' requirement in the legislation exclude providers from setting up their own business? In other words, if they are self employed would they still qualify for the program.

Yes. Language was put into the legislation under the Direct Incentive section on page 4 so that the legislation reads, "An employer or **other entity**..." This language should be sufficient.

13) Are the occupations defined in Tier I and Tier II standard? How were they selected and broken down?

The tiers were selected based on the occupations that are in the most demand. In addition, Tier I occupations generally carry the most debt and require some of the longest academic preparations.

14) Does the employer match applicable to both loan repayment and incentives?

Yes. If determined by the Commissioner of Health that the employer or entity is able to pay a matching amount.

Alaska Center for Rural Health – Alaska's AHEC UNIVERSITY *of* ALASKA ANCHORAGE

August 2007

2007 Alaska Health Workforce Vacancy Study Research Summary

Key Findings: *Alaska is confronted by severe shortages of professional health workers, primarily in high-level primary care occupations that include* ***Family Physician, General Internist, Critical Care Nurse, Nurse Case Manager, Family Nurse Practitioner, Physician Assistant, Pharmacist, Dentist, Physical/Occupational/Speech Therapist,*** *and* ***Behavioral Health*** *occupations. Shortages in* ***RNs*** *and* ***Allied Health*** *are much less acute. Most affected are rural areas and Tribal Health Organizations, though growth-driven high vacancy rates affect the Anchorage-Matsu region as well.*

BACKGROUND

Alaska is confronted by a "perfect storm" of health professional shortages. The state has long suffered from a deficient "supply side" characterized by insufficient numbers of key health workers whose recruitment, retention and training have been impeded by Alaska's remoteness, harsh climate, rural isolation, low population density and scarce training resources. Now exacerbating this already difficult situation is a burgeoning "demand side" for increased health services for a steadily growing and aging population. The health services industry is the fastest growing sector of Alaska's economy, employing over 7% of the state workforce.

METHODOLOGIES

The key questions this study sought to answer were: What health occupations were at this time most critically affected by shortages? Exactly how many budgeted positions existed and how many of these currently remained unfilled? Where were these vacancies regionally and in what types of organizations? What did employers perceive to be the major underlying causes of their vacancies? How many new trainees/graduates could the job market actually absorb annually and how many organizations could absorb them?

Four hundred seventy-six (476) purposively sampled Alaska health service organizations of all types responded to the study survey (Figure 1). Survey data was used to generate estimates of positions and vacancies for the entire state of Alaska.

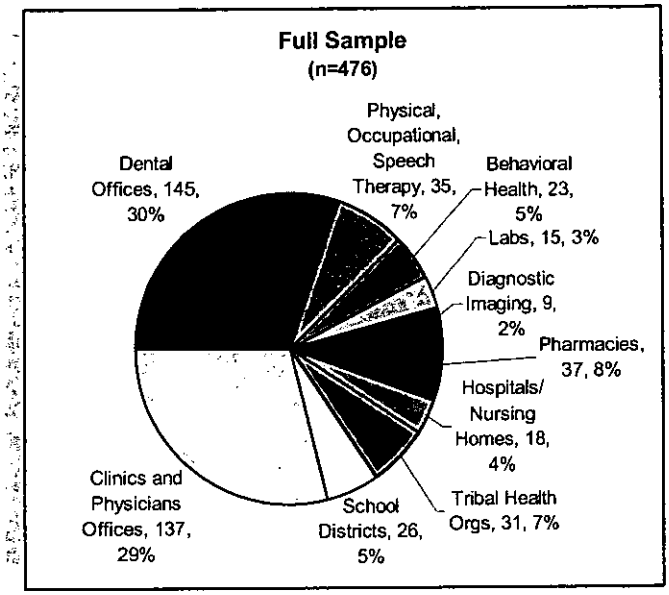


Figure 1

KEY FINDINGS

The findings confirm and quantify the trends cited in recent studies and accumulating anecdotal evidence: despite the recent progress in training and deploying health personnel, such as **Registered Nurses**, critical shortages persist (Tables 1,2).

The situation for key primary care occupations – **Family Physician, General Internist, Nurse Practitioner, and Physician Assistant** – was troubling, particularly in the rural areas, with numerous estimated vacancies and high estimated state vacancy rates between 15% and 20%.

Though vacancies for **Psychiatrists** were not numerous, they were particularly in demand (19.0% estimated vacancy rate) and difficult to recruit (mean vacancy length of 34.5 months).

This study was funded by the Office of Associate VP for Health, University of Alaska Anchorage, through Center for Disease Control and Prevention grant #5-H755-DP024673, and by the Alaska Mental Health Trust Authority.

The national **Pharmacist** shortage has hit Alaska hard and affects every region, with high estimated vacancy numbers (98), and an estimated vacancy rate of 23.7%.

Therapists of all kinds – **Physical, Occupational, Speech, and Speech-Language Pathologists** – were in short supply, with estimated vacancy rates ranging from 15.6% to 29.3%. No part of the state escaped the shortages; vacancy rates were most acute in rural areas, but numerically high in the Anchorage Mat-Su region.

High numbers of vacancies and high vacancy rates were reported for key specialized nursing occupations, particularly for **Nurse Case Manager**, **Family Nurse Practitioner**, and **Critical Care Nurse**. These appeared to be the current areas of most critical shortage in nursing.

The estimated **Registered Nurse** vacancy rate was moderate (8.0%), but this masked 10% rates in hospitals and tribal health organizations, and an estimated rural rate of 16.1%.

While the estimated vacancy rate for **Dentist** was 10.3%, this masked a 15.3% estimated rural rate and a very high 42.0% rate for tribal health organizations, which had 39% of estimated **Dentist** vacancies.

Table 1. Occupational Groups

Occupational Groups	Study Sample (n=476)			State Estimate		
	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
All Occupations	18158	1866	10.3%	34738	3529	**10.2%**
Physicians	730	109	14.9%	1931	226	**11.7%**
Professional Nurses	4202	462	11.0%	7139	696	**9.8%**
Other Nursing Staff	1769	135	7.6%	1762	111	**6.3%**
Professions/ Therapists	1240	217	17.5%	2281	404	**17.7%**
Behavioral Health	2938	327	11.1%	7450	1033	**13.9%**
Allied Health	3209	291	9.1%	5523	434	**7.9%**
Public Health/ Nutrition	154	18	11.7%	189	ND.	**ND**
Other Primary Care (PA & CHAP)	759	132	17.4%	1067	198	**18.5%**
Managers	1337	69	5.2%	2947	160	**5.4%**
Health Information/ Reimbursement	1816	106	5.8%	4451	253	**5.7%**

In the **Behavioral Health** occupational group, the most acute shortages – with both extremely high vacancy numbers and high vacancy rates – appeared to be among **Human Services Workers**. In addition, overall estimated **Behavioral Health** occupation vacancies were extremely numerous (1033), around 29% of all estimated vacancies – more than any other occupational group.

Among **Allied Health** occupations, high vacancy rates were affecting employers of **Physical Therapy Assistants** and **Respiratory Therapists**. **Sonographer** vacancies were difficult to fill, and **Surgical Technician** vacancies, though not numerous, were averaging 3 to 4 years in length.

One hundred (100) vacancies and a vacancy rate of 18.1% were reported for **Community Health Aide/Practitioners (CHA/Ps).**

Among "front office" and "back office" occupations, **Coding Specialist** and **Certified Coder** had 11% estimated vacancy rates and very long mean vacancy lengths.

The managerial occupations for which high vacancy rates were reported were healthcare related: **Behavioral Health Supervisor, Clinical Department Manager, Health Information Manager, Medical Director, Nurse Manager, and Practice Manager.** Behavioral health organizations had the most estimated managerial vacancies.

Table 2. Key occupations

Key Occupations (high numbers of vacancies, high vacancy rates)	Study Sample (n=476)			State Estimate		
	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
Family Physician	252	48	18.3%	675	107	**15.8%**
General Internist	71	15	21.1%	200	40	**20.0%**
Psychiatrist	36	10	27.8%	93	18	**19.0%**
Registered Nurse	3109	299	9.6%	5489	439	**8.0%**
Critical Care Nurse	497	43	8.7%	629	60	**9.5%**
Nurse Case Manager	136	42	30.9%	209	49	**23.4%**
Family Nurse Practitioner	155	36	23.2%	364	71	**19.5%**
Physician Assistant	207	32	15.5%	515	98	**19.0%**
Pharmacist	302	73	24.2%	413	98	**23.7%**
Physical Therapist	271	29	10.7%	510	84	**16.5%**
Dentist	319	47	14.7%	692	71	**10.3%**
Human Services Worker	1568	170	10.8%	4800	697	**14.5%**
Behavioral Health Clinician	297	35	11.8%	555	71	**12.8%**
Case Manager/Care Coordinator	505	52	10.3%	1163	164	**14.1%**
Physical Therapy Assistant	35	11	31.4%	62	18	**28.6%**
Medical Assistant	367	38	10.4%	1092	102	**9.3%**
CHA/P	552	100	18.1%	552	100	**18.1%**
Certified Coder	85	6	7.1%	209	22	**10.6%**
Medical Director	49	6	12.2%	120	18	**14.8%**
Behavioral Health Supervisor	82	13	15.9%	176	22	**12.5%**

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Looking at respondent types, tribal health organizations reported the highest overall vacancy rate (16.5%). These organizations reported 87 **CHA/P** vacancies; approximately half of all estimated vacancies for **Nurse Case Manager, Pharmacist, Chemical Dependency Counselor, Dentist, Medical Lab Tech, Medical Technologist,** and **Health Educator**; and all the estimated vacancies for **Coding Specialist**. But every respondent type was a locus for acute shortages in key occupations, such as clinics/offices of physicians for **PAs**, hospitals/nursing homes for **RNs**, pharmacies for **Pharmacists**, behavioral health organizations for **Human Services Workers**, and school districts for **Speech-Language Pathologists**.

Higher vacancy rates were generally found in the rural respondents, particularly in the North/West and Southwest regions, which reported double digit vacancy rates for nearly all occupational groups, and overall vacancy rates of around 20% (Table 3, Figure 2). Occupations with much higher rural estimated vacancy rates included **RN** (6.9% urban, 16.1% rural), **Behavioral Health Clinician** (9.3% urban, 22.9% rural), **Dentist** (7.2% urban, 15.3% rural), **Physical Therapist** (13.5 urban, 31.6% rural), and **PA** (14.7% urban, 26.8% rural) (Table 4).

DISCUSSION

The "supply side" shortages apparently persist. "Inadequate Pool of Qualified Workers" was the top reason given for vacancies, cited by 54% of respondents, followed by "Transience/Moving Away" (28%), "Insufficient Compensation" (18%), and "Rural Isolation" (16%). Many tribal health organizations also reported "Insufficient/Expensive Housing" as a top reason for unfilled vacancies. The data also indicated a burgeoning "demand side," where shortages were exacerbated by population growth and an increased need and demand for health services, particularly in the high-growth Anchorage Mat-Su region.

Table 3. Regional vacancy rates

Occupational Group	Regions (Study Sample = n=476)						
	North/West (n=10)	Southwest (n=17)	Interior (n=72)	Anchorage Mat-Su (n=232)	Gulf Coast (n=69)	Southeast (n=70)	Statewide/ Multiregional (n=6)
Physicians	26.7%	21.2%	21.6%	12.6%	10.4%	6.8%	30.3%
Professional Nurses	26.0%	21.6%	5.9%	11.1%	8.0%	5.9%	12.1%
Other Nursing Staff	18.6%	18.8%	5.8%	6.2%	4.6%	2.3%	8.8%
Dentists/Pharmacists/Therapists	32.4%	32.4%	20.7%	15.9%	16.5%	16.3%	12.4%
Behavioral Health	19.0%	22.7%	13.1%	8.3%	7.1%	11.1%	11.6%
Allied Health	17.0%	24.6%	7.3%	6.5%	8.4%	7.7%	8.6%
Public Health/ Nutrition	30.0%	6.3%	0.0%	4.0%	18.9%	0.0%	10.5%
Other Primary Care (PA & CHA/P)	19.7%	18.6%	24.5%	9.0%	9.1%	4.0%	0.0%
Managers	13.8%	2.4%	3.5%	3.2%	6.4%	11.7%	4.0%
Health Information/ Reimbursement	15.9%	16.9%	2.0%	5.3%	6.6%	2.8%	7.2%
All Occupations	20.1%	20.3%	9.0%	8.6%	8.1%	7.7%	10.2%

Table 4. Urban vs. Rural vacancies and vacancy rates

Occupation	Urban		Rural	
	Estimated Vacancies	Estimated Vacancy Rate	Estimated Vacancies	Estimated Vacancy Rate
Family Physician	68	14.9%	38	17.6%
General Internist	27	18.8%	13	23.1%
RN	339	6.9%	94	16.1%
Family Nurse Practitioner	36	13.3%	34	36.4%
Pharmacist	68	22.7%	30	25.9%
Behavioral Health Clinician	36	9.3%	34	22.9%
Human Services Worker	158	8.5%	209	10.1%
Dentist	32	7.2%	38	15.3%
Dental Hygienist	14	3.6%	17	10.0%
Dental Assistant	27	4.4%	64	14.9%
Physical Therapist	59	13.5%	26	31.6%
PA	50	14.7%	47	26.8%
All Occupations	1998	8.1%	1162	13.3%

Many respondents provided commentary with their surveys and noted positions that are particularly difficult to fill:

- *"We have been hiring travelers for Physical Therapy positions at $67/hr – we can't find therapists to employ. We have been looking for 2 years."* (Urban Medical Clinic)
- *"Without a state Physical Therapy program, it is very difficult to get PT staff. Usually this area is staffed by PTs that leave competing PT clinics."* (Urban Physical Therapy Office)
- *"We really need a pharmacy school in Alaska. It took two years to fill our last pharmacist position."* (Urban Pharmacy)
- *"Pharmacists are always the most difficult position to fill."* (Rural Pharmacy)

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The availability of military spouses has apparently alleviated some of the workforce pressure, but has exacerbated the "transience" problem. Also affecting the shortages was the absence of local training resources (such as medical, dental, pharmacy, and therapy schools) to provide a local workforce pipeline. In the qualitative data, common refrains were, "we need a pharmacy school," "we need a dental school," "we need a physical therapy school."

The acuity of workforce shortages was also reflected by the high percentage of estimated vacancies the responding employers would consider filling with new grads (Table 5). Respondents indicated that they had the capacity to hire sizeable graduating cohorts of Family Physicians, PAs, Occupational and Physical Therapists, Pharmacists, and Dentists. These may be the occupations likely to yield optimal responses to substantial investments in preparation and training programs and/or targeted recruitment and retention campaigns.

Copies of the full study can be downloaded from the ACRH website at:

http://nursing.uaa.alaska.edu/acrh/

Table 5. New Grad Vacancies

Occupation	Study Sample (n=476)	Statewide Estimate
Human Services Worker – HS diploma	68	266
Registered Nurse	93	226
Human Services Worker – AA degree	47	195
Case Manager/Care Coordinator	37	120
Family Physician	25	89
CHA/P	88	88
Pharmacist	46	84
Medical Assistant	21	84
Physician Assistant	23	80
Occupational Therapist	21	75
Dental Assistant	26	75
Dentist	27	67
Physical Therapist	23	62
Speech-Language Pathologist	28	53
Behavioral Health Clinician	19	53

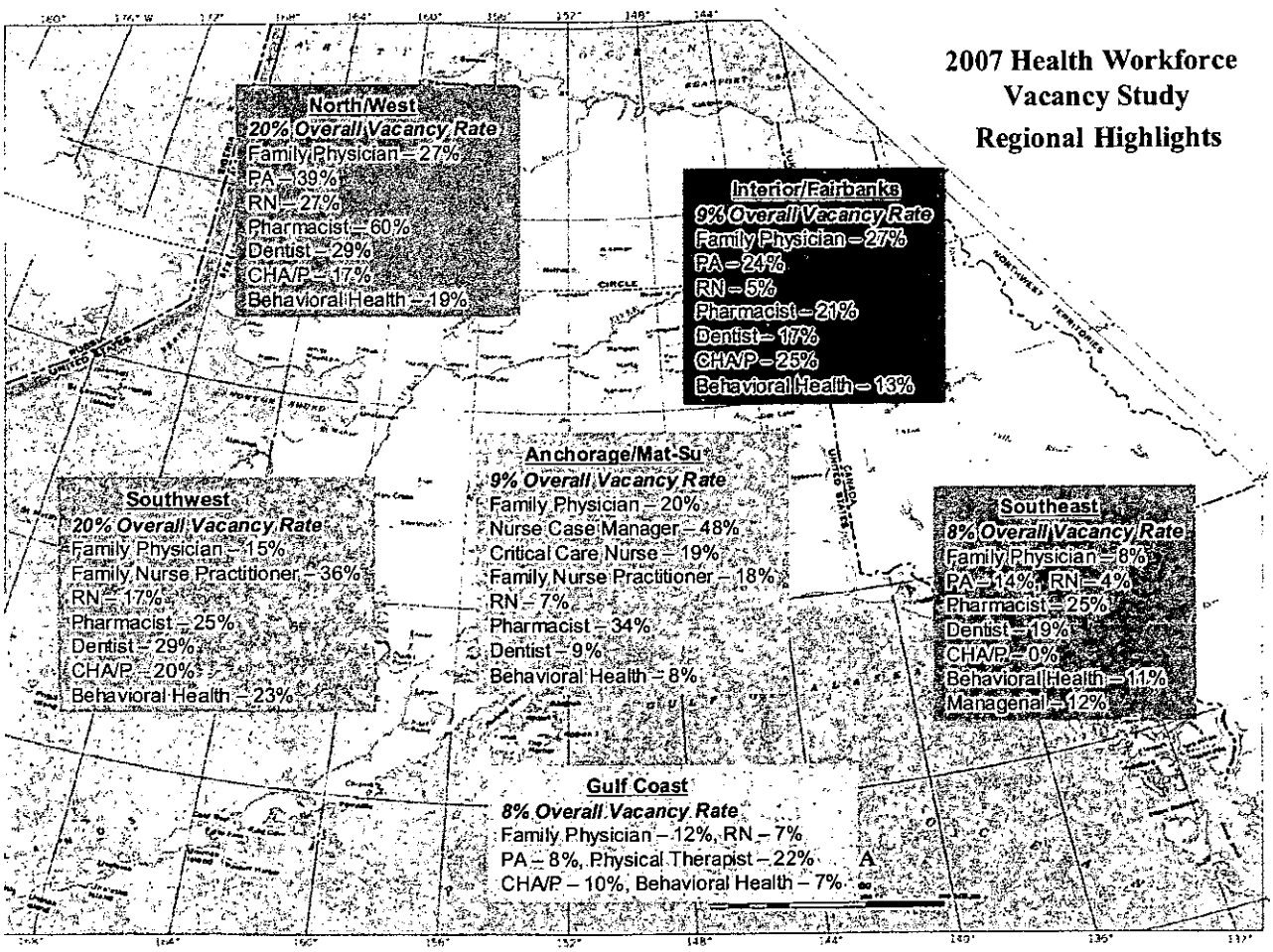

Figure 2. Regional Highlights

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Our view: Attracting doctors

Anchorage Daily News

Legislature can raise Alaska's stake in competition for docs

Published: March 10th, 2009 06:54 PM
Last Modified: March 10th, 2009 06:54 PM

Alaska's shortage of primary care doctors has been described as grim. A study two years ago found we needed 400 more doctors to provide the same level of care as is available elsewhere in the country. One result is that few doctors will accept the low rates paid by Medicare, the government insurance for those 65 and older. It's a horrible situation for Alaska's senior citizens.

Two bills introduced during this legislative session would help relieve the shortage of doctors and other health care workers, and both are worth passing.

Senate Bill 18 would increase the number of state-subsidized medical students in each class of the WWAMI program operated through the University of Washington. Alaska WWAMI students spend their first year of study at UAA.

These students offer an excellent return -- according to the Alaska Physician Supply Task Force study in late 2006, half of Alaska WWAMI students end up practicing in the state, and a few WWAMI students from other states join them.

The state raised the number of Alaska WWAMI students in each class to 20 in 2007.

SB 18 would increase the number by a modest amount, to 24. That's the most UAA can accommodate without incurring expensive overhead costs, said Sen. Bill Wielechowski of Anchorage, the bill's sponsor.

Adding the four students would cost the state little to no money the first year. But by the fourth year, when we would have an additional 16 Alaska students in med school, the state cost is estimated at $550,000 per year.

A second bill, SB 139, calls for the state to pay financial incentives to already-qualified doctors, nurses or other health workers if they take certain jobs in Alaska.

The bill, with a bipartisan group of sponsors, would carry out a plan developed by a group of health care professionals including representatives of the Alaska Primary Care Association and the Alaska State Hospital and Nursing Home Association.

The state would offer financial incentives to as many as 90 workers, from physicians to nurses, to come work in Alaska. Those who take hard-to-fill jobs, or treat a share of uninsured patients or those on Medicare or Medicaid, would get priority.

Each person would be guaranteed the incentive for three years as long as they kept working here.

The state would either repay part of their student loans or, if the health worker didn't have loans, simply pay them directly. The individual payments would range from $20,000 per year for nurses, physicians assistants and some others, to $35,000 for doctors, pharmacists and dentists, to $47,000 for doctors who accept the hardest-to-fill positions.

The state's cost for three years' worth of incentives would be $7.5 million.

That sum is large enough to cause concern this year, with a big drop in state revenues anticipated.

But consider this: Forty-four of the 50 states already offer financial incentives to lure health workers. Alaska is not competitive for health care jobs, and people are suffering because of it.

BOTTOM LINE: The Legislature should pass two bills to relieve a critical shortage of health care workers in Alaska.

Our view: Medicare choices

Legislators should decide on ways to help seniors get care

Anchorage Daily News

(03/16/09 01:17:52)

Rep. Les Gara of Anchorage has added an intriguing idea to the mix of proposals aimed at helping Alaskans 65 and older find medical care.

Many Alaska doctors won't accept patients on Medicare because the federal government won't let doctors collect anything close to the rate they normally charge for service. The feds boosted doctors' payments by 35 percent at the start of this year, but it doesn't seem to be helping much, says Dr. Tom Vasileff, president of the Alaska State Medical Association.

The problem is compounded by the fact that Alaska has a shortage of primary care doctors.

Rep. Gara has proposed that the state help increase the payoff for treating Medicare patients. His bill would pay doctors bonuses depending on how many Medicare patients were served: $6,000 bonus for 200 to 399 visits a year; $14,000 for 400-500 visits, and on up to $28,000 for 700 visits. His bill would directly and immediately reward doctors for taking Medicare patients, and is worth investigating. But the cost to the state is unknown, and there's a question whether Gara's bill would pass legal muster. Under Medicare law, a doctor can't take additional payment beyond what the federal government allows for a doctor visit. Gara thinks the bill gets around that rule because the state money isn't paid for each visit.

Two other bills that would help Medicare clients are further along in the Legislature, and both are worth passing.

SB 18 would increase the number of state-subsidized medical school spots for Alaska students in the WWAMI, a program run by the University of Washington for several western states.

Half of the Alaska medical students and some from other states end up practicing in Alaska. Growing our own doctors is an effective way to relieve the shortage.

But it takes students at least seven years to get through med school and residency programs, so that's a long-term solution.

Another bill, SB 139, would pay incentives -- cash for established doctors, loan repayment for new ones -- to doctors and other health workers who take certain jobs in Alaska. Those who treat Medicare patients would get a priority for the incentives, which would be $35,000 to $47,000 per year for three years, depending on where the doctor practiced in Alaska.

For $7.5 million, the state could recruit 90 health and social service workers and pay the three years' of incentives.

Or the Legislature could start the program with half that amount, and see how it works.

The bill could begin bringing additional doctors to Alaska very soon. It should get expedited consideration in the Legislature.

The Alaska State Medical Association supports both the increased aid for medical students and state incentives to attract new doctors, said Dr. Vasileff. With more doctors, the Medicare patients could be spread around, imposing less of a financial burden on any one doctor.

As for Gara's bill, Dr. Vasileff is concerned it won't pass the legal test. That's a key question the Legislature should investigate. Making sure doctors will take Medicare patients is a huge problem for Alaska. It will take more than one good idea to solve it.

BOTTOM LINE: State bonuses for doctors of Medicare patients? It's worth checking out. And the state should definitely pay to recruit new docs, and put more through med school.

The TRUST

The Alaska Mental Health Trust Authority

November 10, 2008

Re: Support for Alaska Health Care Professions Loan Repayment & Incentive Program

Dear Governor and Members of the Alaska State Legislature:

The Alaska Mental Health Trust Authority (The Trust) strongly supports the concept of a state-sponsored health professional loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a limited and shrinking national pool.

The Trust has invested in workforce development around providers serving our beneficiaries for many years, often partnering with both state and non-state entities. The Trust will be investing over $3,300,000 in FY 10 in our Workforce Development Focus Area and partners such as the University of Alaska will invest much more in this important area. Currently The Trust's Workforce Development Focus Area is investing $200,000 in a loan repayment strategy for behavioral health professionals in underserved areas and another $200,000 in cash incentives because research indicated this is an effective strategy for recruitment and retention. The Trust believes that in order to continue to address health professional recruitment and retention we will have to be innovative and aggressive, and with many other states and the federal government using loan repayment as a key strategy, we must also have a program that is available to our health professional organizations serving Alaska's residents.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. The Department of Labor and Workforce Development's labor data tell us that health and social services jobs are and will be some of the top growth job opportunities in Alaska for the next 10 years. Strategies such as loan repayment are critical to meeting the demand in this high job growth area and Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists, psychiatrists, physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, LCSWs (licensed, certified social workers), and physical therapists are all in short demand in Alaska.
The Trust invests in a semi-annual vacancy rate study conducted by the Alaska Center for Rural Health which shows that behavioral health vacancy rates are some of the highest of all health professionals. Psychiatrist's in all of our public mental health systems have become a critical problem with a mean vacancy length of 34.5 months.

3745 [illegible] Tel [illegible] Fax [illegible]

The TRUST

The Alaska Mental Health Trust Authority

The Health Care Professions Loan Repayment & Incentive Program proposal brings to the table an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. The proposed program designed for Alaska will provide much needed relief for our state.

The Trust recommends the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program and requests that you actively take steps to create and fund the program.

Respectfully,

Delisa Culpepper

Delisa Culpepper
Chief Operating Officer

[illegible] Suite 200 [illegible] Tel: [illegible] Fax: [illegible]

ALASKA PHYSICAL THERAPY ASSOCIATION, INC.

A CHAPTER OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION
PO BOX 140351 ANCHORAGE, AK 99514-0351
PHONE (907) 566-3749

Re: Support for Alaska Health Care Professions Loan Repayment & Incentive Program

November, 26, 2008

Dear Governor and Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Alaska Physical Therapy Association strongly supports the concept of a state-sponsored loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

The Alaska Physical Therapy Associations mission is that it's a member driven organization (290 members) is to represent and advocate for the profession of physical therapy and promote excellent, ethical, and autonomous practice, which serves the culturally diverse population of Alaska.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

At any given time you can contact most remote hospitals and clinics and find at least 1-2 vacancies, or openings for physical therapists. Even urban clinics are constantly recruiting for providers due to turnover, retirement, or keeping up with population growth in their respective communities. There are companies that provide temporary travelling Physical Therapists for 13-16 week assignments which can be extremely expensive for coverage, and again the turn over rate creates changes for patients and can also cause breaks in care or shortage of man power coverage.

The Health Care Professions Loan Repayment & Incentive Program proposal brings to the table an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. The proposed program designed for Alaska will provide much needed relief for our state.

APTA
American Physical Therapy Association

The Alaska Physical Therapy Association highly recommends and advocates for the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program and requests that you actively take steps to create and fund the program for health related assistance to our states residents.

Respectfully,

Sundi Hondl, PT, OCS

Sundi M Hondl, PT, OCS
Alaska Physical Therapy Association President

Alaska Pharmacists Association

Re: Support for SB 139
Alaska Health Care Professions Loan Repayment & Incentive Program

March 12, 2009

Dear Governor and Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, putting Alaskans in jeopardy, the Alaska Pharmacists Association strongly supports the concept of a state-sponsored loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a limited and shrinking national pool.

"The Mission of the Alaska Pharmacists Association is to preserve, promote and lead the profession of pharmacy in Alaska."

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, LCSWs (licensed, certified social workers), and physical therapists are all in short demand in Alaska.

Based on statistics provided by Laura Miller, PhD, Senior Economist with the National Association of Chain Drug Stores, the national average of community pharmacists per 10,000 people is 5.36. For Alaska, the figure is 3.35. To get to the national average, Alaska would need an additional 137 pharmacists. The average number of people per community retail pharmacy is about 5,300 nationally, and in Alaska it is 8,900. Even if you add in the 15 Indian Health Service (IHS) pharmacies, Alaska's pharmacies average about 7,500 people, much higher than the national average.

The Health Care Professions Loan Repayment & Incentive Program proposal brings to the table an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. The proposed program designed for Alaska will provide much needed relief for our state.

Respectfully,

Nancy O. Davis
Executive Director

E-mail: akphrmcy@alaska.net

203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880

Alaska Pharmacists Association

RE: Support for SB 139
Alaska Health Care Professions Loan Repayment & Incentive Program

March 24, 2009

Dear Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, putting Alaskans in jeopardy, the Alaska Pharmacists Association strongly supports the concept of a state-sponsored loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a limited and shrinking national pool.

"The Mission of the Alaska Pharmacists Association is to preserve, promote and lead the profession of pharmacy in Alaska."

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, LCSWs (licensed, clinical social workers), and physical therapists are all in short supply in Alaska.

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Respectfully,

Nancy O. Davis
Executive Director

E-mail: akphrmcy@alaska.net

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Alaska Pharmacists Association

Alaska Pharmacists Association
Board of Directors

RESOLUTION 2009-01

Health Care Professions Loan Repayment and Incentive Program for Alaska

WHEREAS Alaska is competing with other states and nations for the finite pool of available healthcare professionals; and

WHEREAS Alaska is suffering labor shortages in most professional healthcare occupations, and that these shortages are hitting primary care "safety net" agencies particularly hard; and

WHEREAS the harsh conditions of Alaska and the fiscal limitations of safety net clinics makes it difficult for Alaska to compete in the hiring market; and

WHEREAS the entire State of Alaska has been designated either a Health Professional Shortage Area or a Medically Underserved Area;[i] and

WHEREAS a common state-level response to these pressures is the use of financial inducements, collectively known as support-for-service programs (SFSP's), and that good outcomes have been achieved with these; and

WHEREAS national studies have determined loan repayment programs to be one of the most effective of the several SFSP strategies in terms of both recruitment and retention; and

WHEREAS a key problem is that Alaska does not have a robust support-for-service program while most other states do, many have several, and further, some of those are growing; and

WHEREAS most all other states have state-sponsored SFSP programs that influence health professionals' geographic and specialty distributions; and

WHEREAS it is well-established that many healthcare professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away; and

WHEREAS considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of healthcare personnel; and

E-mail: akphrmcy@alaska.net

203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880

WHEREAS in 2006, the Alaska Physician Supply Task Force recommended a number of specific strategies and action steps to assuring an adequate supply of physicians to meet Alaska's need, including creation of a loan repayment program; and

WHEREAS AkPhA serves as a voice on behalf of Pharmacists to preserve, promote and lead the profession of pharmacy n Alaska;

THEREFORE BE IT RESOLVED that the Alaska Pharmacists Association (AkPhA) supports the creation of a state-sponsored "Health Care Professions Loan Repayment and Incentive Program" and will advocate for the necessary authorizing and fiduciary legislation.

SUBMITTED BY:
Melanie Gibson, AkPhA President
Nancy Davis, Executive Director

DONE AND DATED THE 25th DAY OF AUGUST IN THE YEAR 2008

SIGNED BY

_____

Melanie Gibson, AkPhA Board President

[1] Alaska Center for Rural Health. *2007 Alaska Health Workforce Vacancy Study*. July 2007, http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce_7-24-07_body-final.pdf.

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Alaska Osteopathic Medical Association
142 East Ontario Street | Chicago, IL 60611
Phone 800.621.1773, ext. 8128 | Fax 312.202.8428 | Email: AKOMA@osteopathic.org

December 3, 2008

Dear Governor and Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Alaska Osteopathic Medical Association (AKOMA) strongly supports the concept of a state-sponsored loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

The mission of the AKOMA is to promote public health through providing quality, relevant and professional CME that enhances the body of knowledge and skills of those in attendance. Emphasis will be placed upon Osteopathic Practice and Principles to enable attending physicians to better serve the needs of their patients.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Health Care Professions Loan Repayment & Incentive Program proposal brings to the table an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. The proposed program designed for Alaska will provide much needed relief for our state.

AKOMA recommends the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program and requests that you actively take steps to create and fund the program.

Respectfully,

T. Capistrant

Todd Capistrant, DO
President

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."

Alaska Primary Care Association
Board of Directors

RESOLUTION 2009-02

Health Care Professions Loan Repayment and Incentive Program for Alaska

WHEREAS the Alaska Primary Care Association strives toward the goal of a healthy population, it recognizes that a robust health care workforce is necessary to provide adequate health care access for all Alaskans and is a key ingredient in improving the public health of all Alaskans; and

WHEREAS Alaska is competing with other states and nations for the finite pool of available health care professionals; and

WHEREAS Alaska is suffering from labor shortages in most professional health care occupations[1], and these shortages are hitting primary care "safety net" agencies particularly hard; and

WHEREAS most of the State of Alaska has been designated either a Health Professional Shortage Area or a Medically Underserved Area;[2] and

WHEREAS a common state-level response to these pressures is the use of financial inducements, collectively known as support-for-service programs (SFSPs), and good outcomes have been achieved with these;[3] and

WHEREAS national studies have determined loan repayment and incentive programs to be two of the most effective of the several SFSP strategies in terms of both recruitment and retention;[4] and

WHEREAS a key problem is that Alaska does not have a robust SFSP while most other states do, many have several, and further, some of those are growing;[5] and

WHEREAS most all other states have state-sponsored SFSPs that influence health professionals' geographic and specialty distributions;[6] and

WHEREAS it is well-established that many health care professionals carry a heavy debt-burden as they come out of training and are attracted to serving in those locations where a share of that burden can be taken away; and

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4523

WHEREAS for areas in the state where providers are required to work in professional isolation due to remote settings, direct incentives are needed to attract more experienced health care providers who do not carry debt and are considered desirable placements; and

WHEREAS considerable precedent exists for state-level offices to sponsor and manage financial support and inducement programs to thus encourage the within-state service of health care personnel; and

WHEREAS in 2006, the Alaska Physician Supply Task Force recommends a number of specific strategies and action steps to assuring an adequate supply of physicians to meet Alaska's need, including creation of a SFSP, and the 2007 Alaska Workforce Vacancy Study and the 2005-2006 Status of Recruitment Resources and Strategies (SORRAS II) point to the need for a state loan repayment and incentive program in order for Alaska to compete with the lower 48 to recruit from a limited pool of numerous types of health care providers nationwide; and

WHEREAS a concept proposal submitted to the Alaska Primary Care Council by Pat Carr, Chief Health Planning and Systems Development for the Department of Health and Human Services, concludes the following:

> Reported increasing vacancy rates, increasing costs of recruitment [SORRAS report], and comparisons with national norms [PSTF report] suggest that Alaska currently experiences a shortage of healthcare professionals, and, that shortages exist in several key occupational categories. Loan repayment programs have demonstrated substantial and longstanding success as a public strategy which has helped to rectify such shortages;[7] and

WHEREAS the above proposal recommends that "Alaska create a 'Health Care Professions Loan Repayment Program.' "[8]

THEREFORE BE IT RESOLVED that the Alaska Primary Care Association supports the creation of a state-sponsored "Health Care Professions Loan Repayment and Incentive Program" and will advocate for the necessary authorizing and fiduciary legislation.

SUBMITTED BY:
Regan Mattingly, State Affairs Coordinator
Shelley S. Hughes, Government Affairs Director
Marilyn Kasmar, Executive Director

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."

DONE AND DATED THE 21st DAY OF January IN THE YEAR 2009

SIGNED BY _____

Sonia Handforth-Kome, APCA Board President

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[1] Alaska Health Workforce Vacancy Study Research Summary. University of Alaska. August 2007. http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce-summary_final.pdf.

[2] US Department of Human Services, Health Resources and Service Administration. Health Professional Shortage Area. http://hpsafind.hrsa.gov/.

[3] Health Care Professions Loan Repayment Program Concept Proposal. Pat Carr, Chief Health Planning & Systems Development, Alaska DHSS. September 11, 2007. http://www.hss.state.ak.us/primarycare/assets/loan-proposal.pdf.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Health Planning & Systems Development, Alaska Department of Health & Social Services. *Health Care Professions Loan Repayment Program Concept Proposal*, September 11, 2007.

[8] Ibid.

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 17, 2009

Honorable Donald Olson
Alaska State Senate
Capitol, Room 514
Juneau, Alaska

RE: SB 139 – Recruitment Increments for Certain Health Care Professionals

Dear Senator Olson:

As you know, Dr. Olson, the Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

On behalf of all ASMA members, I thank-you for introducing SB 139. ASMA participated as one of the stake holders who came together to develop the concept for the loan repayment and direct incentive program embodied in SB 139. ASMA strongly supports SB 139 as an effective recruitment tool for physicians as well as the other health care professionals covered by the program.

Alaska competes with all other states in the recruitment of an ever shrinking pool of physicians practicing general internal medicine or family medicine. Currently only 2% of medical school graduates are choosing general internal medicine or family medicine residencies. 44 of those states already have a loan repayment or direct incentive program.

SB 139 will help to provide an important part in solving Alaska's chronic and acute (in certain practice specialties) physician workforce shortages. All of the health care system reforms aimed at providing some form of universal insurance coverage provides an empty promise so long as sufficient numbers of appropriately trained physicians (and other health care professionals) do not exist.

ASMA supports SB 139 and urges passage of this important legislation.

Again, ASMA, thanks you in your leadership and efforts to introduce and secure passage of the Alaska Health Care Professions Loan Repayment and Incentive Program.

Sincerely,

Thomas P. Vasileff

By: Thomas Vasileff, MD, President
For: The Alaska State Medical Association

Alaska Dental Society, Inc.
9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
akdental@alaska.net

Re: Support for SB-139 Incentives for Certain Medical Providers

18 March 2009

Sen. Bettye Davis
Alaska State Senate
State Capitol Rm 30
Juneau, AK 99801 + 1182

Dear Sen. Davis,

The Alaska Dental Society **supports the adoption of SB-139 as one of several steps that must be taken** by the legislature to address the growing projected shortfall of private practice dentists and other healthcare practitioners in Alaska.

This bill will provide the state with a much needed tool to provide for loan repayment and direct payment of meaningful incentives to practitioners who might not otherwise choose to establish themselves in Alaska.

Passage of this bill will provide the state, primarily through its hospitals, clinics and other institutional settings a valuable tool to recruit key providers, which the ADS supports. However, **to ensure that Alaska is able to attract dentists into private practice** – the practice model that has traditionally provided the most care to the most Alaskans and which is forecast to see the greatest need in the foreseeable future – **additional steps will need to be taken.** Therefore, while we support the passage of SB-139, we must stress that this must be done in conjunction with **expanding** the state's **participation in** the Western Interstate Commission for Higher Education **(WICHE)** program along with **meaningful reform to the Medicaid program which currently discourages dentists from participating.**

Respectfully yours,

James R. Towle
Executive Director
Alaska Dental Society -- Pursuing Policies that enhance the dental profession and the well-being of Alaskans

March 20, 2009

Re: Support for SB 139 Incentives for Certain Medical Providers

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Alaska Behavioral Health Association strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

One of our primary goals deals with Workforce Development and this bill fits well within the goal to assure that a well trained adequate workforce is available to behavioral health providers.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants, behavioral health clinicians, addiction professionals, and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

The Alaska Behavioral Health Association supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

In Health,

Steve Horn
Executive Director

2009 abha Membership

Organization	Community
Akeela	Anchorage
Alaska Children's Services	Anchorage
Alaska Family Services	Palmer
Alaska Island Community Services	Wrangell
Alaska Youth & Family Network	Anchorage
Anchorage Community Mental Health Services (Southcentral Counseling)	Anchorage
Arc of Anchorage	Anchorage
Assets, Inc.	Anchorage
Mat-Su Health Services	Wasilla
Bristol Bay Counseling Center (BBAHC)	Dillingham
Boys and Girls Home of Alaska	Fairbanks
Catholic Community Service	Juneau
The Center	Homer
Community Connections, Inc.	Ketchikan
Denali Family Services	Anchorage
Edgar Nollner Health Center	Galena
Fairbanks Community Behavioral Health Center, Inc.	Fairbanks
Fairbanks Native Association	Fairbanks
Family Centered Services of Alaska	Fairbanks

Organization	Community
Frontier Community Services	Soldotna
Gateway Center for Human Services	Ketchikan
Impact Counseling	Haines
Juneau Alliance for Mental Health, Inc.	Juneau
Juneau Youth Services	Juneau
Kenai Peninsula Care Center	Kenai
Lynn Canal Counseling	Haines
Maniilaq Association	Kotzebue
North Star Behavioral Health System	Anchorage
Peninsula Community Health Services	Soldotna
Petersburg Mental Health Services, Inc.	Petersburg
Rainbelt MH and Addictions	Nenana
SEARHC - Behavioral Health Service Division	Sitka
SeaView Community Services	Seward
Sitka Counseling and Prevention Services	Sitka
Southcentral Foundation Behavioral Health Services	Anchorage
Volunteers of America of AK	Anchorage
Yukon-Kuskokwim Health Corporation	Bethel

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Iliuliuk Family and Health Services, Inc.
P.O. Box 144
Unalaska, Alaska 99685
Phone: (907) 581-1202
Fax: (907) 581-2331

Re: Support for SB 139 Incentives for Certain Medical Providers

March 17, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, Iliuliuk Family and Health Services, Inc. (IFHS) strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

Our organization, IFHS, is the only comprehensive service provider for medical, dental and behavioral health services within 800 air miles of Unalaska. We are remote, and we frequently find that we are unable to compete with "lower 48" medical practices for providers, since we also cannot compete effectively with salaries. State loan repayment options for our providers would help us offer a competitive package.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

It takes IFHS over a year to recruit a single doctor; six months to recruit a behavioral health specialist, and the last time we recruited a dentist, it took us four years to do so. We cannot recruit RNs – we have had two open RN positions for over two years. A state-sponsored support-for-service program would help make our recruitment package more appealing and more competitive.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB

139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

IFHS supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Sonia Handforth-Kome
Executive Director

Re: Support for SB 139 Incentives for Certain Medical Providers

March, 19, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, I strongly support SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

In my roll as clinical site director for the U.W. DENTEX Training Center, I have had the opportunity to hear about the difficulties health care facilities in Alaska have in recruiting and retaining providers.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

There is already a crisis of dental care access in rural Alaska. We have large numbers of our Alaska Native population who cannot access even the basic services needed, such as a yearly exam or treatment for urgent dental needs. The caries rate is 2 ½ times the national rate in our rural communities. Headstart programs struggle to find local providers to perform the mandatory evaluations for their students, many programs resort to bringing in outside providers at great expense. Teeth are left untreated until it is too late to restore them, because there are not appointments available for routine care. Our communities should not have to suffer with the pain and cost of untreated disease.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

I support SB 139 and urge passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Mary E. Williard, DDS
Clinical Site Director
ANTHC Division of Community Health Services
U.W. DENTEX Training Center
4200 Lake Otis Parkway, Suite 204
Anchorage, AK 99508

Maniilaq Association

Maniilaq Health Center

Administration

Phyllis Boskofsky RN
Hospital Administrator
P.O. Box 43, 436 5th & Stevens Way
Kotzebue, AK 99752
Phone (907) 442-7319
FAX (907) 442-7250

Re: Support for SB 139 Incentives for Certain Medical Providers

March 20, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, especially in remote regions such as ours, the Maniilaq Health Center (MHC) strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

In order for the Maniilaq Health Center to meet its Mission Statement:
"The Maniilaq Health Center provides comprehensive health care to all the people in our service area while promoting prevention, fitness, wellness, holistic strategies, and incorporating local traditional core values and beliefs", its Vision Statement: ***"All customers of Maniilaq health services, including its employees, are empowered, and involved partners in its high quality services and healing atmosphere"***, and its Purpose statement: ***"We are a family of care, helping every person live a healthier life"***, we must have a trained healthcare workforce.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult, and becomes even more difficult as you leave urban area facilities for remote facilities such as MHC. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

Maniilaq Health Centers Professional Vacancy Rates

MD/DO Vacancies	3 vacancies out of 9 positions = 30% vacancy rate
Dentist Vacancies	3 vacancies out of 5 positions= 60% vacancy rate
Pharmacist Vacancies	3 vacancies out of 4 positions= 75% vacancy rate
Registered Nurse Vacancies	12 vacancies out of 24 positions = 50% vacancy rate
Physical Therapist	1 vacancy for > 2 years= 100% vacancy rate

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

The Maniilaq Health Center supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Phyllis A. Boskofsky
Hospital Administrator

Alaska Primary Care Association

"...uncompromising in the pursuit of access to primary care for all Alaskans."

The Honorable Senator Olson
Alaska State Senate
State Capitol, Room 514
Juneau, Alaska 99801-1182

Re: Support for Incentives for Certain Medical Providers – SB 139

March 18, 2008

Dear Senator Olson,

The Alaska Primary Care Association (APCA) represents 26 health care organizations and 141 Community Health Centers (CHCs), as well as other safety net providers throughout Alaska. The APCA knows firsthand that workforce shortages can affect access to health care services in Alaska's Community Health Centers. In 2007, our sites provided primary health care services to over 80,000 patients despite suffering a severe 35% shortage of primary care physicians and a 22% shortage of midlevel providers at Community Health Centers.[1] In fact, Alaska's CHCs have current vacancies for an estimated 22 physicians, 20 physician assistants, 26 nurse practitioners, 6 dentists, and 10 licensed certified social workers – to name a few.

Alaska is suffering from labor shortages in most professional health care occupations[2], while most of the State of Alaska has been designated either as a Health Professional Shortage Area or a Medically Underserved Area[3]. All but six states have addressed similar professional health provider shortages by implementing support-for-service programs which have helped to attract and retain health care providers[4].

The Alaska Primary Care Association supports SB 139 and the creation of a state-sponsored "Health Care Professions Loan Repayment and Incentive Program" to help fill vacancies and help health care facilities recruit and retain health care professionals.

We appreciate your hard work and service to Alaskans and support your efforts to expand access to health care for all Alaskans.

Respectfully,

Regan Mattingly
State Affairs Coordinator

Shelley S. Hughes
Government Affairs Director

[1] Bureau of Primary Health Care. "Alaska Section 330 Grantees Uniform Data System (Provider Utilization)."
2 Alaska Health Workforce Vacancy Study Research Summary. University of Alaska. August 2007. http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce-summary_final.pdf.
3 US Department of Human Services, Health Resources and Service Administration. Health Professional Shortage
4 Health Care Professions Loan Repayment Program Concept Proposal. Pat Carr, Chief Health Planning & Systems Development, Alaska

Alaska Primary Care Association
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www.alaskapca.org

ASDHA
Alaska State Dental Hygienists' Association

P.O. Box 240247 " Anchorage, AK 99524 " www.asdha.com

Re: Support for SB 139--Incentives for Certain Medical Providers

March 23, 2009

Dear Senate and House Members of the Alaska State Legislature:

The Alaska State Dental Hygienists' Association (ASDHA) supports Senate Bill 139 to establish a loan repayment and incentive program. This legislation addresses the shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals that provide direct patient care.

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. This legislation would allow Alaska to compete with other states in the recruitment of numerous providers and help fill the alarming number of vacancies that exist.

Senate Bill 139 provides incentives for dental professionals, including dentists and dental hygienists. While current practice act limitations exist for direct patient care by dental hygienists, we are hopeful SB 139 will attract more dentists and dental hygienists to our state and to rural communities. With up to eighteen dental hygiene students graduating from Alaska universities yearly, we believe SB 139 would provide an additional incentive for them to stay.

The ASDHA supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Gail Walden

Gail Walden, RDH
Alaska State Dental Hygienists' Association

SEARHC
SouthEast Alaska Regional Health Consortium
3245 Hospital Drive, Juneau, AK 99801
907 463-4000 • www.searhc.org

Re: Support for SB 139 Incentives for Certain Medical Providers

March 20, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the SEARHC Ethel Lund Medical Center strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

The SEARHC Ethel Lund Medical Center provides comprehensive outpatient care to Alaska Native/Native American patients in the Juneau area (over 7,000 active patients). We have found recruitment of health providers to be extremely challenging, including physicians, physician assistants, pharmacists, physical therapists, optometrists, and other health care professionals. Almost all potential applicants request loan repayment. Juneau does not qualify for any loan-repayment program, and this puts us at a significant disadvantage in recruiting health care providers.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage that we here at SEARHC Juneau, and that the rest of Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

The SEARHC Ethel Lund Medical Center supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Janice Sheufelt, MD

Janice Sheufelt, MD
Medical Director
SEARHC Ethel Lund Medical Center
Juneau, Alaska

UAA UNIVERSITY of ALASKA ANCHORAGE

School of Social Work

Re: Support for SB 139 Incentives for Certain Medical Providers

Month, 24, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the faculty of the University of Alaska Anchorage School of Social Work strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

The UAA School of Social Work provides educational opportunities for students seeking Bachelor and Masters degrees in social work. Unfortunately, the demand for social workers exceeds our graduation rate. Therefore, it becomes necessary for social service providers to recruit social workers from the lower 48. The costs of recruitment and retention frequently out weigh the ability of urban and rural providers to bring social workers to Alaska.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

Social work is one of the fastest growing professions, with high vacancy rates nationally. The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

The faculty of the UAA School of Social Work supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Elizabeth A. Sirles, Director
UAA School of Social Work

3211 Providence Drive • Anchorage, Alaska 99508-4614 • T 907.786.6900 • F 907.786.6912 • http://socialwork.uaa.alaska.edu

Nome Eskimo Community
Box 1090
Nome, Alaska 99762
Phone (907) 443-2246
Fax (907) 443-3539

March 23, 2009

RE: Support for SB 139 Incentives for Health Care Professions

Dear Senate and House Members of the Alaska State Legislature:

The Nome Eskimo Community strongly supports SB 139 that would establish a loan repayment and incentive program for health care professions in Alaska. The on-going healthcare workforce shortage in Alaska significantly impacts access to and continuity of health care for our residents and the creation of such a program could be a solution to address a critical shortage in our state.

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program. The competition for recruitment of providers is very difficult and the establishment of this program would allow Alaska to compete with the lower 48 for the recruitment of much needed medical providers. Alaska is experiencing a crisis: we have more than 90 pharmacist vacancies in Alaska; many communities have inadequate, if any, access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit, and nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply statewide.

Loan repayment and incentive programs have been proven to effectively alleviate workforce shortage problems in other states and the Alaska Health Care Professions Loan Repayment & Incentive Program could be part of the solution to address this issue in Alaska. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention, and with input from stakeholders statewide that includes consideration of factors that are unique to Alaska; SB 139 will establish a program customized for Alaska.

The Nome Eskimo Community fully supports and encourages the passage of SB 139. Your support to assure the establishment of the Alaska Health Care Professions and Loan Repayment & Incentive program is greatly appreciated.

Respectfully,

NOME ESKIMO COMMUNITY

Denise Barengo, Executive Director

ALASKA PUBLIC HEALTH ASSOCIATION

Committed To Advancing Alaska's Public Health Since 1978

ALPHA

March 20, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the Alaska Public Health Association (ALPHA) strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

With alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

ALPHA supports SB 139 and urges passage of this important legislation. Your active steps to assure the establishment of the Alaska Health Care Professions Loan Repayment & Incentive Program are greatly appreciated.

Respectfully,

Jayne Andreen

President
ALPHA Board of Directors

P.O. Box 9-1825 Anchorage, AK 99509 907/332-1030 *e-mail:* publichealth@alaska.net
www.alaskapublichealth.org

4540

AARP

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 25, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 139 (Olson)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 139, authored by Senator Donald Olson and co-sponsored by Senators Bill Wielechowski, Kevin Meyer and you.

As you know, Alaska has a chronic shortage of health professionals. We compete with the other states who all have their own shortages. SB 139 follows a proven tradition of recruitment incentives by providing loan forgiveness and economic incentives to encourage health professionals to practice in our state. We understand that there is a cost to recruitment and retention. We also understand that there is a greater cost when our citizens are unable to secure the services of health professionals.

AARP requests an "AYE" vote on SB 139.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Donald Olson

P.O. Box 787 (Mile 4.4 Talkeetna Spur Road) Talkeetna, AK 99676 (Ph) (907) 733-2273 (Fax) (907) 733-1735 schc@sunshineclinic.org

RE: Support for SB 139 Incentives Alaska Health Care Professions Loan Repayment & Incentive Program

March 25, 2009

Dear Senate and House Members of the Alaska State Legislature:

Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, Sunshine Community Health Center (SCHC) strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

SCHC's mission is to assist people in the upper Susitna Valley to meet their health care responsibilities by providing affordable, accessible, quality health care, including preventive aspects, to all people regardless of their ability to pay for services. We are a safety-net provider, with our primary focus on patients who are uninsured and unable to pay for basic medical care. We operate two clinics, one in Talkeetna that is open 6 days a week and one in Willow that is open 5 days a week.

The biggest obstacle to accomplishing our mission is our inability to fully staff the organization with the number of medical, dental, and mental health providers we need. As of this writing, SCHC has been recruiting unsuccessfully for a medical provider to staff our Willow clinic for 3 years. We have been recruiting for a full-time mental health professional for 2 years, a nurse for 1 year, and a dentist for 6 months. Two years ago, unsuccessful recruiting and unexpected vacancies shrank our staff of five medical providers (not including dental and mental health) to just two medical providers covering both clinics, and since then we have never been fully staffed.

Our efforts at recruitment during this period have attracted a high level of interest from providers interested in relocating to our community because of the attractive quality of life we offer. Unfortunately, once excitement gives way to realism, the following factors dissuade them from actually accepting a position and moving here:

- the high cost of student loans; medical and dental graduates average over $100,000 of student debt;
- moving expenses;
- high cost of living in Alaska;
- the escalating cost of health insurance.

SCHC's experience is not unusual. With alarming and rising vacancy rates, Alaska is poised for a crisis unless there is some new intervention. Alaska is one of only six states without a state-sponsored incentive program such as a loan repayment program. The competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

Sunshine Community Health Center supports SB 139 and urges passage of this important legislation. Your support and action on this matter are greatly appreciated.

Respectfully,

Mary Loeb, MD
Medical Director of Sunshine Community Health Center

Alaska Native
Tribal Health Consortium

Administration · 4000 Ambassador Drive · Anchorage, Alaska 99508 · Phone: (907) 729-1900 · Fax: (907) 729-1901 · www.anthc.org

POSITION PAPER

CONTACT: Valerie Davidson, Senior Director
Legal and Intergovernmental Affairs
Through Pat Jackson, State Liaison for Alaska Native Health
523-0363 – pajackson@anthc.org

DATE: March 24, 2009

RE: SB 139 - "An Act establishing a loan repayment program and employment incentive program for certain health care professionals employed in the state; and providing for an effective date."

POSITION: Support

The Alaska Native Tribal Health Consortium (ANTHC) strong supports SB 139 – Incentives for Certain Medical Providers.

ANTHC is a tribally controlled, non-profit, statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. It is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. ANMC has 139 physicians, 37 dentists and 500 nurses on staff, along with many more employees working in health-related professions. We have the same workforce challenges our partner health organizations in Alaska face, competing with employers in the Lower 48 to recruit and retain a quality workforce.

Ideally we would "grow our own" health professionals in numbers that would meet our workforce needs. We have made progress over the years—the tribal health system offers internships and scholarships that bring some of our best and brightest to the medical field. More Alaska Natives are choosing Medical and Dental careers; a University of Alaska Anchorage program, Recruitment and Retention of Alaska Natives into Nursing, is graduating more Alaska Native nurses; many of our Community Health Aides have built on their basic training opportunities to prepare for advancing careers; and the Dental Health Aide Program is graduating students who fill a need for dental health services and patient education. But we are increasingly challenged in our efforts to recruit health professionals.

We understand Alaska is only one of six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and that national studies on workforce recruitment and retention have found that loan repayment and incentives are among the most effective way to help alleviate workforce shortages. ANTHC urges your favorable consideration and passage of SB 139 to help us turn the corner on Alaska's health care workforce.

State of Alaska

Department of Revenue

Administrative Services Division

SARAH PALIN, GOVERNOR
333 Willoughby Avenue, 11th Floor
P.O. Box 110400
Juneau, Alaska 99811-0405
Phone: (907) 465-2300
Fax: (907) 465-2394

March 27, 2009

The Honorable John Coghill
Rules Chair, House of Representatives
Alaska State Capitol, Room 214
Juneau, AK 99801

Dear Representative Coghill;

A separate letter should be entered on the record to clarify a sentence in the March 16, 2009 letter to Senator Hollis French. This sentence has been used on correspondence to your office as well. The letter is posted on-line in Basis under "Documents" for SB96. The clarification letter should include the following:

"This letter clarifies that the proposed Uniform Interstate Family Support Act (UIFSA) amendment to SB 96 does not grant authority to Indian tribes either to issue or serve an income withholding order on an employer in the State of Alaska. UIFSA defines the employer's responsibility when the employer receives an income withholding order. Employers in the State of Alaska will be required to comply with income withholding orders issued by an Indian tribe as provided in AS 25.25.501-07."

The same sentence is also found in the March 20, 2009 letter to Representative Coghill.

Thank you for working with us on this issue.

Sincerely,

Ginger Blaisdell
Director

UAA UNIVERSITY of ALASKA ANCHORAGE
Dental Clinic

Re: Support for SB 139 Incentives for Certain Medical Providers

March 15 2009

Dear Senate and House Members of the Alaska State Legislature:
Senator Bettye Davis, Chair, and Members of the Senate HSS Committee

The University of Alaska Anchorage Dental Hygiene Program has produced successful candidates for over thirty years, our graduates placing second nationally in two of the last three years. Our goal is to prepare professionals who are familiar with the most advanced technology and evidenced-based practice and proficient in providing a wide range of dental services to diverse populations in a caring manner. It is a well known fact that we face an increasing demand for dental care with the burgeoning senior population, in addition to the many citizens who lack access to care. Poor dental health directly compromises systemic health, and contributes to a myriad of complications when not addressed. Our rural population suffers the most. Because the health care workforce shortage in Alaska is reducing health care access for our state's residents, the University of Alaska Anchorage Dental Hygiene Program strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete with the lower 48 in recruitment of providers from a shrinking national pool.

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program. The competition for recruitment of providers is very difficult. Due to alarming and rising vacancy rates, Alaska is posed for a crisis without intervention. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacist vacancies exist in Alaska; many communities have inadequate access to dentists or hygienists; physician assistants and nurse practitioners are increasingly difficult to recruit. Dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska.

The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces by providing more support to those willing to serve at risk populations. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. Loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states, proving less costly and more effective than other methods. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

The University of Alaska Anchorage Dental Hygiene Program supports SB 139 and strongly recommends passage of this important legislation.

Respectfully,

Elizabeth Barnett, Clinic Director
UAA Dental Hygiene Program
3211 Providence Drive
Allied Health Science Bldg #121
Anchorage, Alaska 99508
barnett@uaa.alaska.edu
907.786.6926

Comments Regarding Senate Bill 139

These comments are unsolicited support for Senate Bill 139.

My name is David Head, M.D. I have practiced medicine in Nome, Alaska at Norton Sound Health Corporation nearly 21 years, 20 of those years as Chief of Staff. I have also served on the Alaska State Medical Board for the last 7 years, 4 of those years as the Chairman for the Board. In addition I have served on multiple State and National committees and advisory groups regarding Physician Shortage and recruitment and retention strategies.

It is these experiences that cause me to be such a strong supporter for **Senate Bill 139**.

At this time Alaska is entering a crisis situation when it comes to adequate medical providers. For the first 15 years that I was in Nome, if we had a vacancy open up we were able to pick and choose between several qualified, experienced and well educated physicians to fill that slot. We had no difficulty maintaining a full staff. During the last 5 years this has changed dramatically. The national shortage of primary care physicians, along with the dramatic increase in the cost of living in Bush Alaska has led us into operating in crisis mode. We have slowly gone from a full time staff of 8 physicians to now 3. We scramble to maintain adequate coverage with temporary "traveling doctors", often going through 20-30 different physicians per year to provide basic care. This makes it near impossible to maintain the high quality level of care that the people of this area have become accustomed to, as well as burning out our regular doctors. We have hired recruitment firms that over the last 3 years have only been able to find 2 doctors that would even come for interview. Although I do not see Senate Bill 139 as the "cure all", I do believe it offers immediate aid and will greatly help give us additional chips to play in this game of attracting the professionals that we so greatly need until other more long term answers can be found.

Thank you for your time and dedicated service.

David Head, M.D
Chief of Staff
Norton Sound Health Corporation
Nome, Alaska

From: Barbara Hale [mailto:bfhale1@msn.com]
Sent: Sunday, April 05, 2009 3:44 PM
To: Sen. Bettye Davis; Sen. Joe Paskvan; Sen. Johnny Ellis; Sen. Joe Thomas; Sen. Fred Dyson
Cc: Sen. Donny Olson; Sen. Bill Wielechowski; Sen. Kevin Meyer; Natalie Hale
Subject: The Alaska Health Care Professions Loan Repayment & Incentive Program
Importance: High

Dear Senators Davis, Paskvan, Ellis, Thomas and Dyson,

Alaska is one of only six states without a state-sponsored support-for-service program such as a loan repayment and incentive program and is losing ground. Competition for recruitment of providers is very difficult. Currently only 2% of medical students nationally are choosing the primary care field; more than 90 pharmacists vacancies exist in Alaska; many communities have inadequate access to dentists; physician assistants and nurse practitioners are increasingly difficult to recruit; nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists are all in short supply in Alaska. The Alaska Health Care Professions Loan Repayment & Incentive Program provides an important part of the solution to the workforce shortage Alaska faces. This proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. Loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. This proposal is more cost-efficient and results-producing than other methods.

My daughter, Natalie Hale, will be entering her first year of medical school in August at the University of Washington WWAMI program in Anchorage. With more than $50,000 in student loan debt from her undergraduate studies at Yale already, the Alaska Health Care Professions Loan Repayment and Incentive Program will offer an incentive and encouragement for her to be able to pursue her first love, public health policy and primary care, here in Alaska. Thank you all for your consideration of this important policy under SB 139 to help alleviate health care shortages that Alaska is experiencing and to help retain providers who begin their studies here.

Best Regards,
Barbara Hale
P.O. Box 240211
Douglas, AK 99824-0211
907-586-6590

Alaska Native Health Board

1840 Bragaw Street, Suite 220
Anchorage, Alaska 99508

Phone: (907) 562-6006
Fax: (907) 563-2001

April 3, 2009

Senator Donny Olson
State Capital Building, Room 514
Juneau, Alaska 99801-1182

Dear Senator Olson,

We write to express our support for SB 139, an act establishing a health professions loan repayment program and employment incentive program. **Alaska is one of only six states without a state-sponsored health professions support-for-service program such as a loan repayment and incentive program.** This, in combination with national health profession shortage dynamics, has given rise to an alarming vacancy rate among health professions in Alaska, particularly for Alaska Tribal providers, many of whom are located in remote rural areas of Alaska, and many of whom are the only health providers in their regions.

The competition for recruitment of providers is very difficult. Nationally, only 2% of medical students are choosing the primary care field. In Alaska, there are more than 90 pharmacist vacancies, many in rural areas. Many communities, particularly in rural areas, have well-documented shortages of dentists, physician assistants, nurse practitioners, nurses, dental hygienists, psychologists, licensed certified social workers, and physical therapists.

SB 139 provides an important part of the solution to the workforce shortage Alaska faces. The proposal was developed after careful review of national studies of best practices for workforce recruitment and retention and input from stakeholders statewide, including consideration of factors unique to Alaska. More cost-efficient and results-producing than other methods, loan repayment and incentives have been shown to effectively help alleviate shortage problems in other states. SB 139 establishes a loan repayment and incentive program customized for Alaska and will provide much needed relief for our state.

Because of the severe impact of the health workforce shortage on healthcare access for Alaska's residents, particularly among Alaska Natives and others served by Alaska Tribal health providers, the Alaska Native Health Board strongly supports SB 139 to establish a loan repayment and incentive program to allow Alaska to compete in recruitment of health professionals from a shrinking national labor pool.

Respectfully,

Evangelyn Potomain
President/CEO

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/9/09

FURTHER: Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 4/7/09

Health and Social Services Committee considered SENATE BILL NO. 139

SB 139 INCENTIVES FOR CERTAIN MEDICAL PROVIDERS

"An Act establishing a loan repayment program and employment incentive program for certain health care professionals employed in the state; and providing for an effective date."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB139 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[✓] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS/MAA	3/23	✓			1
EED/ACPE	3/20			✓	2

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Ellis	✓			
	Thomas	✓			
	Dyer				✓
	Parkman	X			
CHAIR: Bettye Davis	DAVIS	X			

CS FOR SENATE BILL NO. 139(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS OLSON, Wielechowski, Meyer, Davis

A BILL

FOR AN ACT ENTITLED

"An Act establishing a loan repayment program and employment incentive program for certain health care professionals employed in the state; and providing for an effective date."

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

*** Section 1.** AS 14.43 is amended by adding new sections to read:

Article 8A. Health Care Professions Loan Repayment.

Sec. 14.43.430. Loan repayment; purpose. (a) The commission shall repay a portion of education loans made to eligible tier I and tier II health care professionals under the health care professions loan repayment and employment incentive program established in AS 18.29.010 and the loan repayment procedures established under this section.

(b) The Department of Health and Social Services shall administer the health care professions loan repayment program under AS 18.29.010 - 18.29.099. The commission shall act as a disbursing agent in carrying out the provisions of

AS 14.43.430 - 14.43.449.

(c) Loan repayments under this section shall be made with funds appropriated by the legislature for that purpose. The loan repayments made under this section do not constitute a financial obligation of the corporation.

Sec. 14.43.435. Eligibility. To be eligible for loan repayment under AS 14.43.430, an individual must

(1) meet eligibility and priority criteria established under AS 18.29.030;

(2) have an unpaid balance on one or more education loans verified by the commission; and

(3) meet other criteria established by the commission.

Sec. 14.43.440. Conditions and limitations on loan payments. (a) A loan repayment under AS 14.43.430 - 14.43.449 shall be in an amount not to exceed 33.3 percent of the unpaid loan balance existing in the first year of program participation, multiplied by the percentage of full time equivalent employment for each of up to three years of qualified employment less a matching loan or incentive amount from an employer or other entity as determined under AS 18.29.020.

(b) The commission shall make a loan repayment under this section in quarterly installments payable to the lending institution. A loan repayment made under this section may not exceed the annual benefit amounts established under AS 18.29.020(b). The commission may not make a loan repayment installment for an employment period of less than one calendar quarter.

(c) A loan or interest on a loan is not eligible for repayment under this section if the loan or interest is eligible for repayment from another source, including another loan repayment or forgiveness program or an employer-sponsored repayment program.

Sec. 14.43.449. Definitions. In AS 14.43.430 - 14.43.449,

(1) "qualified employment" has the meaning given in AS 18.29.099;

(2) "tier I health care professional" means a dentist, pharmacist, or physician;

(3) "tier II health care professional" means a dental hygienist,

registered nurse, certified nurse practitioner, physician assistant, physical therapist, clinical psychologist, or clinical social worker holding at least a master's degree in social work.

* **Sec. 2.** AS 18 is amended by adding a new chapter to read:

Chapter 29. Health Care Professions Loan Repayment and Incentive Program.

Sec. 18.29.010. Health care professions loan repayment and incentive program; purpose; advisory body. (a) The health care professions loan repayment and incentive program is established in the department for the purpose of addressing the worsening shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals who provide direct patient care.

(b) The program established under this section must include

(1) loan repayments made under AS 14.43.430 - 14.43.449;

(2) direct incentives paid under AS 18.29.020;

(3) procedures for the commissioner's designation and prioritization of sites eligible for participation in the program;

(4) an application process for participation in the program as

(A) an eligible site; or

(B) a tier I or tier II health care professional;

(5) the dissemination of public information and notices pertinent to the program;

(6) classification by the commissioner of each eligible site as having either regular or very hard-to-fill positions, or both;

(7) a lifetime maximum period of six years for participation in the loan repayment and direct incentive aspects of the program by a tier I or tier II health care professional; and

(8) annual program evaluations and reports.

(c) Except as provided under AS 14.43.430, the program shall be administered by the commissioner in consultation with an advisory body appointed by the commissioner. The advisory body is made up of members with health care expertise, including expertise in economic issues affecting the hiring and retention of health care

professionals in the state. Members of the advisory body serve at the pleasure of the commissioner to provide recommendations for and oversight and evaluation of all aspects of the program. The commissioner shall accept a recommendation of the advisory body on a matter pertaining to the identification and monitoring of areas of shortages, eligible sites, payment priorities, or evaluation of the program, unless the commissioner finds, in writing, that the recommendation cannot be financially or otherwise supported by the department.

Sec. 18.29.020. Direct incentives. (a) The department shall provide direct incentives in the form of quarterly cash payments to eligible tier I and tier II health care professionals engaged in qualified employment. The department may not make an incentive payment

(1) before the employment period begins;

(2) for a period of qualified employment of less than three months; or

(3) under a contract term that is less than one calendar quarter.

(b) Payments made under this section, when combined with a loan repayment amount paid under AS 14.43.440, if any, may not exceed

(1) $35,000 annually for a tier I health care professional employed in a regular position;

(2) $47,000 annually for a tier I health care professional employed in a very hard-to-fill position;

(3) $20,000 annually for a tier II health care professional employed in a regular position; or

(4) $27,000 annually for a tier II health care professional employed in a very hard-to-fill position.

(c) The commissioner shall calculate the annual incentive payment amount by multiplying the annual maximum payment under (b) of this section by the percentage of full time equivalent employment for each of not more than three years of qualified employment less a matching payment amount as determined under (d) of this section and loan repayment amount, if any, under AS 14.43.440.

(d) An employer or other entity that employs an eligible tier I or tier II health care professional at an eligible site shall make nonrefundable quarterly matching

payments to the department. The payments must be in an amount that is

(1) not more than half of the combined annual incentive payment made under (c) of this section and the loan repayment amount paid under AS 14.43.440(a), as determined by the commissioner; and

(2) based on the employer's or entity's ability to pay, as determined by the commissioner, in consultation with the program advisory body.

(e) A payment made under (d) of this section shall be combined with the payment made to the professional by the department.

Sec. 18.29.030. Eligibility and priority. (a) To be eligible for a direct incentive payment under AS 18.29.020, an individual shall

(1) submit an application on a form approved by the commissioner;

(2) be engaged in qualified employment;

(3) be licensed as a tier I or tier II health care professional in the state within 90 days after the first day of employment;

(4) meet a priority for payment established under (b) of this section; and

(5) meet other criteria established by the commissioner.

(b) The commissioner shall establish priorities for payment of a loan and incentive under the program based on the recommendations of the program advisory body and the availability of funding. The commissioner shall prioritize eligible sites based on the percentage of patients treated at the site who

(1) are uninsured;

(2) have or are eligible for medical assistance or Medicare coverage; or

(3) have or are eligible for other federal health program benefits.

Sec. 18.29.099. Definitions. In AS 18.29.010 - 18.29.099,

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

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

(3) "eligible site" means a service area or health care facility that the commissioner has designated as located in a health care services shortage area based on a needs assessment and employment statistics for qualified tier I or tier II health

care professionals;

(4) "program" means the health care professions loan repayment and incentive program;

(5) "qualified employment" means employment of a tier I or tier II health care professional at an eligible site at which the health care professional is hired and paid to work

(A) in a full-time or not less than half-time position;

(B) for a contract term that is not less than three years; and

(C) not less than 50 percent time on direct patient health care services;

(6) "tier I health care professional" means a dentist, pharmacist, or physician;

(7) "tier II health care professional" means a dental hygienist, registered nurse, certified nurse practitioner, physician assistant, physical therapist, clinical psychologist, or clinical social worker holding at least a master's degree in social work.

*** Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

26-LS0503\P
Mischel
3/25/09

CS FOR SENATE BILL NO. 139( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS OLSON, Wielechowski, Meyer, Davis

i Comm' the
moved & accepted
4/6/09

A BILL

FOR AN ACT ENTITLED

"An Act establishing a loan repayment program and employment incentive program for certain health care professionals employed in the state; and providing for an effective date."

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

*** Section 1.** AS 14.43 is amended by adding new sections to read:

Article 8A. Health Care Professions Loan Repayment.

Sec. 14.43.430. Loan repayment; purpose. (a) The commission shall repay a portion of education loans made to eligible tier I and tier II health care professionals under the health care professions loan repayment and employment incentive program established in AS 18.29.010 and the loan repayment procedures established under this section.

(b) The Department of Health and Social Services shall administer the health care professions loan repayment program under AS 18.29.010 - 18.29.099. The commission shall act as a disbursing agent in carrying out the provisions of

AS 14.43.430 - 14.43.449.

(c) Loan repayments under this section shall be made with funds appropriated by the legislature for that purpose. The loan repayments made under this section do not constitute a financial obligation of the corporation.

Sec. 14.43.435. Eligibility. To be eligible for loan repayment under AS 14.43.430, an individual must

(1) meet eligibility and priority criteria established under AS 18.29.030;

(2) have an unpaid balance on one or more education loans verified by the commission; and

(3) meet other criteria established by the commission.

Sec. 14.43.440. Conditions and limitations on loan payments. (a) A loan repayment under AS 14.43.430 - 14.43.449 shall be in an amount not to exceed 33.3 percent of the unpaid loan balance existing in the first year of program participation, multiplied by the percentage of full time equivalent employment for each of up to three years of qualified employment less a matching loan or incentive amount from an employer or other entity as determined under AS 18.29.020.

(b) The commission shall make a loan repayment under this section in quarterly installments payable to the lending institution. A loan repayment made under this section may not exceed the annual benefit amounts established under AS 18.29.020(b). The commission may not make a loan repayment installment for an employment period of less than one calendar quarter.

(c) A loan or interest on a loan is not eligible for repayment under this section if the loan or interest is eligible for repayment from another source, including another loan repayment or forgiveness program or an employer-sponsored repayment program.

Sec. 14.43.449. Definitions. In AS 14.43.430 - 14.43.449,

(1) "qualified employment" has the meaning given in AS 18.29.099;

(2) "tier I health care professional" means a dentist, pharmacist, or physician;

(3) "tier II health care professional" means a dental hygienist,

registered nurse, certified nurse practitioner, physician assistant, physical therapist, clinical psychologist, or clinical social worker holding at least a master's degree in social work.

*** Sec. 2.** AS 18 is amended by adding a new chapter to read:

Chapter 29. Health Care Professions Loan Repayment and Incentive Program.

Sec. 18.29.010. Health care professions loan repayment and incentive program; purpose; advisory body. (a) The health care professions loan repayment and incentive program is established in the department for the purpose of addressing the worsening shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals who provide direct patient care.

(b) The program established under this section must include

(1) loan repayments made under AS 14.43.430 - 14.43.449;

(2) direct incentives paid under AS 18.29.020;

(3) procedures for the commissioner's designation and prioritization of sites eligible for participation in the program;

(4) an application process for participation in the program as

(A) an eligible site; or

(B) a tier I or tier II health care professional;

(5) the dissemination of public information and notices pertinent to the program;

(6) classification by the commissioner of each eligible site as having either regular or very hard-to-fill positions, or both;

(7) a lifetime maximum period of six years for participation in the loan repayment and direct incentive aspects of the program by a tier I or tier II health care professional; and

(8) annual program evaluations and reports.

(c) Except as provided under AS 14.43.430, the program shall be administered by the commissioner in consultation with an advisory body appointed by the commissioner. The advisory body is comprised of members with health care expertise, including expertise in economic issues affecting the hiring and retention of health care

professionals in the state. Members of the advisory body serve at the pleasure of the commissioner to provide recommendations for and oversight and evaluation of all aspects of the program. The commissioner shall accept a recommendation of the advisory body on a matter pertaining to the identification and monitoring of areas of shortages, eligible sites, payment priorities, or evaluation of the program, unless the commissioner finds, in writing, that the recommendation cannot be financially or otherwise supported by the department.

Sec. 18.29.020. Direct incentives. (a) The department shall provide direct incentives in the form of quarterly cash payments to eligible tier I and tier II health care professionals engaged in qualified employment. The department may not make an incentive payment

(1) before the employment period begins;

(2) for a period of qualified employment of less than three months; or

(3) under a contract term that is less than one calendar quarter.

(b) Payments made under this section, when combined with a loan repayment amount paid under AS 14.43.440, if any, may not exceed

(1) $35,000 annually for a tier I health care professional employed in a regular position;

(2) $47,000 annually for a tier I health care professional employed in a very hard-to-fill position;

(3) $20,000 annually for a tier II health care professional employed in a regular position; or

(4) $27,000 annually for a tier II health care professional employed in a very hard-to-fill position.

(c) The commissioner shall calculate the annual incentive payment amount by multiplying the annual maximum payment under (b) of this section by the percentage of full-time-equivalent employment for each of not more than three years of qualified employment less a matching payment amount as determined under (d) of this section and loan repayment amount, if any, under AS 14.43.440.

(d) An employer or other entity that employs an eligible tier I or tier II health care professional at an eligible site shall make nonrefundable quarterly matching

payments to the department. The payments must be in an amount that is

(1) not more than half of the combined annual incentive payment made under (c) of this section and the loan repayment amount paid under AS 14.43.440(a), as determined by the commissioner; and

(2) based on the employer's or entity's ability to pay, as determined by the commissioner, in consultation with the program advisory body.

(e) A payment made under (d) of this section shall be combined with the payment made to the professional by the department.

Sec. 18.29.030. Eligibility and priority. (a) To be eligible for a direct incentive payment under AS 18.29.020, an individual shall

(1) submit an application on a form approved by the commissioner;

(2) be engaged in qualified employment;

(3) be licensed as a tier I or tier II health care professional in the state within 90 days after the first day of employment;

(4) meet a priority for payment established under (b) of this section; and

(5) meet other criteria established by the commissioner.

(b) The commissioner shall establish priorities for payment of a loan and incentive under the program based on the recommendations of the program advisory body and the availability of funding. The commissioner shall prioritize eligible sites based on the percentage of patients treated at the site who

(1) are uninsured;

(2) have or are eligible for medical assistance or Medicare coverage; or

(3) have or are eligible for other federal health program benefits.

Sec. 18.29.099. Definitions. In AS 18.29.010 - 18.29.099,

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

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

(3) "eligible site" means a service area or health care facility that the commissioner has designated as located in a health care services shortage area based on a needs assessment and employment statistics for qualified tier I or tier II health

care professionals;

(4) "program" means the health care professions loan repayment and incentive program;

(5) "qualified employment" means employment of a tier I or tier II health care professional at an eligible site at which the health care professional is hired and paid to work

(A) in a full-time or not less than half-time position;

(B) for a contract term that is not less than three years; and

(C) not less than 50 percent time on direct patient health care services;

(6) "tier I health care professional" means a dentist, pharmacist, or physician;

(7) "tier II health care professional" means a dental hygienist, registered nurse, certified nurse practitioner, physician assistant, physical therapist, clinical psychologist, or clinical social worker holding at least a master's degree in social work.

*** Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON

ALASKA STATE CAPITOL
ROOM 514
JUNEAU, ALASKA 99801-1182
PHONE: (907) 465-3707
FAX: (907) 465-4821

MEMORANDUM

Date: March 18, 2009

To: Senator Bettye Davis, Chair of the Senate HSS Committee

Subject: Hearing Request for SB 139 Incentives for Certain Medical Providers

Senator Davis,

I would like to respectfully request that the Senate Committee on Health and Social Services schedule my bill, SB 139 Incentives for Certain Medical Providers, for a hearing at your earliest convenience. Thank you for your consideration, and if you have any questions, please feel free to contact my aide Kendri Cesar at 465-3877.

Sincerely,

for Kendri M. Cesar
Senator Donald C. Olson

PAGE 1: The following change to Sec. 14.43.430(b): "The commission shall act as ~~**fiscal**~~ **disbursing** agent…"

PAGE 2: The following change to Sec. 14.43.435(2): "have an unpaid balance on one or more education loans ~~**approved**~~ **verified** by the commission;" (REASON: to clarify that the education loans referred to are not provided by the commission, only verified)

PAGE 2: The following change to Sec. 14.43.440(a): "...the unpaid loan balance existing in the first ~~**repayment year, plus interest,**~~ **year of program participation** multiplied by…" (REASON: to clarify calculation)

PAGE 3: The following change to Sec. 18.29.010(c): Replace "AS 14.43.435" with "AS 14.43.430" (REASON: technical correction)

PAGE 5: The following changes to Sec. 18.29.030(b): "The commissioner shall prioritize eligible sites based on the ~~**volume**~~ **percentage** of patients treated at the site who are uninsured; ~~**and**~~ who have **or are eligible for** medical assistance; ~~**or**~~ **who have or are eligible for** Medicare coverage; **or who have or are eligible for other federal health program benefits.** " (REASON: to include those with VA benefits or those who qualify for tribal healthcare)

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON

SENATOR ALBERT KOOKESH
SENATOR JOE THOMAS
SENATOR HOLLIS FRENCH
SENATOR LINDA MENARD

ALASKA STATE CAPITOL
ROOM 514
JUNEAU, AK, 99801-1182
(907) 465-3877
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Senate Bill 139 – Incentives for Certain Medical Providers

Version 26-LS0503\E

SPONSOR STATEMENT

Alaska is facing a serious shortage of healthcare practitioners, especially in the rural areas of our state, and it is projected to worsen significantly in the next few decades. Senate Bill 139 is intended to address this issue by establishing a program to immediately begin filling the vacant healthcare practitioner positions throughout the state.

This legislation will establish a loan repayment and incentive program in the Department of Health and Social Services. The program is designed to attract healthcare practitioners to Alaska. Currently, the WWAMI program serves a similar purpose by giving WWAMI medical students the option of paying off a portion of their loans by staying in Alaska to practice for a specified number of years. Last year, the number of WWAMI seats was increased from 10 to 20, and this year, SB 18 aims to raise that number to 24. However, expanding the WWAMI program only ensures that we have more healthcare practitioners in future years, as WWAMI participants must complete their education before they can begin their service. Therefore, it is not the immediate solution that we need. SB 139 would be an effective way to fill this gap in the very near future, and would attract healthcare practitioners from all areas of country, rather than just from the WWAMI participating states.

Senate Bill 139 will provide loan repayments and incentives for up to 90 applicants per year in 10 different health care occupations. Sixty of the slots will be reserved for "regular" site positions, which can be located anywhere in the state. Thirty of the slots will be reserved for "very-hard-to-fill" positions, which can be located only in areas that are designated by the

Commissioner of Health and Social Services. Priority will be given to sites that treat patients who are uninsured and who have medical assistance or Medicare coverage. The amount of monetary incentive will vary with each slot, according to location and the category of healthcare provided. Prioritized Tier 1 slots are designated according to the relative need in the state, and will include physicians, pharmacists and dentists. A slot in this tier has incentives of up to $35,000 per year for three years at a regular site, and up to $47,000 per year for three years at a very-hard-to-fill site. Tier 2 slots are also designated according to the relative need in the state, and will include dental hygienists, registered nurses, certified nurse practitioners, physician assistants, physical therapists, clinical psychologists, and clinical social workers holding at least a master's degree in social work. A slot in this tier has incentives of up to $20,000 per year for three years at a regular site, and up to $27,000 per year for three years at a very-hard-to-fill site.

It is critical that we promptly address Alaska's healthcare shortages in order to ensure that all Alaskans have adequate access to medical care. SB 139 helps us to save and improve the lives of our constituents by allowing us to provide for those who cannot wait until tomorrow to get the care that they need today.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 17, 2009

SUBJECT: Sectional Summary (SB 139; Work Order No. 26-LS0503\E)

TO: Senator Donald Olson
Attn: Kendri Cesar

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Requires the Alaska Commission on Postsecondary Education to repay education loans made to health care professionals, as defined, under eligibility criteria established in sec. 2. Specifies that the loan repayment obligation is not a financial obligation of the corporation. Provides for quarterly payments based on the fulfillment of qualified employment at eligible sites located in the state.

Section 2. Establishes the health care professions loan repayment and incentive program in the Department of Health and Social Services for the purpose of addressing a shortage of certain health care professionals in the state and for improving the distribution of those professionals. Requires the commissioner of health and social services to administer the program, to designate and prioritize eligible employment sites, and to monitor the program in consultation with an advisory body established under this section. Provides for maximum combined loan repayment and employment incentives base on the type of employment.

Section 3. Provides for an immediate effective date for the bill.

JMM:ljw
09-162.ljw

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 139
() Publish Date:

Identifier (file name): SB139-DHSS-MAA-03-23-09
Dept. Affected: Health & Social Services
Title: Incentives for Certain Medical Providers
RDU: Health Care Services
Component: Medical Assistance Administration
Sponsor: Olson, Wielechowski, Meyer, Davis
Requester: Senate HSS
Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	181.4		181.4	181.4	181.4	181.4	181.4
Travel	9.0		9.0	9.0	9.0	9.0	9.0
Contractual	2,478.4		4,818.4	7,193.4	7,193.4	7,193.4	7,193.4
Supplies	4.0		4.0	4.0	4.0	4.0	4.0
Equipment	15.2						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**2,688.0**	**0.0**	**5,012.8**	**7,387.8**	**7,387.8**	**7,387.8**	**7,387.8**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match	1,781.2		3,562.4	5,343.8	5,343.8	5,343.8	5,343.8
1004 GF	313.0		262.8	262.8	262.8	262.8	262.8
1005 GF/Program Receipts	593.8		1,187.6	1,781.2	1,781.2	1,781.2	1,781.2
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**2,688.0**	**0.0**	**5,012.8**	**7,387.8**	**7,387.8**	**7,387.8**	**7,387.8**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	**2**		2	2	2	2	2
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 139 creates a loan repayment program for identified health professional occupations and provides for cash incentives for eligible health professionals engaged in qualified employment. The intent of the legislation is to "address the worsening shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals who provide direct patient care."

(continued on next page)

Prepared by: William J. Streur, Deputy Commissioner
Phone (907) 334-2520
Division: DHSS Health Care Services
Date/Time 3/23/09 12:00 PM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/23/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB 139

ANALYSIS CONTINUATION

The Division of Health Care Services estimates that it will need a total of 2 FTE's to fully administer the loan repayment and employment incentive programs.

Health Care Professions Loan Repayment & Incentive Program

The Division assumes it will need $2,375.0 for practitioner payments in FY2010. This funding will be used for either practitioner payments as cash incentives, or payments to lender institutions for loan repayments, or there can be a combination of the two types of payments. Maximum payments established for any combination of loan repayment and cash incentive are: $35.0 annually for tier I health care professionals employed in "regular" positions; $47.0 annually for tier I health care professionals employed in "very hard-to-fill" positions; $20.0 annually for tier II health care professionals employed in "regular" positions; and $27.0 annually for tier II health care professionals employed in "very hard-to-fill" positions. The need for $2,375.0 in FY2010 assumes the following:

Tier I	27 Practitioners	$1,017.0
Tier II	63 Practitioners	$1,358.0
Total	90 Practitioners	$2,375.0

The Division assumes the employing entity will provide 25% of the $2,375.0 as contributing match as specified in SB139. Therefore the expected GF match is $1,781.2. The match for the employing entity is $593.8.

Administrative Costs

1 Health Program Manager III, $104,675, 1 Accounting Technician III, $76,700. All personal services costs include benefits. Assumes $9.4 per FTE annually for office space, phones, and other contractual costs; $2.6 one time costs per FTE for computers and software; $5.0 one time costs per FTE for office equipment; $2.0 per FTE annually for supplies; $9.0 per year for travel; $50.0 per year for a program evaluation contract.

Health Program Manager III.
Serve as lead program manager for the loan repayment and employment incentive program.
Establish procedures for the commissioner's designation and prioritization of sites eligible for participation in the program.
Develop the application process for participation in the program for sites and professionals.
Develop and disseminate public information and notices pertinent to the program.
Lead the development of the methodology and procedures for classifying each eligible site as having either regular or very hard-to-fill positions.
Prepare annual reports that document the successes and challenges of the program.
Facilitate the creation of and ongoing work of the advisory committee.
Establish procedures and manage the employer contribution portion of the program.

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB 139

ANALYSIS CONTINUATION

Accounting Technician III.
The Accounting Technician III will prepare, submit for approval, and update as needed, RSA's between the DHSS and EED. The technician will be responsible developing all spreadsheets for tracking payments to each cohort of practitioners. In addition, the technician may be required to develop a database to assist financial tracking procedures. The technician will be responsible for preparing monthly financial reports that are to be provided to HCS administrative and program staff. The position will be responsible for the proper close-out of all financial case files for all practitioners, monthly reconciliation of all HCS financial transactions related to the loan repayment program, and for the close-out of all RSA's related to the program.

Assumes one time cost of $35.0 for contractual services/software development for Alaska Commission on Postsecondary Education (ACPE).

ACPE will facilitate the disbursement of the loan repayment benefit. It will not to be the budgetary agency for requesting and receiving the funds. After HCS selects program participants, ACPE will verify the existence of their qualifying education debt and, on a periodic basis, transmit the appropriate benefit amount to the individual's lender.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: SB139
Bill Version:
() Publish Date:

Identifier (file name): SB139-EED-ACPE-03-20-09
Dept. Affected: Education
Title: An Act establishing a loan repayment program and employment incentive program for certain health care...
RDU: ACPE
Component: Program Administration and Operations
Sponsor: Senator Donald Olson
Requester: (S)HSS
Component Number: 2738

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation will require the Alaska Commission on Postsecondary Education (ACPE) to serve as fiscal agent for a loan repayment program for certain health care professionals employed in the state. As drafted, the Department of Health and Social Services (HSS) is the primary administrative agency. Based on HSS estimates of the number of individuals participating in the program, it will be of sufficient size that ACPE, in order to mitigate the need for manual processing and related personal services expenses, will need to procure services to develop a program database to ensure program benefits are paid out in compliance with program statutes and ensure accurate annual reporting of benefits paid to the Internal Revenue Service. We estimate the one-time contractual costs would be $35 thousand and will be included in the HSS fiscal note associated for this bill. Due to the anticipated functionality of the database, including the ability to electronicaly share files between HSS and ACPE, no additional staffing will be needed to provide these fiscal agent services in support of the loan repayment program.

Prepared by: Diane Barrans, Executive Director — Phone 465-6740
Division: Alaska Commission on Postsecondary Education — Date/Time 3/20/09 4:00 PM
Approved by: Diane Barrans, Executive Director — Date 3/20/2009
Alaska Commission on Postsecondary Education

(Revised 9/10/2008 OMB)

4572

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: SB139
Bill Version:
() Publish Date:

Identifier (file name): SB139-EED-ACPE-03-20-09
Dept. Affected: Education
Title: An Act establishing a loan repayment program and employment incentive program for certain health care...
RDU: ACPE
Component: Program Administration and Operations
Sponsor: Senator Donald Olson
Requester: (S)HSS
Component Number: 2738

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation will require the Alaska Commission on Postsecondary Education (ACPE) to serve as fiscal agent for a loan repayment program for certain health care professionals employed in the state. As drafted, the Department of Health and Social Services (HSS) is the primary administrative agency. Based on HSS estimates of the number of individuals participating in the program, it will be of sufficient size that ACPE, in order to mitigate the need for manual processing and related personal services expenses, will need to procure services to develop a program database to ensure program benefits are paid out in compliance with program statutes and ensure accurate annual reporting of benefits paid to the Internal Revenue Service. We estimate the one-time contractual costs would be $35 thousand and will be included in the HSS fiscal note associated for this bill. Due to the anticipated functionality of the database, including the ability to electronicaly share files between HSS and ACPE, no additional staffing will be needed to provide these fiscal agent services in support of the loan repayment program.

Prepared by: Diane Barrans, Executive Director — Phone 465-6740
Division: Alaska Commission on Postsecondary Education — Date/Time 3/20/09 4:00 PM
Approved by: Diane Barrans, Executive Director — Date 3/20/2009
Alaska Commission on Postsecondary Education

(Revised 9/10/2008 OMB)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 139
() Publish Date:

Identifier (file name): SB139-DHSS-MAA-03-23-09
Dept. Affected: Health & Social Services
Title: Incentives for Certain Medical Providers
RDU: Health Care Services
Component: Medical Assistance Administration
Sponsor: Olson, Wielechowski, Meyer, Davis
Requester: Senate HSS
Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	181.4		181.4	181.4	181.4	181.4	181.4
Travel	9.0		9.0	9.0	9.0	9.0	9.0
Contractual	2,478.4		4,818.4	7,193.4	7,193.4	7,193.4	7,193.4
Supplies	4.0		4.0	4.0	4.0	4.0	4.0
Equipment	15.2						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**2,688.0**	**0.0**	**5,012.8**	**7,387.8**	**7,387.8**	**7,387.8**	**7,387.8**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match	1,781.2		3,562.4	5,343.8	5,343.8	5,343.8	5,343.8
1004 GF	313.0		262.8	262.8	262.8	262.8	262.8
1005 GF/Program Receipts	593.8		1,187.6	1,781.2	1,781.2	1,781.2	1,781.2
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**2,688.0**	**0.0**	**5,012.8**	**7,387.8**	**7,387.8**	**7,387.8**	**7,387.8**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	2		2	2	2	2	2
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 139 creates a loan repayment program for identified health professional occupations and provides for cash incentives for eligible health professionals engaged in qualified employment. The intent of the legislation is to "address the worsening shortage of certain health care professionals in the state by increasing the number and improving the distribution of health care professionals who provide direct patient care."

(continued on next page)

Prepared by: William J. Streur, Deputy Commissioner
Phone (907) 334-2520
Division: DHSS Health Care Services
Date/Time 3/23/09 12:00 PM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/23/2009
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB 139

ANALYSIS CONTINUATION

The Division of Health Care Services estimates that it will need a total of 2 FTE's to fully administer the loan repayment and employment incentive programs.

Health Care Professions Loan Repayment & Incentive Program

The Division assumes it will need $2,375.0 for practitioner payments in FY2010. This funding will be used for either practitioner payments as cash incentives, or payments to lender institutions for loan repayments, or there can be a combination of the two types of payments. Maximum payments established for any combination of loan repayment and cash incentive are: $35.0 annually for tier I health care professionals employed in "regular" positions; $47.0 annually for tier I health care professionals employed in "very hard-to-fill" positions; $20.0 annually for tier II health care professionals employed in "regular" positions; and $27.0 annually for tier II health care professionals employed in "very hard-to-fill" positions. The need for $2,375.0 in FY2010 assumes the following:

Tier I	27 Practitioners	$1,017.0
Tier II	63 Practitioners	$1,358.0
Total	90 Practitioners	$2,375.0

The Division assumes the employing entity will provide 25% of the $2,375.0 as contributing match as specified in SB139. Therefore the expected GF match is $1,781.2. The match for the employing entity is $593.8.

Administrative Costs

1 Health Program Manager III, $104,675, 1 Accounting Technician III, $76,700. All personal services costs include benefits. Assumes $9.4 per FTE annually for office space, phones, and other contractual costs; $2.6 one time costs per FTE for computers and software; $5.0 one time costs per FTE for office equipment; $2.0 per FTE annually for supplies; $9.0 per year for travel; $50.0 per year for a program evaluation contract.

Health Program Manager III.
Serve as lead program manager for the loan repayment and employment incentive program.
Establish procedures for the commissioner's designation and prioritization of sites eligible for participation in the program.
Develop the application process for participation in the program for sites and professionals.
Develop and disseminate public information and notices pertinent to the program.
Lead the development of the methodology and procedures for classifying each eligible site as having either regular or very hard-to-fill positions.
Prepare annual reports that document the successes and challenges of the program.
Facilitate the creation of and ongoing work of the advisory committee.
Establish procedures and manage the employer contribution portion of the program.

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB 139

ANALYSIS CONTINUATION

Accounting Technician III.
The Accounting Technician III will prepare, submit for approval, and update as needed, RSA's between the DHSS and EED. The technician will be responsible developing all spreadsheets for tracking payments to each cohort of practitioners. In addition, the technician may be required to develop a database to assist financial tracking procedures. The technician will be responsible for preparing monthly financial reports that are to be provided to HCS administrative and program staff. The position will be responsible for the proper close-out of all financial case files for all practitioners, monthly reconciliation of all HCS financial transactions related to the loan repayment program, and for the close-out of all RSA's related to the program.

Assumes one time cost of $35.0 for contractual services/software development for Alaska Commission on Postsecondary Education (ACPE).

ACPE will facilitate the disbursement of the loan repayment benefit. It will not to be the budgetary agency for requesting and receiving the funds. After HCS selects program participants, ACPE will verify the existence of their qualifying education debt and, on a periodic basis, transmit the appropriate benefit amount to the individual's lender.

SB 156

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/18/09

FURTHER: Judiciary

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 4/3/09

Health and Social Services Committee considered SENATE BILL NO. 156

SB 156 COMPACT FOR JUVENILES; INTERSTATE COUNCIL

"An Act relating to the Interstate Compact for Juveniles; relating to the State Council for Interstate Adult and Juvenile Offender Supervision; amending Rules 4 and 24(b), Alaska Rules of Civil Procedure; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
COR	3/26			✓	1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	✓			
	PASKVAN	X			
CHAIR:	DAVIS	X			

4578

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
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Fax (907) 269-0249

SENATOR LESIL MCGUIRE

Co-Chair
Senate Resources Committee

Chair
Senate Special Committee on Energy
Senate Special Committee on World Trade, Technology & Innovation

Member
Senate Judiciary Committee
Joint Armed Services Committee

MEMORANDUM

To: Senator Bettye Davis
Chair, Senate Health & Social Services Committee

From: Senator Lesil McGuire

Date: March 25, 2009

Re: Hearing Request: SB 156 – Compact for Juveniles; Interstate Council

I respectfully request that SB 156 – Compact for Juveniles; Interstate Council be scheduled for a hearing in the Senate Health & Social Services Committee at your earliest convenience.

SB 156 updates Alaskan laws regarding juveniles under court supervision by adopting a new Interstate Compact for Juveniles. It is important that, before the end of the year, Alaska joins the other 36 states that have already adopted the new compact, otherwise we will have no agreement with those 36 states.

Attached you will find the most current version of the resolution, a sponsor statement, and all backup information.

If you have any questions or concerns, please feel free to contact me personally or my staff, Trevor Fulton, at x3579. Thank you for your time and consideration.

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
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Co-Chair
Senate Resources Committee

Chair
Senate Special Committee on Energy
Senate Special Committee on World Trade, Technology & Innovation

Member
Senate Judiciary Committee
Joint Armed Services Committee

SENATOR LESIL MCGUIRE

SPONSOR STATEMENT

SB 156: Compact for Juveniles; Interstate Council

SB 156 updates Alaskan laws regarding juveniles under court supervision by adopting a new Interstate Compact for Juveniles developed by the Council of State Governments in collaboration with the US Office of Juvenile Justice and Delinquency.

Since 1960, Alaska has relied on the Interstate Compact on Juveniles to provide us with model language to regulate the movement of juveniles under court supervision across state lines.

SB 156 adopts a new Interstate Compact on Juveniles and significantly updates the 50-year-old mechanism for tracking and supervising juveniles that move across state borders. Providing enhanced accountability, enforcement, visibility and communication, the new compact seeks to update a crucial, yet outdated tool for ensuring public safety and preserving child welfare.

Primary changes to the original Juvenile Compact include requiring that Alaska:

- Support establish and contribute members to an independent, national compact operating authority (a "national commission") to administer ongoing compact activity;
- Agree to be subject to sanctions if the state fails to support essential compact operations;
- Collect and provide standardized information as requested by the national commission;
- Financially support essential compact operations.

Thirty-six other states have adopted the new compact and there is pending legislation to adopt the compact in at least four others.

If Alaska chooses not to adopt the new Interstate Compact, the state will soon face serious and costly challenges in its ability to monitor juveniles who arrive here from out of state, including potentially dangerous juveniles who may present a risk to public safety and a liability concern for Alaskan agencies. In addition, other states would be under no compulsion to accept Alaskan juveniles who seek to visit or reside within their borders. Not adopting the Compact would also likely result in requiring Alaska to form individual agreements with each state, which could prove to be time-consuming, expensive, and less effective.

SB 156 is a timely and important piece of legislation that will help ensure public safety and preserve child welfare.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 30, 2009

SUBJECT: Sectional Summary - SB 156 (Work Order No. 26-LS0758\A)

TO: Senator Lesil McGuire
Attn: Trevor Fulton

FROM: Gerald P. Luckhaupt
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, please note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill - the bill itself is the best statement of its contents.

Section 1 amends AS 33.36.140(a) by changing the name of the State Council for Interstate Adult Offender Supervision and designating the council to implement the compact set out in AS 33.36.110 (current law) and the juvenile offender supervision compact newly created in AS 47.15.101, added by sec. 4.

Section 2 increases the number of members of the council from seven to nine.

Section 3 makes a conforming change.

Section 4 is the new Interstate Compact for Juveniles.

Section 5 allows the commissioner of health and social services to designate a compact administrator.

Section 6 provides that the State Council for Interstate Adult and Juvenile Offender Supervision (see sec. 1) shall serve as the state council for the new juvenile compact (see sec. 4).

Section 7 provides that the Department of Health and Social Services may adopt regulations to implement the juvenile compact.

Section 8 amends AS 47.15.070 to clarify that additional procedures are not precluded by the juvenile compact.

Section 9 provides a conforming change.

Section 10 provides a repealer.

Section 11 provides indirect court rule amendments.

Section 12 provides that the Department of Health and Social Services may continue to implement the old juvenile compact with those states that have not adopted the new juvenile compact.

Section 13 provides notice that the provisions of the new compact that indirectly amend court rules only take effect if they receive the two-thirds majority vote required by the constitution.

Section 14 provides that this Act only takes effect if at least 34 states adopt the juvenile compact.

Section 15 provides a special effective date.

GPL:ljw
09-193.ljw

The New Interstate Compact for Juveniles & Alaska

Since 1955, the Interstate Compact on Juveniles has provided states with the procedural means to regulate the movement of juveniles under court supervision across state lines. (Alaska adopted the original compact into statute in 1960.) A new compact has been developed by the Council of State Governments in collaboration with the U.S. Office of Juvenile Justice and Delinquency Prevention.

What are the major differences between the old compact and the new one?

The old compact set out the rules under which states would operate to return runaways, escapees, and absconders to their home states; a voluntary return procedure; cooperate on supervision of probationers and parolees; responsibility for costs; and other factors. The new compact places more emphasis on how the compact itself will be administered, and what the responsibilities (regarding rules, enforcement procedures, financial management, communications, data sharing) are for states that are party to the compact.

What would change for Alaska under the new compact?

Alaska would be required to:

- Support establishment and contribute members to an independent, national compact operating authority (a "national commission") to administer ongoing compact activity;
- Agree to be subject to sanctions if the State fails to support essential compact operations;
- Collect and provide standardized information as requested by the national commission;
- Financially support essential compact operations.

How many youth are subject to interstate supervision in Alaska?

About 160 juveniles under the supervision of the Department of Health and Social Services leave or enter the State of Alaska each year. This includes about 100 juveniles who make brief, temporary visits either from other states or to Alaska for work or family needs, and about 60 juveniles who move to assume a new residency with relatives, attend college, or assume placement in a residential program or facility. In addition to these 160 juveniles, another 20-25 juveniles are continuing their placement or residency in Alaska or elsewhere from a prior year, and continuing supervision under the Interstate Compact for Juveniles.

Have other states adopted the new compact?

As of January 26, 2009, 35 states have adopted the new compact; legislation to adopt was pending in 5 others. The new Interstate Compact for Juveniles is now officially active. The

interstate commission has held its first meeting and now has less than one year to adopt bylaws that will govern operation of the compact.

What if Alaska doesn't adopt the new compact?

If Alaska chooses not to adopt the new Interstate Compact for Juveniles, the State would soon face serious challenges in its ability to monitor juveniles who arrive here from out of state, including potentially dangerous juveniles who may present a risk to public safety and a liability concern for Alaska. In addition, states would be under no compulsion to accept Alaskan juveniles who seek to visit or reside within their borders. Ultimately, Alaska would be forced to develop individual agreements with each state, perhaps specific to each case, which would ultimately prove more expensive and less effective than adopting the new Interstate Compact for Juveniles.

What will it cost to implement the new compact?

The Division of Juvenile Justice estimates a total cost of $45.0 per year. This costs includes:

- $13.0 for travel associated with membership participation, including travel to required meetings by staff;
- $27.0 Membership Dues, teleconferences, overhead costs that include chargeback, etc;
- $ 5.0 Supplies for staff and required meetings

Contacts:

Tony Newman, Legislative Contact
AK Dept. of Health and Social Services, Juvenile Justice
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Barb Murray, Deputy Compact Administrator
AK Dept. of Health and Social Services, Juvenile Justice
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Keith Scott, Director
National Center for Interstate Compacts
Council of State Governments
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FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: SB156-DOC-OC-3-26-09
Bill Version:
() Publish Date:

Identifier (file name): SB156-DOC-OC-3-26-09
Dept. Affected: DOC
Title "An Act Relating to the Interstate Compact for Juveniles"
RDU Administration & Support
Component Office of the Commissioner
Sponsor Senator McGuire
Requester Governor
Component Number 694

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Passage of this legislation should not have a significant impact on the Department of Corrections.

Prepared by: Leslie Houston, Director
Phone 465-3339
Division Administrative Services Division
Date/Time 3/26/09 1100
Approved by: Dwayne Peeples, Deputy Commissioner
Date 3/26/2009
Office of the Commissioner

(Revised 9/10/2008 OMB)

4585

4/3 4:24pm

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB156**
() Publish Date:

Identifier (file name): **SB156-DHSS-PS-03-26-09**
Dept. Affected: Health & Social Services
Title: Compact for Juveniles: Interstate Council
RDU: Juvenile Justice
Component: Probation Services
Sponsor: McGuire
Requester: Senate HSS
Component Number: 2134

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel	13.0		13.0	13.0	13.0	13.0	13.0
Contractual	27.0		27.0	27.0	27.0	27.0	27.0
Supplies	5.0		5.0	5.0	5.0	5.0	5.0
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**45.0**	**0.0**	**45.0**	**45.0**	**45.0**	**45.0**	**45.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	45.0		45.0	45.0	45.0	45.0	45.0
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**45.0**	**0.0**	**45.0**	**45.0**	**45.0**	**45.0**	**45.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Since 1960, the Interstate Compact on Juveniles has provided states, including Alaska, with the procedural means to regulate the movement of court-supervised juveniles across state lines. Approximately 160 juveniles under the supervision of the Department of Health and Social Services leave or enter Alaska each year. This bill would place a new, extensively revised compact into Alaska statute replacing the current compact. The new compact seeks to correct deficiencies in the existing compact that have been identified at the national level with regard to administration, rules, enforcement procedures, financial management, communications and data sharing.

Prepared by: Stephen F. McComb, Director
Phone 907-261-4335
Division: Juvenile Justice
Date/Time 3/2/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/26/2009
DHSS Finance & Management Services

(Revised 9/10/2008 OMB)

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FISCAL NOTE

STATE OF ALASKA BILL NO. SB 156

2009 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Participation in the new compact requires that the state council implement and oversee compact functions. However, because some of the membership requirements for the juvenile compact council are the same as those required for the Alaska State Council for Interstate Adult Offender Supervision, the state intends to have a single state council oversee both compacts. Combining the two responsibilities under the authority of a single council will save the state the effort and duplication of creating and managing two councils with similar functions.

Being part of the new compact will create additional costs to the division. Costs include the following:

$13.0 Travel associated with membership participation, including travel to required meetings by staff
$27.0 Membership Dues, teleconferences, overhead costs that include chargeback, etc.
$ 5.0 Supplies for staff and required meetings

Dues to participate in the current compact are $400 per year. Dues to participate in the new compact are expected to be $14,000 per year.

The cost estimates for the participation in the state council only reflect those anticipated for the operations for the juvenile justice compact and do not include operational and other costs associated with the ongoing adult council activities. The existing adult council has not had in-person meetings for several years, and at least initially the division anticipates that such meetings will be necessary to address the added juvenile justice functions. The travel costs reflected in this fiscal note are again only intended to portray the costs for the juvenile compact activities. The travel costs also reflect the intent that council members represent all areas of the state.

A possible one-time additional cost to the division may also be incurred by adoption of this bill. The new compact will require use of a national database management system that may need to communicate with the division's MIS. The national system is still under development. Without knowing when the new system will be available, or how difficult it will be to link the two systems, we are not prepared to estimate a cost at this time. The division may need to make a specific request to meet this cost at some point in the future.

In addition, the division will be monitoring the amount of additional staff time required to participate in the new compact. At some point an increment request may be needed to fund a position if absorption of these duties is too challenging for our existing staff. The division needs to ensure we do not hamper our ability to research, apply for, and successfully win grants, such as the federal Re-Entry and Gang Prevention grants that have been invaluable in improving public safety and helping the state monitor and improve its response to gang issues. If the increase in workload forces staff to spend less time involved in the management of existing programs (these include the federal Juvenile Justice and Delinquency Prevention Formula Program, the Enforcing Underage Drinking Laws program, Title V, Juvenile Accountability Block Grants, Bureau of Justice Assistance grant management, and Youth Court earmark) current federal funding that the division receives could be at risk.

Interstate Compact for Juveniles Resource Kit

The Council of State Governments

The Council of State Governments

THE INTERSTATE COMPACT FOR JUVENILES

Resource Kit

Table of Contents

1. The Interstate Compact for Juveniles: Language
2. Frequently Asked Questions
3. Case Studies
4. Fiscal Note
5. Projected State Assessments
6. Current AJCA Rules
7. Rosters
8. Resolutions, Endorsements and Articles
9. Original Compact Language (circa 1955)
10. Interstate Compact Backgrounder
11. Resource Guide

Frequently Asked Questions

FREQUENTLY ASKED QUESTIONS CONCERNING THE INTERSTATE COMPACT FOR JUVENILES

1. A juvenile compact already exists. Why should we replace it?

Answer: The existing Interstate Compact on Juvenile was created in 1955 when only a few hundred juveniles were being apprehended or found in states other than where they were residents or where their cases were adjudicated. Today that number exceeds twenty thousand (20,000) juveniles. In addition, the existing compact authority and structure are seriously outdated.

Examples include:

- Limited knowledge of who is moving, where and when they are going;
- Limited agreement between states regarding what supervision means;
- Limited ability and commitment to notify victims, communities and law enforcement officials of the movement of juveniles;
- The Association of Juvenile Compact Administrators may identify failures to comply with established rules, but it is severely limited in its ability to enforce compliance when that becomes necessary; and
- No recognized authority to promulgate rules.

2. Why is it important to replace the compact right away?

Answer: Because the existing interstate agreement has been severely compromised by individual state actions; incomplete adoption of three (3) subsequent amendments to the compact; and inability to promptly gather and transmit data concerning these juveniles or enforce provisions for their care and supervision. As soon as the new compact takes effect the 35 (or more) participating states will promptly commence administrative, by-law and rule making decisions to address these deficiencies.

- Since 1958, three amendments to the compact have been drafted and only a few states have adopted all three with a majority adopting only one or two. This lack of uniformity has created substantial inconsistency in interpretation and application of the existing compact. There is no longer a common agreement between states concerning what types of juveniles can be sent to other states for supervision, and no authority to hold other states accountable for following existing compact rules. The existing compact will soon become so dysfunctional that a nationwide system for tracking and monitoring this population will not exist at all. In 2000, a nationwide effort to develop workable alternatives to the existing system commenced and materialized in 2002 with an amended compact entitled *The Interstate Compact for Juveniles*. Without passage of the new interstate compact, individual states will resume addressing concerns by enacting various statutes and executive orders, and even the appearance of interstate cooperation in managing these juveniles will cease.

- The new compact language was subject to critique and comment from a mailing to 200 individuals, agencies and associations. Transition and timing activities were identified as major concerns. As a result, the final compact language raises the number of required jurisdictions (states, the District of Columbia, Puerto Rico or territories) to 35 before implementation; and added July 1, 2004 as the "earliest implementation date" so that states could evaluate and consider their participation.

- After July 1, 2004, the Compact will take effect once it has been enacted into law by the 35th jurisdiction. States that have passed the compact will join together and begin making administrative decisions, by-laws, and the rules to govern signatory states. Non-member states may be present to voice their concerns, but may not vote. When a state joins the compact, after the initial 35, they will have an equal voice in all subsequent rule making matters, but will inherit the decisions made by other states during the start-up phase.

3. We keep hearing that there are over 20,000 juveniles in states other than where they were adjudicated. How reliable is that number and is it changing?

Answer: Nobody can accurately answer this question. The lack of reliable interstate data has long been a problem. The National Institute of Corrections' Information Center completed a survey of states in 1999, the beginning of the project. At that time, the estimated number of individual cases being supervised in other states totaled 15,000. This number does not include juveniles who moved to another state without going through the transfer process or had been issued travel permits, figures that are currently impossible to gather.

The Association of Juvenile Compact Administrators gathers statistics annually on the number of compact transfer requests for juveniles entering and exiting compacting states. According to statistics gathered from July 1, 2001 to June 30, 2002, there were an estimated 25,870 interstate compact transactions. Travel permits are cases not officially transferred, even though the juvenile has been authorized to travel to another state for a period of time. The universal opinion of compact and agency administrators consulted was that more individuals were in the travel category than in the supervised group. Therefore, it is safe to assume that the 20,000 figure is an extremely low estimate of the interstate movement of adjudicated juveniles.

4. Will there be more juveniles under interstate supervision as a result of the new compact?

Answer: Enacting the compact will not directly affect the number of juveniles under interstate supervision. However, several things could happen:

- The information system that will be developed will equip states with reliable data about how many of their juveniles are being supervised in other states, and how many they are

supervising for other states. Reliable data may indicate that a different number of juveniles are actually under supervision.

- A number of juveniles are currently in other states and transferred to other states unbeknownst to compact administrators and without formal authority by the interstate compact. The goal of bringing states into compliance with mutually agreed upon rules will result in an increase in the number of compact cases as the states account for these "stealth" movers and provide appropriate supervision and care.

5. Will the new compact eliminate the problems experienced under the current compact, and how will member states assure compliance?

Answer: Nobody can guarantee elimination of all problems experienced under the current compact. The proposed compact will have in place a staff and committee structure that will permit swift identification of potential problems and a manageable process for addressing concerns of member states in a timely manner. This ability to attend to compliance concerns in the early stages will identify and avert major conflicts.

With regard to authority, the revised compact clarifies that the member states will have a contractual obligation to comply with the terms of the compact as well as the by-laws and all rules promulgated by the National Commission. The new compact provides various tools (Article XI, Sections B & C), which provide for compliance and enforcement of the compact. These range from technical assistance, mediation and arbitration to suspension, termination, and legal action in federal court that will result in recovery of legal fees and costs by the prevailing party.

6. States do not have similar structures and systems to supervise juveniles. What effect will this have on interstate compact enforcement?

Answer: States are organized differently and have unique systems in place to supervise and manage their juvenile population. Some states have juvenile supervision within the department of corrections and elsewhere it is with a child protective services or welfare agency. Some states have probation within judicial districts, and in others it is a county executive function. However, an interstate compact is state law and the compact law supersedes conflicting state and local laws. It does not matter which branch or level of government provides the supervision services, the compact must be followed and enforced. Compliance requirements apply equally to any agency providing supervision in a state that has enacted the compact.

7. Why is it necessary to have State Councils?

Answer: State Councils address at least three significant problems:

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- Interstate supervision is unknown outside the agency or agencies where deputy compact administrators work. Consequently, in many states there is scant awareness that interstate issues are a significant public concern until a horrific crime occurs.

- Each state has one designated compact administrator, yet interstate compact compliance is not exclusively an issue for one state agency. In many instances juvenile supervision takes place in separate agencies within the executive branch, or in different (executive and judicial) branches and levels of government (state and county). Extradition funding and decision-making may be administered elsewhere. Judges and juvenile supervision agencies are obligated to observe compact rules regardless of where compact administration is housed. An ongoing awareness of interstate supervision issues is necessary in many areas of state government.

- Interstate supervision is a significant public policy concern that it merits the working knowledge of all State Council members, including victims of crime. However, states individually determine the specific role and membership of their State Council.

The states have discretion to decide whether the State Council is to be a separately constituted body or whether it assigns the duties of the State Council to an existing state entity, provided that representation from the executive, legislative and judicial branches of government and victims groups is present as required under the compact. The requirement for a State Council does not assume creation of a new or costly bureaucracy.

8. Who will be my state's commissioner?

Answer: The commissioner will be that person appointed by the State Council or the governor under Article III (B), subject to qualifications determined by each state.

9. The National Commission will develop the by-laws and regulations after the new compact becomes operational. Isn't that expecting states to "sign-up blindly" before knowing the rules. Why is this necessary?

Answer: The most effective way to manage the movement of juveniles is through an enforceable compact between states that results from member states' ongoing participation in administrative and rule-making duties. Therein lies the "Catch 22". States, through the National Commission, cannot write the rules and regulations until the new compact exists and the initial member states are known. However, this also means that states must pass the legislation and then trust the process in place to develop appropriate rules during the compact's first twelve-months of existence. The alternative of including all the rules in the compact itself would not only sacrifice state input and participation in the development of those rules, but it would also require each compacting state the burdensome task of legislatively approving these rule changes.

States are currently obligated to a full set of rules as developed and passed by compact administrators through the Association of Juvenile Compact Administrators. These rules were passed without any "Sunshine" or open-meeting provisions or conventional administrative law constraints as outlined in the new compact. As the new compact is ratified and the 35the jurisdiction is reached, it is expected that many of the rules for the new compact will be similar, if not identical, to the old rules as they are currently written. In fact, the new compact states that the existing rules governing the operation of the Interstate Compact on Juveniles will be null and void after twelve (12) months from the first meeting of the Interstate Commission. For more information on the current rules, please visit: http://www.ajca.us.

The new compact will create a governing structure with the capacity and authority to effectively manage rule making and compliance by member states. Rule making authority is left to representatives of those states that choose to enact the compact. The compact creates a process for rules to be made and enforced and when necessary, to be modified without returning to each state legislature. However, as a safeguard of states authority, the compact drafters created a provision for a majority of state legislatures to nullify any rule passed by the National Commission.

10. Will the new compact enable states to deny transfer of juveniles into their state?

Answer: Yes, states will only be obligated to accept juveniles classified and transferred under the provisions of the compact, its by-laws, and rules. Transfer denials, which contradict the terms of the compact and its rules, will not be permitted and would subject any non-compliant state to enforcement action as determined by the National Commission.

11. What control will states have over the National Commission?

Answer: It is important to remember that the National Commission is comprised of one voting representative from each member state. All proposed rules of the National Commission are required to be published in advance. Therefore, your state will have every opportunity for input before a vote is taken, and any member state will have the opportunity to have their position heard and to vote for passage or rejection of rules, by-laws and routine business. The standard for passage is a majority of members present at a meeting, unless a greater percentage is established in the by-laws (Article V).

Three relevant provisions are also included:

- Article VI concerning individual rules: "If a majority of the legislatures of the compacting states reject a rule by enactment of a statute or resolution in the same manner used to adopt the compact, then such rule shall have no further force and effect in any compacting state."

- Article X concerning amending the compact itself: "Amendments to the compact may be proposed by the Interstate Commission for enactment by the compacting states. No amendment shall become effective and binding upon the Interstate Commission and the compacting states unless and until it is enacted into law by unanimous consent of the compacting states."

- Article XI: "...a compacting state may withdraw from the compact by enacting a statute specifically repealing the statute which enacted the compact into law."

12. What are the limitations, if any, on the ability of the commissioner to sue member states (injunctive as well as mandatory relief)? What assurances can be given to states considering adoption?

Answer: No unilateral authority is given to an individual commissioner to sue another state. The National Commission is empowered, under Article XI (b) and Article XI (c) to enforce the compact against any member state, in the exercise of its reasonable discretion, through a variety of means ranging from alternative dispute resolution to judicial enforcement. Under Article XI (c) judicial enforcement is authorized by majority vote of the National Commission members in the U.S. District Court where the National Commission headquarters is located or the District of Columbia to enforce the provisions of the Compact, its by-laws and rules. Both injunctive relief and monetary damages may be sought and the prevailing party is entitled to an award of costs including reasonable attorney's fees. However, the intent of the Drafting Committee was that disputes under the compact be resolved at the lowest level, and with the least severe action necessary to ensure compliance.

13. Can any of the language in the new compact be changed or must all states use identical language? Can my state pass only certain parts of the revised compact?

Answer: Generally, the compact language must be identical with regard to the substantive provisions of the agreement. However, the enabling legislation, which embodies that agreement, does not have to be uniform in all party states and can be utilized to fit variations into the compactual pattern. The enabling legislation can be used to condition the impact of a compact in a particular state. While these allowances may be made for format, the operative language of the agreement must be identical from state-to-state; otherwise these material differences in language in any state statute purporting to adopt the compact could render it "void" or "voidable". The compact also contains a provision in Article XIII (B) (4) which preserves the limits placed on the Legislature's obligations, duties, powers, or jurisdiction under the constitution of that state.

14. Does the compact language conform to state constitutional language?

Answer: The compact language was drafted with cognizance of state constitutional requirements common to most state constitutions such as separation of powers, delegation of

power, and debt limitations. The validity of the state authority to enter into compacts and delegate authority to an interstate agency was specifically recognized and unanimously upheld by the U.S. Supreme Court in ***West Virginia vs. Sims, 341 U.S. 22 (1951).*** This decision also approves of a provision practically identical to the provisions of Article X of the Interstate Compact for Adult Offender Supervision concerning constitutional debt limitations. Under Article XIII (B)(4), provisions of the compact exceeding the constitutional limits imposed on the legislature of any state are ineffective.

15. Aren't we creating an expensive bureaucracy without the promise of anything better than what we already have?

Answer: Key concerns with the existing compact are accountability for member states and the ability to promulgate and enforce compact rules. An interstate compact that cannot assure compliance by member states is in effect a "toothless tiger." Despite remarkable efforts by those working in compact administration to hold the system together, governance issues have evolved to the point that greater compact authority is essential for states to function effectively. This illustrates the need for a national office to oversee administrative issues. Nothing in the drafting process requires an expansive bureaucracy, although it will create an administrative structure that will hold member states accountable for compliance. Given the degree of dissatisfaction with the current compact, many feel that a realistic question is whether the existing compact will survive if it is not replaced quickly. At the state-level, nothing mandates an expansive bureaucracy.

16. The new compact establishes the need for a data-sharing/information system. What type of information system will be necessary?

Answer: With the assistance of a Management and Information Systems consultant, a working committee of compact administrators has developed a plan for a comprehensive, secure and affordable information system. Development and maintenance of the information system would be part of the National Commission funding and responsibility. The system utilizes an "open technology" design and implementation of an Internet-based system accessible by industry standard software products. In some state compact offices, the minimal technology already exists. In others, it could be achieved with minimal enhancements of existing systems and for the balance, an initial investment of $2000 - $3,000 would provide the capacity to utilize form templates and to transmit and receive the information via an Internet e-mail connection. The working committee was sensitive to privacy concerns of transferred information, potential costs, and the reality that states utilize the full range of hardware and software products. Similar Internet-based systems are used extensively in the medical field and successfully accommodate these same concerns. The system is being designed so that the state compact office must be automated, while regional or field offices may use the system if they have access to the minimal equipment. Determination of privacy policies regarding the resulting national database will be made by states through the National Commission's enactment of rules and/or by-laws.

17. Will the National Commission's rulemaking authority allow it to preempt a state's privacy laws?

Answer: Under Article VI the National Commission's rulemaking authority is subject to the provisions of the ***Model State Administrative Procedures Act, 1981 Act Uniform Laws Annotated, Vol. 15, p.1 (2000),*** or such other Administrative Procedures Act as it deems appropriate and consistent with the requirements of due process. It is anticipated that rules promulgated by the National Commission would not conflict with state privacy laws except to the extent that any particular state privacy law is in direct contravention of a compact rule pertaining to the transfer and supervision of juveniles under the compact. In that case, the provisions of the Compact would supersede the conflicting state law provision under Article XIII (A) (2). It is not possible to predict what specific rules of the Interstate Commission will possibly conflict with a particular provision of the privacy laws of a particular state until a specific rule has been promulgated and a specific state privacy law has been identified.

18. How much will the new compact cost my state?

Answer: Based on a preliminary estimate contained within the fiscal note, the start-up costs to establish the National Commission will cost approximately $1 million. Support for the National Commission will come from state dues as determined by the National Commission as contained in the compact (Article VIII, (B)). Funding support for each State Council will be determined by individual state based on their specific needs and circumstances, (e.g. some states currently have existing mechanisms and/or councils that could absorb the duties of the proposed State Councils with some minor modifications).

19. Are there any the hidden costs associated with the new compact?

Answer: There are no costs mandated aside from the annual state assessment. However, it is possible that states might encounter additional costs. Examples may include:

- The proposed commission budget would pay for the voting representative from each member state to attend National Commission meetings. If a state decided to send more than one person to the meetings, the additional travel and per diem costs would be the responsibility of that state. However, states currently pay for their voting representative to attend meetings.

- The additional costs anticipated are limited to travel and per diem for members to meet within their state. It is possible that a state could decide to create a more formal structure and additional costs could be incurred.

- It is possible after examining the current level of state commitment to their centralized interstate compact administrative function that a state may determine they need more or a different level of staff assigned to that function. No additional staff would be required by

adoption of the new compact, but in many states it has long been an under-funded activity.

- It is possible that more juveniles could be under supervision if compact requirements are faithfully followed and all juveniles going to other states are processed through the compact. It is not anticipated that numbers under supervision would increase (as a result of enacting the compact) to the point that additional community supervision staff will be required. Also, it is anticipated that automation will reduce the per-case work-effort required.

- The information system is discussed in question 16. The system is being designed so that it may be accessed from common computers and will not require specialized equipment. The state compact office will require a computer and scanner and the system is being designed so that regional and field supervision units could also use the automated information system. Necessary state compact office equipment is estimated to cost $2,000 - $3,000 and compact administrators estimate that only a few states currently lack this equipment in their compact office.

20. Can a state create a law that limits its costs to the National Commission?

Answer: To the extent costs exceed a defined limit imposed by the constitution of a state on the legislature, such a provision could be determined under state law based on Article XIII (B)(4).

21. How can we determine the current status of efforts to implement The Interstate Compact for Juveniles?

Answer: Thirty-five jurisdictions (states, the District of Columbia, Puerto Rico and territories) must pass this legislation before it may take effect. The 2003 legislative session will be the first time states have an opportunity to consider the revised compact. A current "State-by State" status page may be accessed on the Internet at: http://www.csg.org/. Also, you may contact either of the two individuals listed in the final portion of this document.

Questions may be directed to:

Chris Holloway
The Office of Juvenile Justice and Delinquency Prevention
Phone: 202/305-9838
E-mail: holloway@ojp.usdoj.gov -OR-

Chad Foster
The Council of State Governments
Phone: 859/244-8032
E-mail: cfoster@csg.org

4599

Interstate Compact on Juveniles

State-by-State Status

State	Statute	A	B	C	D	E
Alabama	§§ AL Code 44-2-1	x		x		18
Alaska	A.S. §§ 47.15.010	x			x	18
Arizona	A.R.S. § 8-361	x		x	x	18
Arkansas	A.C.A. §§ 9-29-101	x	x	x		18
California	W.A.C.W. & I.C. § 1300	x		x	x	18
Colorado	C.R.S. §§ 24-60-701	x	x	x		18
Connecticut	C.G.S.A. § 46b-151a-q	x		x		16
Delaware	31 Del. C. §§ 5201	x		x	x	18
Florida	F.S.A. § 985.501	x	x	x	x	18
Georgia	O.C.G.A. §§ 39-3-1	x		x		17
Hawaii	HRS §§ 582-1	x		x	x	18
Idaho	I.C. §§ 16-1901	x	x	x		18
Illinois	45 ILCS 10/0.1	x	x	x	x	17
Indiana	IC 31-37-23-1	x	x	x	x	18
Iowa	I.C.A. § 232.171	x		x	x	18
Kansas	K.S.A. 38-1002	x	x	x		18
Kentucky	KRS § 615.010	x	x	x		18
Louisiana	LSA-R.S. ChC 1623	x	x	x		17
Maine	34-A M.R.S.A. § 9001	x		x		18
Maryland	MD Ann. Code, Art. 83C §§ 3-101	x	x	x	x	18
Massachusetts	ALM Spec L 97:1	x	x	x		17
Michigan	M.C.L.A. § 3.701	x		x		17
Minnesota	M.S.A. §§ 260.51	x	x	x		18
Mississippi	Code 1972, §§ 43-25-1	x	x	x		18
Missouri	V.A.M.S. § 210.570	x		x		17
Montana	MCA Title 41, Chap. 6	x	x	x	x	18
Nebraska	R.S.N. §§ 43-1001	x	x	x	x	19
Nevada	NRS 214.010	x		x		18
New Hampshire	RSA 169-A:1	x	x	x		18
New Jersey	N.J.S.A. 9:23-1	x		x		18
New Mexico	NMSA 1978 §§ 32A-10-1	x		x	x	18
New York	M.U.L. §§ 1801	x	x	x		16
North Carolina	G.S. §§ 7B-2800	x		x	x	16
North Dakota	NDCC 27-22-01	x		x		18
Ohio	RC 2151.56	x		x		18
Oklahoma	10 Okl. State Ann. § 531	x	x	x		18
Oregon	ORS 417.030	x		x		18
Pennsylvania	62 P.S. § 731	x	x	x	x	18
Rhode Island	Gen. Laws 1956, §§ 14-6-1	x		x		18
South Carolina	Code 1976, § 20-7-8705	x	x	x		18
South Dakota	SDCL §§ 26-12-1	x		x		17
Tennessee	T.C.A. §§ 37-4-101	x				18
Texas	V.T.C.A. Family Code § 60.001	x	x	x		17
Utah	U.C.A. 1953, 55-12-1	x		x		18
Vermont	V.S.A. 33 § 551	x	x	x		18
Virginia	Code 1950, §§ 16.1-323	x		x		18
Washington	RCW 13.24.010	x		x		18
West Virginia	Code, §§ 49-8-1	x		x		18
Wisconsin	W.S.A. 938.991	x		x		18
Wyoming	W.S. § 14-6-101	x		x		19
District of Columbia	DC Code §§ 32-1101	x	x	x		18
Guam	GCA § 90.82	x				18
Virgin Islands	3.39.1172	x	x	x		18
Puerto Rico	n/a					
N. Mariana Islands	n/a					
American Samoa	n/a					

KEY (X = signatory)

- **A - Interstate Compact on Juveniles**
- **B - Runaway Amendment**
- **C - Rendition Amendment**
- **D - Out-of-State Confinement Amendment**
- **E - Age Offenders are Classified as Adults**

Case Studies

THE INTERSTATE COMPACT FOR JUVENILES - CASE STUDIES

All types of juveniles may potentially be supervised under The Interstate Compact for Juveniles. The tragic problems caused by very serious juvenile offenders raise many public safety concerns for the states. The number of offender cases involving out-of-state juveniles has grown exponentially over the past few decades with the increase in the national highway system and air travel. Violent and non-violent offenders on probation and parole need to cross state lines every day and the compact is the only mechanism to insure continued supervision. Likewise, the compact insures the return of juvenile escapees and absconders to the supervising state, preventing those juveniles from committing other crimes or becoming victims themselves.

In addition to public safety, an important reason for supervision is to insure that each juvenile receives the best possible services to avoid future lawbreaking and/or to safeguard their well-being. Unfortunately, the current compact does not have an administrative process or governing structure in place with authority to hold member states accountable for compliance with their mutually agreed upon rules. There are more than 20,000 interstate compact cases processed annually. Consider the range and types of interstate supervision issues that arise and need to be governed effectively by rules agreed upon by member states:

- A 17-year-old juvenile parolee, serving a sentence for burglary and armed with a dangerous weapon, absconded from state supervision. The sending state issued a warrant for his arrest and extradition. One month later, the juvenile was picked up in another state for a minor traffic violation. The receiving state detained the youth in a detention center for juveniles and sent a notice to the youth's home state with details of his detainment and a request for transportation. Disagreements between both states over transportation payments ensued. Meanwhile, the local jurisdiction holding the juvenile ignored the interstate compact law and released the juvenile on grounds of local laws governing the detainment of out-of-state juveniles for misdemeanor charges. The juvenile walked away from the detention center unsupervised. While robbing a convenient store one year later, the juvenile shot and killed the store clerk. The juvenile remains locked-up in state prison today.

- A 15-year-old adjudicated juvenile received specialized and high-cost sex offender treatment and services in his state of residence. The terms of the juveniles' probation included weekly counseling and regular therapy by a state sanctioned non-profit organization. The father of the juvenile was fired from his employment and was forced to accept employment in another state. After hearing about the juveniles' need to move, the sending state terminated the juveniles' court order for treatment early due to the high-costs associated with the sex offender treatment and failed to notify the receiving state about the juvenile. Under the compact rules, sending states are obligated to fund necessary treatment, services and supervision for juveniles moving across state lines. As expected, the youth moved with his father unsupervised and without treatment. Not until he was adjudicated for another sex offense one year later did the receiving state find out about the youth's troubled past.

- The mother of a runaway filed a report with the National Crime Information Center. The 16-year-

old runaway was identified in a non-neighboring state three days later and was placed in temporary housing with minimal supervision. Youth workers in the receiving state discovered that the youth suffered from an extreme case of depression but could not provide needed therapy without permission by the youth's parents and payment by their home state. In the meantime, the mother was notified but lacked the funds to arrange for transportation to fly her daughter home. The youth's home state forbade the use of state funds for travel and other expenses for a runaway not in their custody. Likewise, the receiving state law required a lengthy legal process to handle custody issues for out-of-state runaways. One week later, the youth escaped from the temporary housing and supervision. Her remains were found three months later and it was determined that she committed suicide by consuming lethal amounts medicine.

- A 14-year-old juvenile was on probation for a gang related crime involving the murder of a citizen. After receiving a lenient sentence for providing fellow gang member names to local law enforcement, the juvenile began receiving threats on his life from the other gang members. To provide temporary protection for the juvenile, the sending state decided to relocate the youth to family in another state for an undetermined length of time. Before gaining approval from the receiving state, local authorities released the youth to family members in the receiving state without arranging for appropriate supervision. Two weeks later, the gang members found the 14-year-old in the receiving state, assaulted and hospitalized the youth, and made threats to the juveniles' extended family. Only after the assault and threats did local authorities realize that a juvenile probationer was located in their jurisdiction.

- A 16-year old juvenile was on probation for a shopping mall theft. She came from an abusive family and marks on her body reflected regular abuse by her parents. Local social services were ordered to provide the youth and her family with regular counseling and supervision. Midway through her probation period, the juvenile escaped to another state and was arrested for another theft one week later. The receiving state notified the youth's home state about the arrest. Under terms and rules of the current compact, the youth's home state is required to transport that youth under an appropriate level of supervision. In an attempt to save dollars, the youth's home state decided to buy a one-way bus ticket for the juvenile but decided not to provide an escort. The youth escaped while enroute home at a gas station and remains unaccounted for today.

- A 17-year-old juvenile absconded from his state of residence while on parole for drug possession and drug use. The juvenile was identified and picked-up in another state where 17-year-olds are considered adults. Under compact rules, juveniles are defined by their home state's laws, not the receiving states laws. The juvenile's home state issued a court order for the juvenile's detainment and extradition. Due to the lengthy and formal process to detain and transport juveniles, the youth's home state could not extradite the youth in a timely manner. Meanwhile, the local jurisdiction holding the juvenile released him on the grounds that he was an adult and their local law forbade them from detaining adults over a specified period of time without formal criminal charges. The juvenile was arrested three months later in the same state for cocaine possession and is now serving two new sentences for drug possession and use.

SB 168

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/27/09

FURTHER: Finance

Date of 5-Day Notice: Feb 18, 2010
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: February 23

Health and Social Services Committee considered SENATE BILL NO. 168

SB 168 TRAUMA CARE CENTERS/FUND

"An Act relating to state certification and designation of trauma centers; creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [X] **CS** SB168 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
REV	2/8/10			✓	1
Health	2/8/10			✓	2
HSS	2/10/10	✓			3

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS			X	
	Thomas	✓			
	PASKVAN			X	
	Dyson	✓			
CHAIR:	DAVIS	✓			

4605

26-LS0799\R
Mischel
2/17/10

CS FOR SENATE BILL NO. 168(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATE HEALTH AND SOCIAL SERVICES COMMITTEE BY REQUEST

A BILL

FOR AN ACT ENTITLED

"An Act relating to state certification and designation of trauma centers; creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers and including a portion of the tax levy on alcohol as a source of money that may be appropriated to the trauma care fund; and providing for an effective date."

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

*** Section 1.** AS 18.08.082 is amended by adding a new subsection to read:

(c) The commissioner shall establish special designations in regulation for varying levels of trauma care provided by a certified trauma center that shall be used to set compensation eligibility and amounts under AS 18.08.085. The designations shall be based on nationally recognized standards and procedures.

*** Sec. 2.** AS 18.08 is amended by adding a new section to read:

Sec. 18.08.085. Uncompensated trauma care fund; creation. (a) The

uncompensated trauma care fund is created. The purpose of the fund is to compensate certified trauma centers in the state that receive a special designation under AS 18.08.082(c) for care uncompensated by the person receiving the care or by any other source.

(b) The fund consists of money appropriated to it by the legislature, including donations, recoveries of or reimbursements for awards made from the fund, income from the fund, and other program receipts from activities under this chapter. Appropriations to the fund do not lapse.

(c) The commissioner shall administer the fund in accordance with the provisions of this chapter. The commissioner shall spend money from the uncompensated trauma care fund for the purpose established in (a) of this section. The commissioner may establish and seek the advice of a special committee for review of statewide trauma care and compensation standards.

(d) The commissioner may not provide more than 25 percent of the total assets, including earnings, of the fund in a fiscal year to one trauma center.

* **Sec. 3.** AS 43.60 is amended by adding a new section to read:

Sec. 43.60.055. Disposition of proceeds; availability for appropriation to the uncompensated trauma care fund. The portion of the tax collected under AS 43.60.010 that is not separately accounted for under AS 43.60.050(a) may be appropriated to the uncompensated trauma care fund (AS 18.08.085). Nothing in this section creates a dedicated fund.

* **Sec. 4.** This Act takes effect immediately under AS 01.10.070(c).

26-LS0437\R.3
Bullock
2/16/10

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE HERRON

TO: HB 168

Page 1, line 3, following "**centers**":

Insert "**and including a portion of the tax levy on alcohol as a source of money that may be appropriated to the trauma care fund**"

Page 2, following line 12:

Insert a new bill section to read:

"*** Sec. 3.** AS 43.60 is amended by adding a new section to read:

Sec. 43.60.055. Disposition of proceeds; availability for appropriation to the uncompensated trauma care fund. The portion of the tax collected under AS 43.60.010 that is not separately accounted for under AS 43.60.050(a) may be appropriated to the uncompensated trauma care fund (AS 18.08.085). Nothing in this section creates a dedicated fund."

Renumber the following bill section accordingly.

4608

Alaska State Legislature

Senate Health & Social Services Committee
Senator Bettye Davis, Chair

Senate Bill 168 – Sponsored by Senate Health & Social Services Committee

"An Act relating to state certification and designation of trauma centers; creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers; and providing for an effective date."

Sponsor Statement

SB 168 addresses the urgent need for a comprehensive state-wide trauma center system coordinating and integrating the efforts of Emergency Medical Services (EMS), public safety agencies, air medial services, and health care facilities to ensure that patients receive the most efficient, effective care possible from time of injury through rehabilitation. Trauma care systems have been shown to reduce death from injury by as much as 25 percent and are recognized as an integral part of a state's EMS and disaster response system. Only eight states reportedly have fully functioning systems and 15 states have no system.

Trauma is any life-threatening occurrence, either accidental or intentional, that causes injuries. The leading causes of trauma are motor vehicle accidents, falls, and assaults. Trauma is the leading cause of death among Americans under 44 years of age. A trauma center is a hospital, clinic, or other certified entity equipped to provide comprehensive emergency medical services to patients suffering traumatic injuries. Trauma centers were established by the medical establishment in response to traumatic injuries that often require complex and multi-disciplinary treatment including surgery, in order to give the victim the best possible chance for survival and recovery.

SB 168, Section 1, adds subsection (c) to AS 18.08.082, Emergency Medical Services, to address the state certification and designation of trauma centers; it creates the "Uncompensated Trauma Care Fund" under Section 2, AS 18.08.085, to offset uncompensated trauma care provided at certified and designated trauma centers; and it provides for an immediate effective date. The bill requires the commissioner to establish special designations in regulation of Levels I-IV of certified trauma centers that shall be used to set compensation eligibility and amounts under the Uncompensated Trauma Care Fund.

4609

Although the current Alaska statutes revised in 1993 require certification of hospitals, clinics, or other entities represented as trauma centers, the statutes do not require or provide incentives for participation. The Uncompensated Trauma Care Fund will provide the needed incentive for hospitals, clinics, and other entities to seek certification as trauma centers. Since the state statutes and regulations in this area were enacted over 15 years ago only three of 24 eligible Alaska hospitals reportedly have successfully completed the verification and certification process as trauma centers.

In order to qualify as a trauma center, a hospital must meet certain criteria as established by the American College of Surgeons. Trauma centers vary in their specific capabilities and are identified by "Level" designation: Level-I being the highest, to Level-IV being the lowest. Higher levels of trauma centers will have trauma surgeons available, including those trained in such specialties as neurosurgery and orthopedic surgery as well as highly sophisticated medical diagnostic equipment and specialized treatment units. Lower levels of trauma centers may only be able to provide initial care and stabilization of a traumatic injury and arrange for transfer of the victim to a higher level of trauma care.

Under the Alaska trauma center system, it is anticipated that tertiary hospitals designated as higher level trauma centers will ensure availability of critical care specialists 24 hours a day, seven days a week. The Alaska Native Medical Center is a Level II trauma center, Yukon Kuskokwim Regional and Norton Sound Regional Hospitals are Level IV. It is believed that there are adequate medical resources to establish more Level II trauma centers in Anchorage, and it is considered feasible to establish level III and IV centers throughout the state. Because of long transport times, trauma centers at all levels are necessary to improve patient outcomes. Level I trauma centers have critical care specialists in the hospital or on call at all times. The closest Level I trauma center is Harborview Medical Center in Seattle.

The operation of a trauma center is extremely expensive. Some areas are under-served by trauma centers because of this expense. For example, Harborview Medical Center in Seattle is the only Level I trauma center to serve the entire states of Washington, Idaho, Montana, and Alaska. In Florida, Orlando Regional Medical Center, reportedly built to serve five counties, now serves more than twenty.

Patient traffic at trauma centers can vary widely, as there is no way to schedule the need for emergency services. A variety of different methods have been developed for dealing with this. Halifax Health in Daytona Beach, Florida reportedly is deploying a "pod system," allowing trauma care to be provided by several different small emergency departments at different hospitals, rather than at one central large trauma center. It is anticipated that Alaska, likewise, will have to develop a trauma center system which best suits its needs. It is anticipated that persons critically injured in remote areas of Alaska will be transported directly to a distant trauma center by plane and helicopter for faster and better medical care than if they had been transported to a closer hospital or clinic which is not a designated trauma center. The designation, coordination, and funding of a trauma center system in Alaska as provided by SB 168 will save time and lives. SB 168 will also provide the financial incentives for more participation by hospitals, clinics and other certified trauma care entities which are not available under present law.

lature's intent regarding how the money appropriated is to be spent; (2) must not administer the program of expenditures; (3) must not enact law or amend existing law; (4) must not extend beyond the life of the appropriation; and (5) must contain language that is germane, or appropriate, to an appropriations bill. Alaska Legislative Council v. Knowles, 21 P.3d 367 (Alaska 2001).

Sec. 24.08.035. Fiscal notes on bills. (a) Before a bill or resolution, except an appropriation bill, is reported from the committee of first referral, there shall be attached to the bill a fiscal note containing an estimate of the amount of the appropriation increase or decrease that would result from enactment of the bill for the current fiscal year and five succeeding fiscal years or, if the bill has no fiscal impact, a statement to that effect shall be attached. The fiscal note or statement shall be prepared in conformity with the requirements of this section by the department or departments affected and may be reviewed by the office of management and budget. The fiscal note or statement shall be delivered to the committee requesting it within three days of the request. If the bill is presented by the governor for introduction in accordance with AS 24.08.060(b) and the uniform rules of the legislature, the fiscal note or statement shall be attached to the bill before the bill is introduced. An amendment or a substitute bill proposed by a committee of referral that changes the fiscal impact of a bill shall be explained in a revised fiscal note or statement attached to the bill.

(b) In addition to the fiscal note required by this section, the sponsor of a bill or resolution may prepare a fiscal note in conformity with the requirements of this section and submit it to the committee of first referral or the finance committee. A committee may prepare an additional fiscal note in conformity with the requirements of this section.

(c) A fiscal note for a bill or resolution must contain the following information:

(1) the fiscal impact on existing programs;

(2) the fiscal impact of new programs or activities;

(3) a line item detail of the fiscal impact;

(4) the source of funds expected to be utilized by general fund source, federal fund source, or other identified source;

(5) the number of new positions that may be required, identified as full-time, part-time, or temporary;

(6) an analysis of how the figures in the fiscal note were derived;

(7) additional information necessary to explain the fiscal note;

(8) a fiscal impact projection for the current fiscal year and for the succeeding five fiscal years; and

(9) formal information consisting of

(A) the bill or resolution number,

(B) the name of the prime sponsors,

(C) the date the fiscal note was prepared,

(D) the name of the committee requesting the fiscal note,

(E) the name and phone number of the person who prepared the fiscal note, and

(F) the budget request unit, program, or subprogram affected.

(d) The original of a fiscal note shall be submitted to the Division of Legislative Finance and copies shall be sent to the prime sponsor, the committee requesting the fiscal note, and the office of management and budget.

(e) *[Repealed, § 2 ch 64 SLA 1992.]* (§ 1 ch 153 SLA 1968; am § 1 ch 20 SLA 1972; am § 1 ch 42 SLA 1976; am § 2 ch 60 SLA 1979; am §§ 3, 4 ch 63 SLA 1953; am §§ 1, 2 ch 64 SLA 1992; am § 4 ch 34 SLA 2007)

Revisor's notes. — Formerly AS 24.30.035. Renumbered in 1985.

Effect of amendments. — The 2007 amendment, effective January 1, 2008, substituted "three days of the request" for "five days of the request or within two days if the request is made after the 90th day of a regular session, or during a special session of the legislature" in the third sentence of subsection (a).

Sec. 24.08.036. Fiscal notes on bills affecting state retirement systems. Before a bill which would have an effect on the retirement systems of the state is reported to the

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB168**
() Publish Date:

Identifier (file name): **SB168-DHSS-IPEMS-02-08-10**
Dept. Affected: Health & Social Services

Title: Trauma Care Centers/Fund
RDU: Public Health
Component: Injury Prevention/Emergency Medical Services
Sponsor: HSS By Request
Requester: Senate HSS
Component Number: 2876

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 168 establishes a mechanism to provide a financial incentive for hospitals to become designated as certified trauma centers in order to encourage their participation in a statewide trauma system, with the goal of improving delivery of trauma care in the Alaska medical system. This bill establishes a fund for reimbursement of trauma care for uninsured or underinsured patients, and allows designated trauma centers to apply for compensation of claims that are otherwise uncompensated by insurance or other funds.

The Department proposes to manage this fund using existing staff resources.

Prepared by: Ward B. Hulburt, M.D., MPH, Chief Medical Officer / Director — Phone 269-8126
Division: Public Health — Date/Time 2/4/10 2:27 PM

Approved by: Alison Elgee, Assistant Commissioner — Date 2/8/2010
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 168
() Publish Date:

Identifier (file name): SB168-REV-TRS-2-8-10
Dept. Affected: Revenue
Title: Uncompensated Trauma Care fund
RDU: Taxation and Treasury
Component: Treasury Division
Sponsor: Senate HSS committee
Requester: Senate Health and Social Services
Component Number: 121

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Part-time	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Temporary	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

ANALYSIS: *(Attach a separate page if necessary)*

These bills establish a $5 million fund to compensate certain certified trauma centers in Alaska for care uncompensated by the person receiving the care or by another source. This fund will be invested within the GeFonsi investment pool. No additional costs have been identified.

Prepared by: Pamela J. Leary, Comptroller
Phone 465-2300
Division: Treasury
Date/Time 2-8-10; 10:01am
Approved by: Ginger Blaisdell, Director
Date 2-8-10; 8:16pm
Administrative Services Division

(Revised 11/5/2009 OMB)

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB 168**
(S) Publish Date: 2/10/2010

Identifier (file name):
Dept. Affected: Health & Social Services
Title: Relating to state certification, designation of trauma centers, creating the uncompensated trauma care fund
RDU
Component
Sponsor: Senate Health & Social Services Committee
Requester:
Component Number

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	5,000.0	5,000.0					
Miscellaneous							
TOTAL OPERATING	**5,000.0**	**5,000.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	3,100.0	3,100.0					
1003 GF Match							
1004 GF	1,900.0	1,900.0					
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**5,000.0**	**5,000.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill creates the uncompensated trauma care fund to be used to compensate certified trauma centers for practicing at the highest national standards for trauma care.

Prepared by: Celeste Hodge, Committee Aide
Phone 465-3822
Division: Senate Health & Social Services Committee
Date/Time
Approved by: Senator Bettye Davis
Date
Senate Health & Social Services Committee

(Revised 11/19/2007 OMB)

Medicaid Disproportionate Share Payments

- Medicaid is a joint federal/state partnership with many requirements outlined in federal law.
- One federal requirement is that Medicaid hospital payment rates must take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs (DSH).
- Federal requirements also provide for two limits on DSH expenditures. One limits Medicaid DSH individual hospital payments to the costs of Medicaid services and services to the uninsured less the payments received for those services, and another limits the state's total DSH payments made to all hospitals.
- In order to facilitate the required calculations, each hospital that wishes to participate in the Medicaid DSH program must submit by October 1, of the calendar year preceding the state fiscal year the payment will be made, the Medicare cost report (form 2252) filed for the qualifying year; Medicaid reporting forms for the qualifying year from the *Medicaid Hospital and Long-Term Care Facility Reporting Manual*; and a log for the qualifying year for each patient having uninsured care; the log must be prepared using the *Medicaid Log of Uninsured Care Reporting Form,* the hospital must certify the log as accurate, the log must specify, in sufficient detail for the department to verify uninsured care, Charges, Admissions, Patient days, Any payments made by the patient, or on behalf of the patient by a third party, for services, and Dates of services.
- Federal law mandates three methods of qualifying for Medicaid DSH payments. Those methods are high Medicaid utilization, high low income client utilization, and pediatric outliers DSH payments (which are very insignificant under our current program, and we do pay if necessary). Currently few payments are made utilizing these qualifying standards.
- States can create additional methodologies to pay out DSH as long as those methodologies comply with state and federal law, but the foundation of any payments is still the uncovered Medicaid and uninsured costs.
- The department is currently in the process of revising our Medicaid DSH distribution methodologies as current processes were in place primarily as a Medicaid refinancing tool and have since been rendered obsolete by federal regulations and related appeal decisions. The Department of Law is working with us to identify a methodology we can legally use to target DSH funds towards a particular purpose like trauma centers.
- For 2009, we estimated there was about $23.8 million in DSH funding available under the state's overall DSH cap that we did not distribute because of a lack of funding. Under current regulation and funding availability, future years would likely look similar.

Information provided by Bill Streur, Deputy Commission of HSS and director of the Division of Health Care Services.

Alaska's federal allotment for 2010, expressed in terms of federal funds, is $20,964,262. With our average 61.12% match rate in 2010 that's total allowable DSH expenditures of $34,300,167 for non-tribal providers.

Following is a list of SFY2010 DSH Payments:

DSH SPEP paid to Providence: $3,343,719 FFY10
DSH DET paid to Fairbanks Memorial Hospital: $1,787,856 FFY10
DSH DET paid to Bartlett Regional Hospital: $1,953,050 FFY10
DSH IMD to API: $3,584,010 FFY09
DSH IMD to API: $9,639,615 FFY10
Total 2010: $20,308,250

To the department's knowledge there are no more planned DSH payments for SFY10, which would leave them with approximately $13,991,917 that they will not spend in 2010.

Alaska Medicaid DSH facility specific limits for 2010 are as follows:

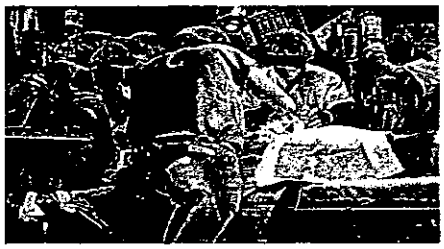
[redacted]	16,336,231

Alaska Regional Hospital	5,104,508
Bartlett Regional Hospital	6,727,455
Central Peninsula General Hospital	5,054,361
Cordova Community Medical Center	0
Fairbanks Memorial Hospital	11,807,068
Ketchikan General Hospital	1,881,611
Mat-Su Regional Medical Center	0
North Star Behavioral Health System	0
Norton Sound Regional Hospital	0
Petersburg Medical Center	213,838
Providence Alaska Medical Center	12,307,371
Providence Kodiak Island Medical Center	1,276,910
Providence Seward Medical Center	462,700
Providence Valdez Medical Center	2,074,347
Saint Elias Specialty Hospital	1,529,795
Sitka Community Hospital	0
South Peninsula Hospital	1,134,695
Wrangell Medical Center	0
TOTALS (Not including API)	**49,574,659**

Information provided by Bill Streur, Deputy Commission of HSS and director of the Division of Health Care Services.

The 2011 Alaska DSH allocation is up in the air because of potential health reform adjustments to the formula from Congressional action. Without health reform, assuming a 4% increase from 2010, and the state's 54.34% FMAP for 2011 the department estimates a 2011 DSH allocation at approximately (21,582,340/.5434) $39,717,226. The department will probably not have the 2011 facility specific limit calculations completed until approximately July 2010.

TRAUMA CARE IN ALASKA 2008



Treating Trauma

- Like heart disease, cancer or malaria, trauma is best combated with a strategy that addresses prevention, acute care and rehabilitation.

What is Trauma?

- 1966 National Academy of Sciences whitepaper: Accidental Death and Disability: The Neglected Disease of Modern Society"

  During this period, more people were dying on our highways each year then during the entire Vietnam conflict.

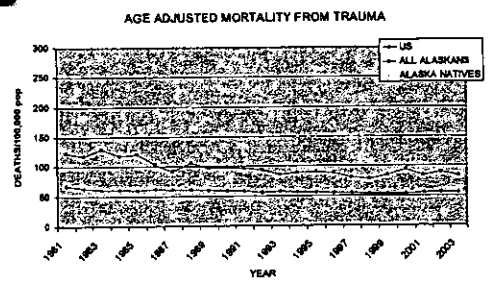
Trauma in Alaska

- Leading cause of death age 1-44
- 400-500 Alaskans die each year
- Over 5000 admitted to the hospital
- Over 1000 with permanent disability
- 800 Alaskans hospitalized with brain or spinal cord injuries

Trauma in Alaska

- Motor vehicle crashes leading cause of death
- Firearm related injuries, second
- 2004 hospital cost for Alaska trauma patients over $73 million
- ~ 25% over trauma admissions uncompensated

DEATH FROM TRAUMA IN ALASKA



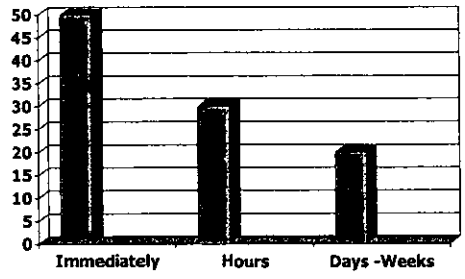
HISTORY OF TRAUMA SYSTEMS

- National Highway Safety Act 1966
- EMS System Act 1973
- Trauma Systems Planning and Development Act 1990
- Skamania conference 1998

Trauma Systems

- A trauma system consists of hospitals, personnel, and public service agencies with a preplanned response to caring for the injured patient

Death from Trauma



Trauma Systems

- Facilities (trauma center designation)
- Personnel (training)
- Patient transport
- Triage

Facilities-Trauma Centers

- Level I -Definitive subspecialty care, research
- Level II – Definitive subspecialty care, surgery, ortho, neurosurgery
- Level III- General surgery, ortho, no neurosurgery
- Level IV- Stabilization, limited or no surgical capacity

Personnel

- ATLS
- TNCC
- ETT first responders

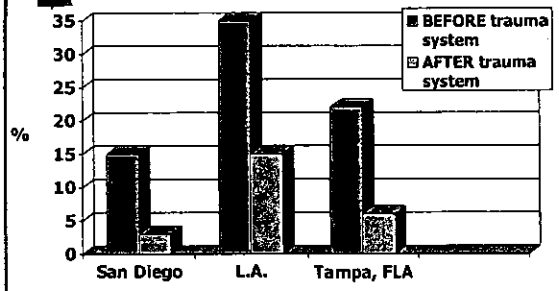
Transport and triage

- Guidelines that take into account local resources and capabilities
- Head Injury Guidelines
- Burn Triage

Trauma Systems

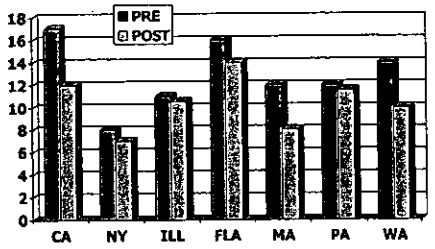
- 15-20% improvement in survival of the seriously injured
- Increase productive working years
- Improve statewide disaster preparedness
- Inclusive systems

Preventable Deaths: The impact of Trauma Systems



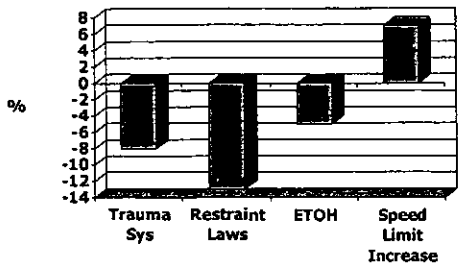
Trauma Systems & crash mortality

Nathens et.al. 2000



Trauma Systems & Crash Mortality

Nathens et.al. 2000



Trauma Centers and Disaster Preparedness

- Trauma centers have usually received the first wave after terrorist attack or natural disaster
- WTC 1993, 2001
- Oklahoma City
- Katrina

Trauma Center and Disaster Preparedness

- Maintain readiness
- Staffed for all types of injury
- Broad communications with regional hospitals and aeromedical resources
- Surge capacity
- Decontamination
- Resources to facilitate patient recovery

Trauma Systems and Disaster Preparedness

- Terrorism- Worldwide explosive attacks cause the majority of deaths and casualties from acts of terrorism
- Economical, readily available

Trauma Systems and the Public

- 2004 Harris poll
- Most people want a trauma system in their area
- 83% felt it was as important as fire department
- 80% were willing to pay extra for it

Trauma Systems and the Public

- 75% of those interviewed "thought" there was a trauma system in their state
- Only 8 states have comprehensive systems
- 15 no system at all
- 27 states including Alaska are "works in progress"

Alaska Trauma System

- 1993 statute- EMS authority for designating trauma centers created
- Hospital participation voluntary
- Standards for trauma center designation follow American College of Surgeons criteria

Alaska Trauma System

- Verification of compliance by outside reviewers for Level I, II, III
- In-state review for Level IV

Alaska Trauma Systems Review Committee

- MDs, nurses, admin, and prehospital
- Oversight- Trauma designation
  - EMS/ prehospital triage and inter-facility transfer guidelines
  - Trauma system performance improvement

Alaska Trauma System-14 years later

- Twenty–four hospitals in Alaska
- One level II center - ANMC
- Four level IV centers - NSH - MEH - YKHC - SCH

8 other reviews or consultations

Alaska Trauma System: Where do we go now ?

- Increasing facility participation is paramount
- "Carrots and sticks"

"Sticks"

- Require participation
- Tie to facility licensing or Medicaid participation

Carrots

- Caps on the medicolegal liability of designated trauma centers taking care of injured patients
- Cover the cost of uncompensated care of trauma patients treated at designated trauma centers

"Carrots"

- Funding of trauma systems.
- Sin Taxes
- Oil revenues- i.e. WY
- Homeland Security

Where do we go now? Proposed Legislation

- Draft legislation being prepared
- Cap liability of designated trauma facilities at $500,000 for injury or death
- Creation of a Trauma System Fund- defray the cost of uncompensated care when given at designated trauma centers

Alcohol Screening and Brief Intervention in the Injured Patient:

Injury Prevention in the Hospital and ER

Public Health Impact of Alcohol Use & Abuse

- Alcohol abuse is a preventable public health problem contributing to 100,000 deaths and costing 185 billion dollars annually
- Alcohol misuse has far-reaching implications for the individual drinker, family, workplace, community, and health care system

Alcohol and Injury

What Percent of American Indian and Alaska Native Deaths Are Alcohol-Related?

- Motor Vehicular— 73%
- Pedestrian—75%
- Homicide—85 %
- Suicide —84%

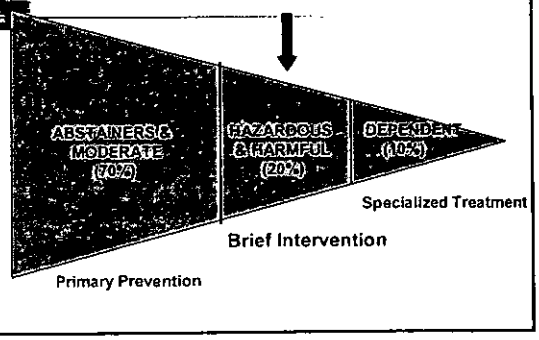
Sources: May P, *The Epidemiology of Alcohol Abuse Among American Indians: the Mythical and Real Properties.* The Primary Care Provider, Volume 20, March 1995, Indian Health Service; . *Ethnicity and Alcohol-Related Fatalities, 1990-1994, by* Voas RB and Tipetts AS, National Highway Traffic Safety Administration, 1999. Courtesy of D. Wallace

Literature Review

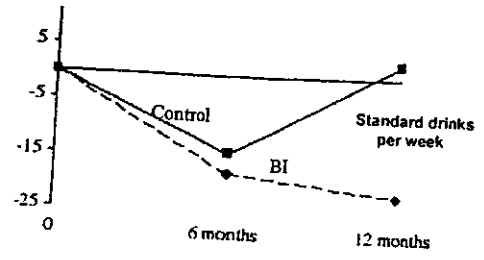
- Prochaska and DiClemente* (1983)
- Bien et al (1993)
- Gentilello* (1999)
- D'Onofrio* and Degutis* (2002, 2005)
- Dischinger* and Soderstrom* (2001)
- Moyer et al (2002)
- Soderstrom* and DiClemente*, (2005)
- Sanddal(s)* and Upchurch*, (2005)
- Schermer*, (2006)

*Assisting the IHS-Tribal ASBI Program

The Spectrum of Alcohol Use: Who Are We Targeting?



Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence
Gentilello LM (Dunn CW) et al: Ann Surg 1999;230:473-483

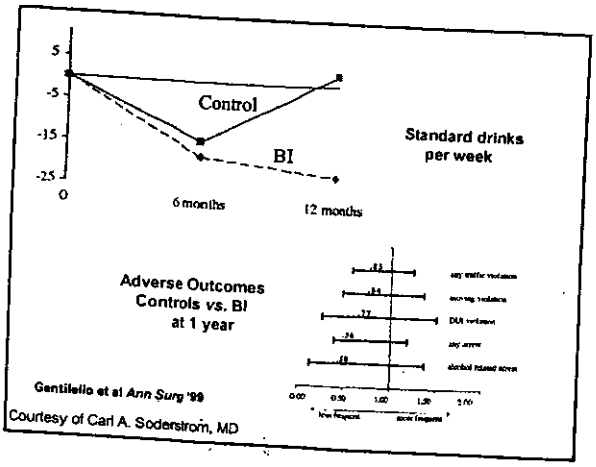


Key Trauma Center Study

Showed beneficial results with a brief intervention in TC patients

- The experimental group demonstrating decreases in drinking at 6 months and at one year
- The control group returned to pre-injury level (or higher) at one year
- The experimental group had a 47% reduction in injuries requiring emergency department care or trauma center admission

Gentilello LM, Rivara FP, Donovan DM, Jurkovich GJ, et al: Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Ann Surg*, 1999;230: 473-483.



Courtesy of Carl A. Soderstrom, MD

R.A. Cowley STC Longitudinal Death Study

- Not offering advice/intervention to STC patients who test positive for alcohol misuse results in significant subsequent higher death rates from injury
- 27,000 patients discharged from the STC and followed for 1.5 to 14.5 years
- A subsequent injury death occurred in 1,631 or (23%) in those who tested toxicology positive at the initial STC admission

Dischinger PC, Mitchell KA, Kufera JA, Soderstrom CA, et al: A longitudinal study of former trauma center patients: the association between toxicology status and subsequent injury mortality. *J Trauma* 2001;51:55-564.

Billings Area Injury Death Study

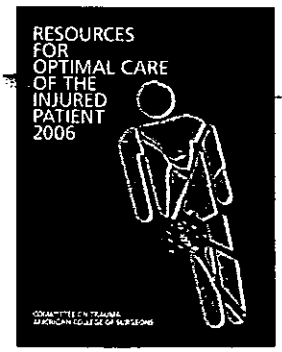
- 38% of patients with fatal injuries had a previous IHS Service Unit ETOH encounter without prevention counseling within the previous six months
- Injury-Prevention activities should be initiated at the time of any health-system contact in which alcohol use is identified
- Intervention strategies should be developed that convey the immediate risk of death from injury in these patients

Analysis of Prior Health System Contacts as a Harbinger of Subsequent Fatal Injury in American Indians. TL Sanddal, J Upchurch,ND Sanddal and TJ Esposito; Journal of Rural Health, 2005

"Prevention Paradox"

- For every known alcohol dependent person there are more than six persons who have alcohol-related problems, but are not dependent
- A majority of this group of non-dependent alcohol user group are in the hazardous and harmful alcohol use group

Personal Communication with Daniel Hungerford, DPH, MS; CDC; May 2006



Prevention

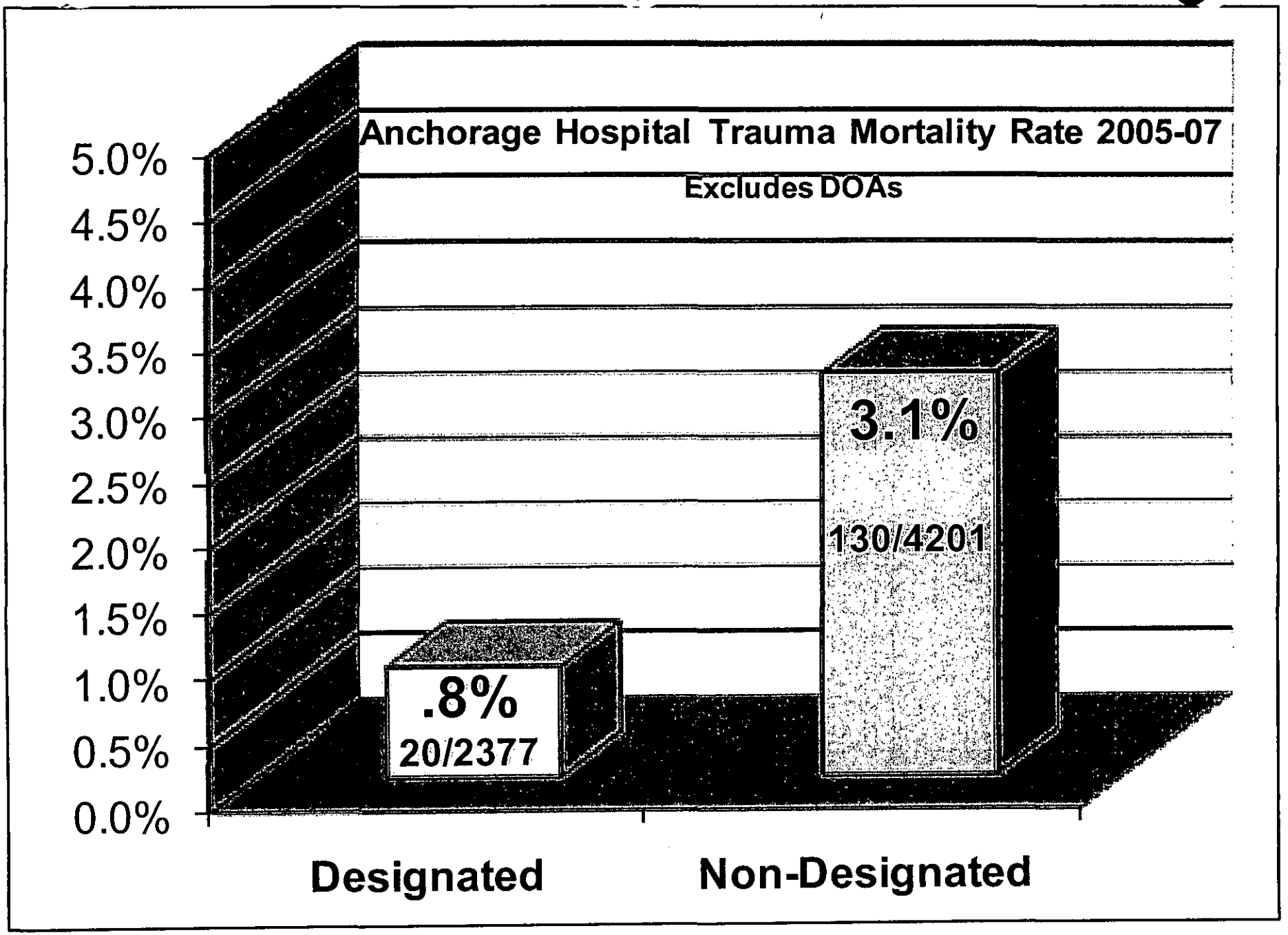
Level I & II - Essential
"Have a mechanism to identify patients who are problem drinkers"

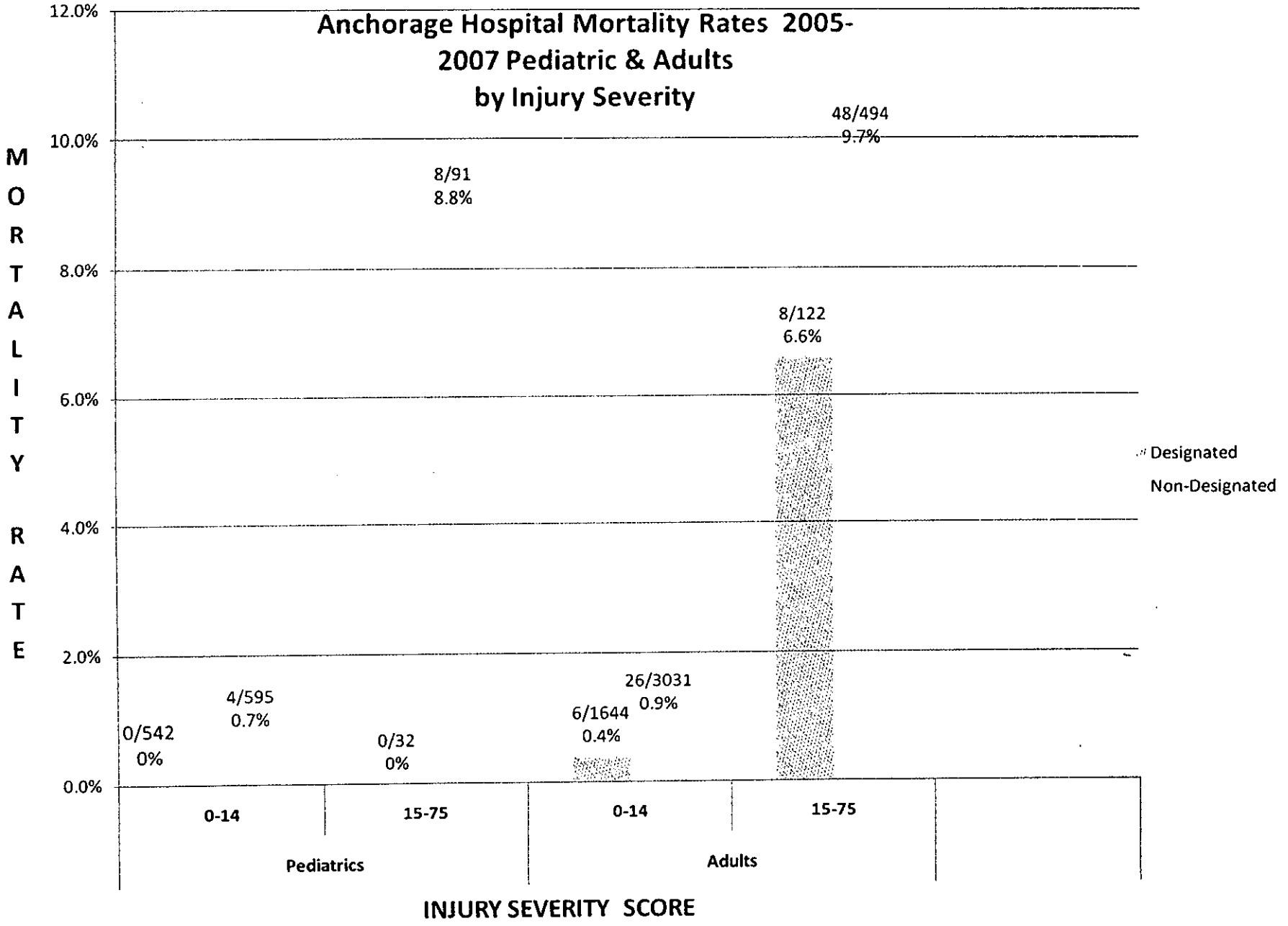
Level I – Essential
"Must have the capability to provide an intervention for patients identified as problem drinkers."

2006 ACS Frequently Asked Questions (FAQ) website in development as of Jan 15, 2007 (facs.org/trauma/faq_answers.htm)

ASBI Documentation and Reimbursement

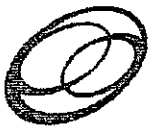
- Chart Documentation, PCC and HER
- Pre-Screen, Alcohol Screen (AS) & Brief Intervention (BI)
- Coding
- CPT-HCPCS Codes
- H-0049 Screening
- H-0050 Screening and Brief Intervention
- RPMS
- CRS... GPRA
- Billing and Reimbursement
- ICDA Codes


Anchorage Hospital Trauma Mortality Rate 2005-07
Excludes DOAs
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
.8%
20/2377
3.1%
130/4201
Designated
Non-Designated


Anchorage Hospital Mortality Rates 2005-2007 Pediatric & Adults by Injury Severity
MORTALITY RATE
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
0/542
0%
4/595
0.7%
0/32
0%
6/1644
0.4%
26/3031
0.9%
8/91
8.8%
48/494
9.7%
8/122
6.6%
Designated
Non-Designated
0-14
15-75
0-14
15-75
Pediatrics
Adults
INJURY SEVERITY SCORE

Objectives and Methodology

- The Coalition for American Trauma Care commissioned Harris Interactive to conduct a survey of the public's views of and support for trauma systems.
- Telephone interviews were conducted with a nationally representative sample of 1000 adults aged 18 and over, between November 3rd and 14th, 2004.
- Final data were weighted by age, education, gender, income, and region, where necessary, using 2003 Current Population Survey data to adjust for sampling biases, if any.
- With 1,000 respondents, the sampling error is +/- 3%.



Key Topics

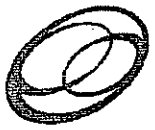
- Knowledge about leading causes of death
- Perceived value of and expectations about trauma centers
- Perceived value of and expectations about trauma systems
- Willingness to support funding of trauma centers and systems
- Disaster preparedness and trauma systems

Harris Interactive Ground Rules For Publicly Released Surveys

- Harris Interactive Inc. has very strong ground rules for surveys which may be publicly released. No other survey firm has stronger rules.
- Our **Five Rules** ensure that our surveys are never used to lead or mislead policymakers or the public. We do not do "hired gun surveys."
  1. **The survey must be fair, balanced and comprehensive.**
  2. **If the survey is publicly released, the full survey report must be released.**
  3. We will not include questions for possible publication about our clients' company or their products or brand names, or the names of their competitors. (The one exception: we sometimes do readership surveys or audience measurement surveys which ask about our clients.)
  4. **The survey must not be used to mislead the public, the media, policymakers or anyone else.**
  5. **We need to review the information that is being released prior to its release in order to check for accuracy.**

Overview

- Most Americans are not aware that injury is the leading cause of death for children, youth, and adults under the age of 34.
- After hearing a description of a trauma center, Americans value them highly and appreciate the importance of having one within easy reach.
  - Almost all Americans feel it is extremely or very important to be treated at a trauma center in the event of a life-threatening injury.
  - Nearly nine in ten Americans think it is extremely or very important for an ambulance to take them to a trauma center in the event of a life-threatening injury, even if it is not the closest hospital.
  - Nearly all Americans *believe* that if they had a serious or life-threatening injury, they *would* be taken to the hospital that is best equipped to handle their specific injury in less than 1 hour.
- Majorities of Americans feel that having a trauma center nearby is as important as or more important than having a Fire Department or Police Department.



Overview (cont.)

- After hearing a description of a trauma system, nearly all Americans recognize the importance of having a trauma *system* in place in their state.
- Large majorities feel that having a trauma *system* in place is as important as or more important than having State Police or HAZMAT teams.
- About two in three Americans would be extremely or very concerned if they learned that the trauma system in their state did not meet recognized standards. (*However, a 2002 survey of the status of trauma system development conducted by the Health Resources and Services Administration of the U.S. Department of Health and Human Services shows that only 8 states have fully developed trauma systems, 12 states do not have the authority to designate trauma centers, and the rest are in varying stages of partial development.*)
- Americans are willing to spend their own money to have trauma centers and systems in place in their states.
- Generally, Americans have high expectations of their states' trauma centers and systems when it comes to handling natural disasters or terrorist attacks.

Trauma System Consultation
State of Alaska
Anchorage, Alaska

November 2nd -5th , 2008
American College of Surgeons
Committee on Trauma

PRIORITY RECOMMENDATIONS AMERICAN COLLEGE OF SURGEONS ALASKA TRAUMA SYSTEM REVIEW

November 2-5 2008

Definitive Care Facilities

- Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with American College of Surgeons Committee on Trauma (ACS-COT) verification criteria to meet the existing volume and acuity demands.
- Mandate participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center certification/designation appropriate to their capabilities.
  - Facilities should seek trauma center designation at a level appropriate for their capabilities.
  - Other facilities, such as remote health care clinics, should participate with rapid patient assessment and stabilization and by following guidelines for trauma triage and transfer.
- Study pediatric trauma care needs with the goal of establishing one or more centers of excellence in pediatric trauma care.

Coalition Building and Community Support

- Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.

Lead Agency and Human Resources Within the Lead Agency

Develop an appropriate position classification and duty statement for a 1.0 full time equivalent (FTE), permanent trauma system manager that specifies education as a health professional, experience in trauma or emergency health care, and the administrative skills and clinical understanding necessary to support trauma system development.

Trauma System Plan

- Develop a comprehensive trauma system strategic plan consistent with the Health Resources and Services Administration (HRSA) *Model Trauma System Planning and Evaluation* document.

Coalition Building and Community Support

- Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.

System Integration

- Ensure that the Injury Prevention and Emergency Medical Services

(IPEMS) Section is engaged in planning with disaster preparedness, emergency management, and public health functions for integration of the trauma system.

Financing

• Provide state funding to hire a fulltime trauma system manager.

Emergency Medical Services

• Develop a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (e.g., load capacity, instrument rating, landing requirements, etc); and to monitor the availability and location of air resources in near real-time.

System Coordination and Patient Flow

• Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).

Disaster Preparedness

• Integrate all components of the trauma system into state and local disaster planning activities.

System-wide Evaluation and Quality Assurance

• Develop an initial set of 3-5 statewide system performance indicators from among the list of nine provided in the Pre-Review Questionnaire.

Trauma Management Information Systems

• Ensure that all elements considered essential to system development, evaluation and performance improvement in the State of Alaska are included and functional in the new trauma registry and are consistent with the National Trauma Data Standard definitions.

Statutory Authority and Administrative Rules

System Leadership

• Form an Alaska Technical Advisory Committee (ATAC) and task it with providing the Alaska Council on Emergency Medical Services (ACEMS) with recommendations regarding the following functions: data systems, trauma system planning, system-wide performance improvement and patient safety, trauma education (Advanced Trauma Life Support [ATLS], Trauma Nurse Core Curriculum [TNCC], Prehospital Trauma Life Support [PHTLS], etc), trauma center review and certification, injury prevention and control, public policy, and research.

• Enact legislation to expand the membership of the ACEMS to represent the trauma system and to include the following members appointed as follows:

- One member, appointed by the Governor, shall represent the Alaska Chapter of the American College of Surgeons Committee on Trauma.
- One member, appointed by the Governor, shall be a general surgeon who routinely participates in the care of injured patients.
- One member, appointed by the Governor, shall represent the Alaska Chapter of the American Academy of Pediatrics.
- One member, appointed by the Alaska Legislature, upon the recommendation of the Speaker of the House of Representatives.
- One member, appointed by the Alaska Legislature, upon the recommendation of the President of the Senate.

IN DEPTH
STATE HEALTH *NOTES*

Volume 27, Issue 461 February 20, 2006

PREPARING FOR THE WORST: STATES ADDRESS TRAUMA CENTERS' TROUBLES

By Christina Kent

Victims of traumatic events are at least 25 percent more likely to live if they're taken to a certified trauma center than if they are taken to a non-trauma center, according to a carefully controlled, nationwide study in the Jan. 26 *New England Journal of Medicine*.

That finding could give a boost to state legislators who are scrambling to find new sources of funds for the centers, which provide care for the most expensive conditions in the nation. In January, the Agency for Healthcare Research and Quality reported that trauma disorders have become, for the first time, the most expensive condition to treat. According to the agency's Medical Expenditure Panel Survey, trauma-related disorders cost the nation $71.5 billion in 2003

– topping the cost of treating heart conditions ($68 billion), cancer ($48 billion), mental disorders ($47 billion), and cardiopulmonary disease and asthma ($46 billion).

Trauma centers differ from general hospital emergency departments in that they provide, on a 24/7 basis, teams of trauma surgeons, plastic surgeons and other specialists who can deal with the most severe injuries within the "golden hour" – the early period of trauma where skilled intervention may mean the difference between life and death or life-long disability. The centers are capable of dealing with the most severe, life-threatening injuries, including blunt force wounds, multiple internal injuries, burns, broken bones and severe shock.

"Trauma is the number one killer of people aged one to 40," said Dr. J. Wayne Meredith, chairman of the American College of Surgeons' trauma committee. "One of the most prominent tools to prevent those deaths is the trauma system."

The nation's approximately 600 regional trauma centers – which also are often public and teaching hospitals – collectively lose $1 billion a year, according to Connie Potter, executive director of the National Foundation for Trauma Care. And they're facing growing pressure from rising health-care costs, increases in the number of un- and underinsured patients, and physicians' growing unwillingness to provide on-call trauma care, which many regard as underpaid and highly risky (because of possible malpractice lawsuits).

A 2004 report by the Foundation says that, without corrective action, the current rate of closures among the nation's trauma centers will increase, and 10 percent to 20 percent will close within three years.

Preventing Closures

States play an enormously important role in providing trauma care. Not only do they pass legislation authorizing state agencies to design trauma systems, but they strive to keep the trauma centers functioning by channeling to them special funding streams.

Since car crashes are the number one cause of trauma (see chart), many states elect to help pay for trauma care by imposing fines on individuals who are convicted of drunken or reckless driving, or who lose their driver's license. Some states also use revenues from tobacco, alcohol or firearms taxes, while others tax auto insurance or fine persons convicted of illegal drug distribution.

A number of states are currently considering legislation to shore up their trauma centers; some

bills would address the crisis in getting physicians to provide on-call trauma care by increasing their reimbursement.

In New Mexico, HB 356 and SB 356, introduced at the behest of Gov. Bill Richardson, would provide $6 million to create a trauma system fund. Of that amount, $4 million would go to support trauma services at the University of New Mexico hospital and $2 million would go to strengthen the trauma system throughout the state.

In Hawaii, the Legislature is considering HB 3142, which states that Hawaii's "extreme isolation and limited physician re-supply capability renders Hawaii uniquely vulnerable to natural disasters that may occur in a mid-Pacific environment." The bill would create a fund to reimburse the state's only trauma center for documented un- or under-compensated care (including supplemental funding for treatment given to Medicaid beneficiaries). The fund would draw money from state surcharges, the state's environmental response revolving fund, as well as any funds that are separately appropriated by the Legislature or granted by Congress (as long as they don't place an obligation upon the Legislature to continue the purpose for which the federal funds are made available).

In Florida, HB 1697 and HB 497 were signed into law in 2005 after first being vetoed by the governor, who reportedly had concerns about the way the funds were to be distributed. The first bill is expected to raise as much as $4.7 million annually for the state's trauma centers by increasing the penalties for motorists who cause serious injuries (they now will be charged $500) or fatalities ($1,000) in traffic accidents.

The second bill will provide new funding for in-state trauma care by increasing the fine for running a red light from $60 to $125. Florida's 20 trauma centers incur an annual net loss of $96 million, said Amy Maguire, director of the Alliance to Save Florida's Trauma Care. The funds will be distributed to the hospitals based on their state of "readiness" (e.g., how many physicians are on call), and the severity and volume of injuries treated.

Pennsylvania, which has one of the oldest trauma systems in the nation, is considering a bill (HB 502) that would seek to retain trauma providers by increasing their reimbursement. The bill notes that many high-risk health-care providers and institutions in the state are being paid less than Medicare rates by private insurers. "[H]igh-risk health-care providers and institutions may leave this Commonwealth or close down if the low reimbursements continue," the bill states. It would require insurers to pay 25 percent more than the Medicare fee to high-risk providers

(defined as those who pay malpractice premiums in one of the four highest classes) for providing covered treatment to trauma patients at a state-accredited Level 1 or 2 trauma center – or the provider's "usual and customary charge," whichever is less.

If states play the primary role in creating trauma centers, the federal government historically also has contributed. For years, the Health Research and Services Administration's (HRSA) Trauma/Emergency Medical Services program provided grants to states to help them plan trauma systems. But the federal FY 2006 budget zeroed out funds for that program. It had been funded at about $3.4 million a year since 2001, Potter said, and grants to individual states had averaged about $40,000 per state.

Both Potter and Meredith were highly critical of the fact that the program was eliminated. "Having a federal agency that supports trauma care is critical," Meredith said. "It's the catalyst, the grist of the mill." Trauma costs the nation billions of dollars a year, he noted. "Spending $3 to $4 million to keep that on track seems like a pretty good investment to me." Repeated calls to HRSA for comment were not returned.

How Many?

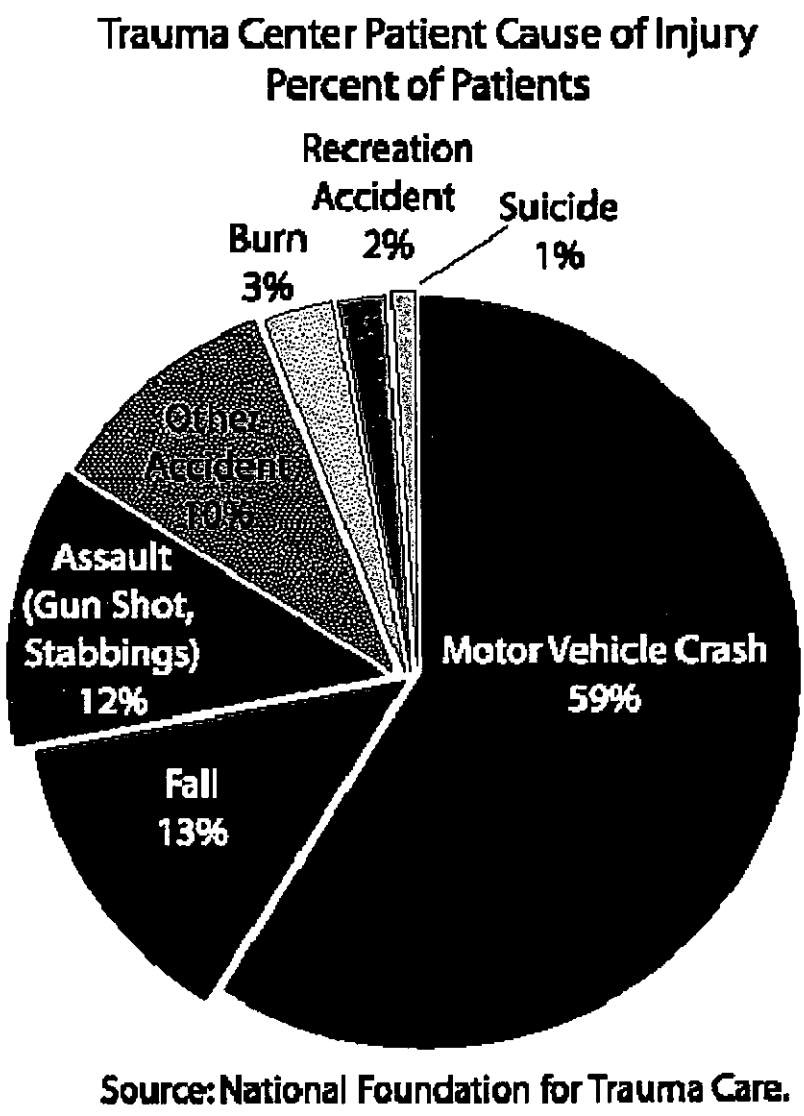
September 11th and Hurricanes Katrina and Rita have raised the profile of trauma centers. But it's not clear how many centers the nation needs. A September 2005 issue brief by Charles Branas at the University of Pennsylvania notes that the geographic distribution of trauma centers varies widely across states and regions. Branas and colleagues calculated that 84.1 percent of the U.S. population has access to a Level 1 or 2 trauma center within one hour. (Level 1 and 2 trauma centers provide the most sophisticated care; Level 3 centers transport the most severely wounded patients to a Level 1 or 2 center.)

The Northeast has the greatest access, followed by the West, the Midwest, and the South. About 36.7 million people – most of whom live in rural areas – do not have access within one hour, Branas found.

A significant proportion of people could reach a trauma center within the "golden hour" by crossing state lines, Branas pointed out. As of 2005, 47 states had protocols to enhance interstate cooperation during mass casualty incidents, but just 31 states had standardized protocols for border crossing of day-to-day trauma patients.

Policymakers who are trying to evaluate their trauma systems can measure how long it takes

their state's residents to reach a trauma center, in comparison to national norms, Branas suggested. This would enable policymakers to "more realistically allocate scare resources," he wrote.



Tara Lubin contributed reporting to this story.

(printer-friendly version)

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SUPPORT LETTERS FROM:

1. Alaska State Medical Association

2. Alaska State Hospital and Nursing Home Association

3. Mark S. Johnson and Frank Sacco, MD

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

October 13, 2008

Regina Chennault, MD
Frank Sacco, MD
4315 Diplomacy Drive
Anchorage, AK 99508

Via fax: 729-2746

RE: Alaska Trauma System

Dear Drs. Chennault and Sacco:

Thank you, Dr. Chennault for presenting at the ASMA House of Delegates Meeting on Saturday, September 27, 2008.

By consensus the ASMA HOD supported the concept of an appropriate trauma system for Alaska. However, the proposal recommended that there be a $500,000 cap on all damages for treatment of trauma patients in a state certified trauma center. The HOD recommended that be dropped from your proposal as any cap on economic damages would likely be found unconstitutional in Alaska. Additionally, the HOD also recommended that the proposal be amended to provide for a mechanism to directly compensate physicians for providing treatment for uninsured trauma patients in a state certified trauma center. (This would be for physicians who are not employees of that certified trauma center).

Several individual HOD members also suggested that you may wish to explore Alaska's "Good Samaritan" laws in lieu of any special economic damages caps which, as previously stated, are constitutionally problematic.

Please let me know if I may be of any future assistance.

Sincerely,

By: James J. Jordan, Executive Director
For: The Alaska State Medical Association

CC: John Raster, MD, Speaker of the House
Tom Vasileff, MD, President
J. Ross Tanner, MD, Immediate Past President

ASHNHA
Alaska State Hospital and Nursing Home Association

426 Main St
Juneau, Alaska 99801
(907) 586-1790
www.ashnha.org

TESTIMONY ON SENATE BILLs 168 and SENATE BILL 169
February 8, 2010

ASHNHA represents 27 private, federal, state, and tribal health care facilities located throughout Alaska. The testimony presented here has been approved by ASHNHA's general membership (see detailed member list at bottom of testimony).

ASHNHA's membership supports **SB 168** and its companion bill **SB 169.**

This incentive based approach to increasing trauma treatment capability in Alaska is well reasoned and addresses one key barrier that discourages facilities from seeking trauma designation. A key barrier not addressed by SB 168 is the availability and cost associated with assuring certain physician specialties are on hand to deal with trauma cases. This barrier will continue to limit the ability of hospitals to achieve optimal trauma designation levels unless it too is addressed. In order to solve this problem Alaska's physician community will have to be included in the discussion.

A possible approach might be to broaden Section 18.08.085 to allow the Commissioner of DHSS discretion to use the 'fund' to help offset costs incurred to meet physician staffing requirements necessary to achieve trauma designation. We understand other states are deploying innovative strategies to address the physician staffing challenge which Alaska could possibly learn from and incorporate into this incentive based program if the language of Section 18.08.085 were broader.

ASHNHA supports **SB 168 and SB 169** and urges their passage from Senate HSS to the next committee of referral at the earliest possible time. Thank you for the opportunity to testify.

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Bartlett Regional Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, North Star Behavioral Health, Wildflower Court Nursing Home.

ASHNHA Contact: Rod Betit • rbetit@ashnha.com • 907 586-1790

4643

[redacted]

To: Sen. Bettye Davis
Subject: RE:

From: peggmac@aol.com [mailto:peggmac@aol.com]
Sent: Monday, February 08, 2010 12:41 AM
Subject:

Dear Senator Bettye Davis, Representative Sharon Cissna, Representative Bob Herron, and Representative Jay Ramras,

I am a nurse practitioner in Anchorage in district K and am writing to support House and Senate Bills 168 and 169, sponsored by Senator Bettye Davis and Representatives Bob Herron and Jay Ramras. Although I don't directly take care of seriously injured patients I have been teaching Community Health Aides for 31 years how to take care of seriously injured patients. Trauma patients do better when there are trauma centers and a trauma system to take care of them. This is not a partisan issue as anybody can be seriously injured.

There is no trauma system in Alaska and there are very few trauma centers. Alaska ranks last in availability of quality trauma care for the majority of the population. A 2008 review by the American College of Surgeons recommended that the State move as quickly as possible to create a trauma system. Alaska needs a trauma system that is there for all Alaskans. Please help by supporting this legislation. I would espcially like to thank Senator Bettye Davis, Representatives Bob Herron and Jay Ramas for sponsoring this legislation.

Sincerely,

Peggy McMahon, RN, CPNP

ANMC, Community Health Aide Program Instructor

[redacted]

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Emergency trauma care needs improvement in Alaska

COMPASS: Other points of view

By MARK S. JOHNSON and FRANK SACCO, M.D.

(03/23/09 19:34:23)

Imagine you and your family driving across Anchorage. As you pass through a major intersection, a drunk driver runs a red light and hits your vehicle broadside. In an instant, you and your passengers face a life or death situation. If you're still conscious, you may think, thank God this happened in Anchorage where we have state of the art emergency medical services.

The Anchorage Fire Department has exceptional ambulance services, staffed with well-trained paramedics. Local hospitals have sophisticated emergency departments staffed 24 hours a day with qualified emergency medicine physicians, nurses and support personnel.

You can be confident that you will receive emergency trauma care that compares favorably with care virtually anywhere else in the nation. Right?

Maybe, but maybe not.

Though Alaskans die from injury at the second highest rate in the U.S., there is no statewide system of trauma care. In Anchorage, only the Alaska Native Medical Center has been verified by the American College of Surgeons and certified by the State of Alaska as a trauma center (Level II). Neither Providence nor Alaska Regional Hospital has achieved this national standard.

Trauma center certification means that a hospital has surgical teams readily available to take care of the most seriously injured patients at all times. Backup teams are available and outcomes are continuously reviewed to improve care.

Serious traumatic injuries can produce internal bleeding in the brain, spinal cord or internal organs. Often, this bleeding can be stopped only by surgeons in hospital operating rooms. Studies have verified the "golden hour of trauma," meaning that critically injured persons have increased chances of survival if treated within that time. Trauma centers, as part of a system of care, have been shown to decrease the mortality of the seriously injured 15 percent to 25 percent. Although rural areas may not meet the golden-hour standard, improvements in the statewide systems have been shown to achieve better outcomes for patients seriously injured in remote areas as well.

The Alaska Department of Health and Social Services recently contracted with the Committee on Trauma of the American College of Surgeons (ACS) to review Alaska's trauma care. That review notes Alaska has excellent injury prevention programs, extensive and creative networks for ground and air medical transport, medical specialists in Anchorage and a good relationship with Harborview Trauma Center (Level I) in Seattle.

Among Alaska's deficiencies: Anchorage does not have another Level II trauma center, so there are two systems of trauma care, one for Alaska Natives that follows national standards and another for non-Natives. The team identified no statewide trauma plan and no incentives or requirements for hospitals to participate in the system. State government devotes few resources to coordinating trauma care, and there seems to be very little public awareness of these issues.

The review team recommended requiring all acute-care hospitals to become designated as trauma centers at a level appropriate to their resources and size within two years (Levels II, III or IV). They recommended getting a second level II trauma center in Anchorage as soon as possible, along with a pediatric trauma center. Currently, due to a shortage of Anchorage surgeons willing to take care of children, some seriously injured non-Native children may need to be treated at the Alaska Native Medical Center.

Representative John Coghill Jr. recently introduced House Bills 168 and 169 to create incentives for hospitals to become trauma centers and to offset some of the cost of uncompensated trauma care. The Department of Health and Social Services should be commended for this comprehensive and impartial review of trauma care in Alaska. We urge Alaskans to support these bills and encourage the legislature and Gov. Palin to carefully consider the recommendations in the ACS report.

We hope the scenario above never happens to you but, if it does, let's make sure that the care we expect for our loved ones is available for all Alaskans when we need it.

Mark S. Johnson, MPA, retired as chief of Community Health and Emergency Medical Services for the State of Alaska in 2004. Frank Sacco, M.D., is chairman of the Alaska Trauma Systems Review Committee. The full report on Alaska's trauma care system is available at www.chems.alaska.gov.

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...gherty — Larry Persily
...sident & Editor — Editorial Page Editor

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...ne Fanning, Editor and Publisher, 1971-1983
...ce Fanning, Editor and Publisher, 1967-1971

OPINION

COMPASS: *Points of view from the community*

Alaska needs a better trauma system

By FRANK SACCO and MARK S. JOHNSON

Sacco

Alaska is blessed with exceptional physicians and quality medical resources, but lack of an organized trauma system means that access to timely, quality care cannot be assured.

Johnson

Alaska is much safer than it was a generation ago. From 1980 to 2004, the unintentional injury death rate dropped more than 50 percent. Without this improvement, an additional 300 Alaskans would have died in 2004. However, Alaska's 2004 rate remained 30 percent above the national average.

We are all aware of the terrible toll of cancer and cardiovascular diseases, but the leading cause of death for people younger than 44 is injury. It remains a major cause of death and disability for all age groups. For every death approximately three people are left with permanent disabilities.

As with other diseases, prevention is preferable to treatment. Alaska's dramatic reduction in injury deaths is largely attributable to prevention, including use of child restraints and safety belts, reduced rates of drunken driving, and increased use of personal flotation devices. Though prevention is paramount, we also must be prepared to provide the best possible care for those who become injured.

A trauma system is an organized, state-coordinated effort to deliver the full spectrum of care to injured people. The integration of EMS systems, public safety agencies, air medical services and health care facilities ensures that patients receive the most efficient, effective care possible from time of injury through rehabilitation. Trauma systems have been shown to reduce death from injury by as much as 25 percent and are recognized as an integral part of a state's EMS and disaster response system.

According to a 2004 Harris poll, most people want a comprehensive trauma system in their area. Throughout the United States, 83 percent of those surveyed felt a trauma system was as essential as having a fire department and 80 percent were willing to pay extra for it. Interestingly, though 75 percent thought there was a trauma system in their state, only eight states have fully functioning systems and 15 states have no system.

Where do we stand? In 1993, the Alaska Legislature provided authority to the Department of Health and Social Services to verify and certify trauma centers. The statute does not require, or provide incentives for, hospital participation. It does state that no hospital can represent itself as a trauma center unless certified by the state.

Regulations adopted in 1996 require trauma centers to meet standards developed by the American College of Surgeons. Four levels are recognized, from Level I (highest) to Level IV (trauma stabilization facility). There are adequate medical resources to establish Level II trauma centers in Anchorage. In addition, it is feasible to establish Level III and IV centers throughout the state. Because of long transport times, centers of all levels are essential for improving outcomes.

Since the statute and regulations were enacted, only three of 24 eligible hospitals have successfully completed the verification and certification process. (Alaska Native Medical Center — Level II, Yukon Kuskokwim Regional and Norton Sound Regional Hospitals — Level IV).

Alaska is blessed with exceptional physicians and quality medical resources, but lack of an organized trauma system means that access to timely, quality care cannot be assured. In recent years there have been times when critical specialties such as neurosurgery and vascular surgery have been unavailable for emergencies, necessitating transfer of some critical patients to Seattle.

Here are four steps to improve trauma care in Alaska:

1. Residents need to let legislators know that quality trauma care is important.

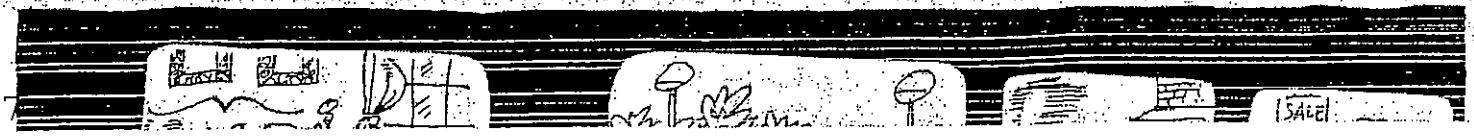
2. The Legislature should put teeth and incentives in the current statute. Successful approaches in other states include requiring trauma center certification at some level as a condition for hospital licensing and limiting medical liability for injuries treated at trauma centers.

3. Tertiary hospitals should ensure availability of critical sub-specialists 24 hours a day, seven days a week.

4. Local EMS and medical providers should organize regional trauma systems and integrate them with the statewide system.

Developing a comprehensive statewide trauma system, and expanding injury prevention efforts, will make Alaska a safer, healthier place to live.

■ Dr. Frank Sacco is chief of surgery at the Alaska Native Medical Center and chairman of the Alaska Chapter of American College of Surgeons Committee on Trauma. Mark S. Johnson was chief of Emergency Medical Services in the Department of Health and Social Services from 1979 until he retired in 2004.



Alaska Statewide Trauma System

Fact Sheet

What is Trauma?
Trauma is any bodily injury from external force. Although many people think of trauma as "accidents", it is better thought of as a disease. Like heart disease and cancer, trauma has identifiable causes and risk factors; and like these conditions, prevention is the best strategy. However, even with the best prevention efforts we still need to be able to take care of the seriously injured. We need to show the same commitment that we brought to cardiac and cancer treatment to trauma care. The seriously injured require timely diagnosis and treatment by health care professionals who are appropriately trained and provided with the necessary resources to reduce the risk of death or permanent disability.

Impact of Trauma in Alaska
Trauma is a tremendous burden on families and communities. In the 1990s, nearly 5,000 Alaskans died from trauma.

- For Alaskans, ages 1 to 44, trauma is the leading cause of death.
- On average, more than 400 Alaskans die from trauma each year. For every injury death, eleven people are hospitalized for trauma-related injuries. For every trauma death that occurs in the hospital, there are an estimated 3 people discharged with permanent disability.
- On average, more than 800 Alaskans are hospitalized each year for central nervous system injury (spinal cord and brain injuries).
- In 2004, motor vehicles were the leading cause of injury death (117), followed by firearm-related injuries (116).
- In 2004, the economic cost of hospital stay alone for trauma patients in Alaska was estimated at over $73 million. One in four hospital admissions were uncompensated.

Years of Potential Life Lost to Trauma
Death from trauma is tragic at any age. Society's loss is especially great because so many young people die from trauma. The impact can be measured in "years of potential life lost:" the number of years between early death from injury and the average age of death at age 70. Using years of potential life lost, trauma is the leading cause of potential life lost for all Alaskans followed by cancer and heart disease.

What is a Trauma System?
A trauma system is a predetermined, organized, multidisciplinary response to managing the care and treatment of severely injured people. It spans the full spectrum of care; from prevention and emergency care to recovery and rehabilitation. Best practice standards guide each stage of care to ensure that injured patients are promptly transported to and treated at facilities appropriate to their severity of injury and that they receive optimal care at each stage of their treatment.

A statewide trauma system also provides a framework for disaster preparedness and response. As part of its activities, a trauma system coordinates and monitors the

movement and care of severely injured people. Ideally, the trauma system identifies the needs and resources available at any moment and responds to insure optimal care.

Why Have a Trauma System?

For a severely injured person, the time between an injury and receiving definitive care is the most important predictor of survival—the "golden hour." The chance of survival diminishes with time, despite of the availability of resources and modern technology. A trauma system enhances the chance of survival by making sure that patients are brought to the most appropriate facility in the most efficient manner and that they receive optimal care each step of the way. Trauma systems benefit everybody regardless of income, race, party affiliation or locale. States with mature, comprehensive statewide trauma systems have experienced:

- A 9 percent decrease in motor vehicle crash deaths.
- A 15-20 percent increase in the survival rates of seriously injured patients.
- An increase in productive working years.
- An improvement in statewide disaster preparedness.

Disaster Preparedness

Trauma systems play a vital role in the community response to natural disasters or manmade incidents. Despite concerns over bioterrorism, experience has shown that the vast majority of terrorist attacks will involve explosive devices. We also do know that Alaska will experience major earthquakes in the future. A functioning trauma system is the framework for developing an organized coherent response to these incidents

Alaska's Trauma System

In 1990, state authority for designating trauma centers was created in Alaska. Under this statute hospital participation is entirely voluntary. Criteria were established and the process for designation at Levels I-IV outlined. Since the original legislation there have been only five hospitals that have been designated by the state, one level II and four level IV centers. Clearly, in order to fully realize the benefits of a trauma system, more widespread participation is needed. Alaska's trauma system is ideally an inclusive system, recognizing the vital role that rural communities, hospitals and health care professionals play in the care and management of the trauma patient. Wide-scale involvement is critical to get optimal outcomes for the seriously injured.

The Alaska Trauma Systems Review Committee oversees the statewide trauma system in Alaska. The system addresses four primary components: trauma hospital designation criteria; trauma registry (monitors system performance and provides feedback for improvement); EMS/pre-hospital triage and transport guidelines; and inter-facility (hospital to hospital) transfer guidelines.

Where to Go From Here

- Increased hospital participation is necessary for the statewide trauma system to function optimally.

- There need to be incentives for hospitals to provide the staff and resources required for trauma center designation.

- Legislation to cover the cost of uncompensated trauma care and to limit the medical liability for care given at designated trauma centers are two incentives that have been successful in other states.

- The goal of the statewide trauma system is to see every hospital in Alaska become designated at an appropriate level.

- *Surveys show that the general public overwhelmingly supports having a hospital in their community that is prepared for and capable of effectively managing a seriously injured patient—and are willing to pay for it!

*2005 Harris Interactive poll, "The American Public's Views of and Support for Trauma Systems: A Congressional Briefing."

Alaska Statewide Trauma System contact information:

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Chair Trauma Systems Review Committee

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907-465-8635

Mailing Address:
Alaska Department of Health and Social Services
Division of Public Health
Section of Injury Prevention & EMS
P.O. Box 110616
Juneau , Alaska 99811-0616

SENATE BILL NO. 169

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE BY REQUEST

Introduced: 3/27/09
Referred: Health and Social Services, Finance

Funding Information:	**General Fund**	**$**	**5,000,000**
	Other Funds		**-0-**
	Total	**$**	**5,000,000**

A BILL

FOR AN ACT ENTITLED

"An Act appropriating $5,000,000 to the uncompensated trauma care fund; and providing for an effective date."

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

* **Section 1.** The sum of $5,000,000 is appropriated from the general fund to the uncompensated trauma care fund (AS 18.08.085) to capitalize the fund.

* **Sec. 2.** The appropriation made by sec. 1 of this Act is for the capitalization of a fund and does not lapse.

* **Sec. 3.** CONDITIONAL EFFECT. The appropriation made by sec. 1 of this Act takes effect only if an Act enacted by the Twenty-Sixth Alaska State Legislature establishing the uncompensated trauma care fund becomes law.

* **Sec. 4.** If this Act takes effect under sec. 3 of this Act, it takes effect July 1, 2009.

Alaska State Legislature

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Session: (Jan. - May)
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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

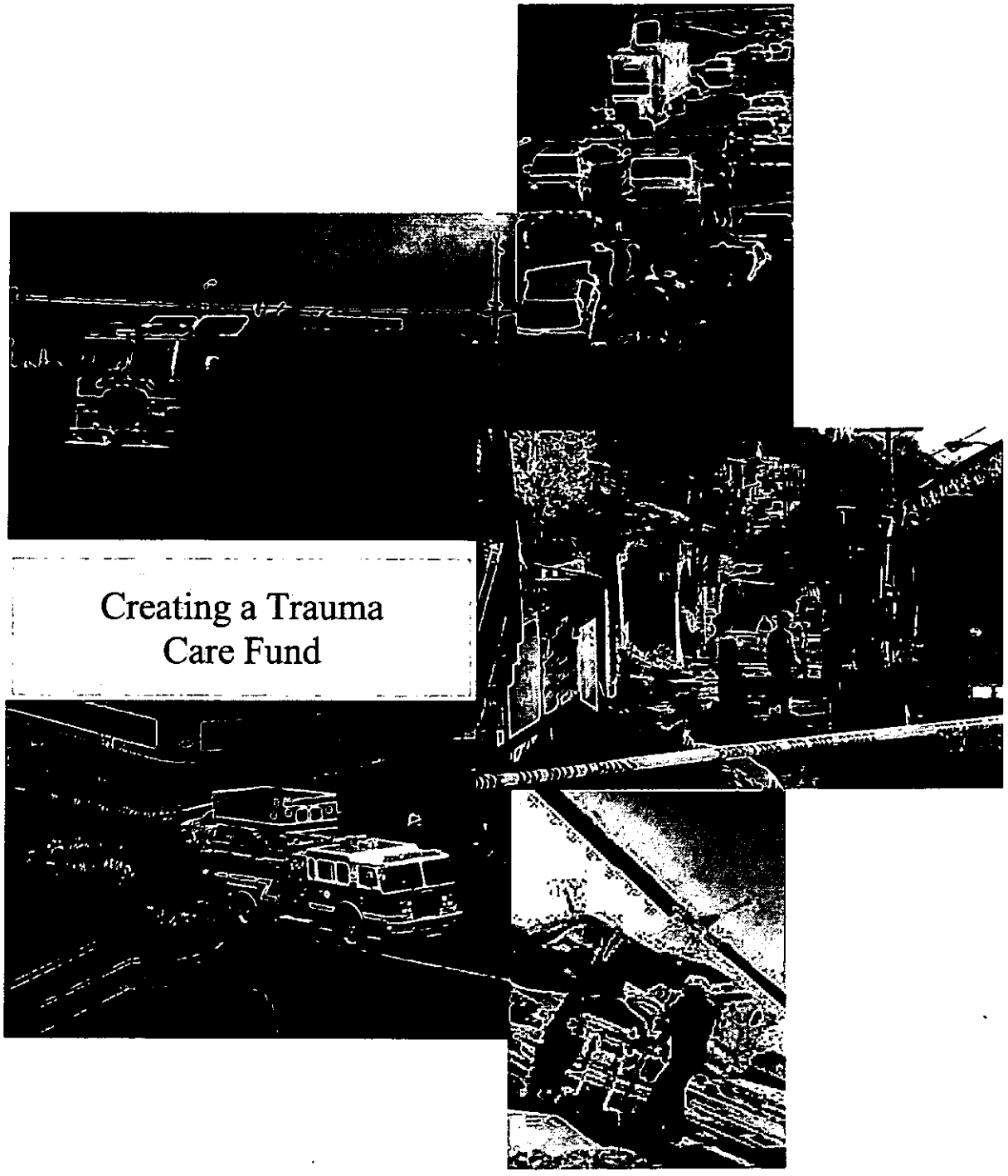
Senate Bill 168

"An Act relating to state certification and designation of trauma centers; creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers; and providing for an effective date."

People to Testify for SB 168
Senate HSS Committee 4/7/09
(arranged by Dr. Chennault, 244-1689)

- Dr. Regina Chennault, ANMHC, from Trauma Center meeting in Las Vegas.
- Mark Johnson, Juneau, former Chief EMS State of Alaska
- Dr. Sacco, ANMHC
- Jerry Godfrey, son of Trooper Chief killed in Anchorage
- Joel and Mindy Stesenski, Alaska Fair, hit by log, MedVac'd to Harborview
- Dr. Head, Anchorage
- Dr. Head, Nome
- Dr. Greenberg, Bethel
- Dr. Robinett, Fairbanks
- Dr. Burton, Nebraska, prepared Alaska Trauma Care review for American College of Surgeons

TRAUMA CARE IN ALASKA



Creating a Trauma Care Fund

House Bill 168

Senate Bill 168

ALASKA'S TRAUMA SYSTEM DEVELOPMENT FOLDER
TRAUMA LEGISLATION HOUSE AND SENATE BILLS 168

SECTION	TOPIC
1	SPONSOR BACK UP & HB 168
2	TRAUMA FACT SHEET
3	TRAUMA CARE IN ALASKA 2009 SLIDES
4	TRAUMA MORTALITY RATES-ANCHORAGE
5	EMERGENCY TRAUMA CARE NEEDS IMPROVEMENT IN ALASKA LETTER
	ALASKA NEEDS A BETTER TRAUMA SYSTEM LETTER
6	AMERICAN COLLEGE OF SURGEONS RECOMMENDATIONS
7	TRAUMA SUSTEM CONSULTATION – STATE OF ALASKA, November 2008
8	APPENDIX

-HARRIS POLL OBJECTIVES AND METHODOLOGY

-ALASKA STATE MEDICAL ASSOCIATION (ASMA) LETTER OF SUPPORT

-NATIONAL CONFERENCE OF STATE LEGISLATURES

-TRAUMA SYSTEM FUNDING MECHANISMS BY STATE

-UNCOMPENSATED TRAUMA CARE BY STATE

-TRAUMA LEGISLATION STICKS FROM OTHER STATES

1
SPONSOR BACK UP
&
HB 168

ALASKA STATE HOUSE OF REPRESENTATIVES

SENATOR JOHN COGHILL

HB 168 Certification and Designation of Trauma Centers

Sponsor Statement

This legislation would create a trauma care fund which could reimburse trauma centers for uncompensated or undercompensated services. The bill would create incentives for becoming a certified trauma center but does not force facilities to become certified trauma centers.

Trauma is the leading cause of death for Alaskans between the age of one and forty-four and more than 800 Alaskans are hospitalized each year for spinal cord and brain injuries.

There is a "golden hour" after the injury during which proper treatment and appropriate interventions will potentially save a patient's life and prevent further damage to an injured person. Personal trauma is any bodily injury from an external force including car crashes, shootings, falls, snow machine crashes, and stabbings.

A good trauma system is an organized multidisciplinary response to managing treatment of severely injured people and it spans the full spectrum from prevention and emergency care to recovery and rehabilitation. A trauma system enhances the chance of survival by making sure patients are brought to the most appropriate facility in the most efficient manner and that optimal care is delivered every step of the way. Alaska has many good parts to our trauma response but we must do better.

ALASKA STATE HOUSE OF REPRESENTATIVES

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Session

(907)-465-3719
FAX# (907)-465-3258
State Capitol
Room 214

SENATOR JOHN COGHILL

HB 168 Designate Trauma Centers and the Uncompensated Trauma Care Fund

Sectional

Section 1. AS 18.08.082 currently prescribes by regulation criteria for training programs and for personnel involved in emergency medical services. This section adds a requirement for the commissioner of Health and Social Services establish special designations for varying levels of services offered by a certified trauma center.

Section 2. Establishes a trauma care fund to be used to compensate certified trauma centers for uncompensated trauma care. The fund can accept money appropriated by the legislature, which can include donations, income from the fund, and of the other designated receipts. The commissioner is given authority to establish a special committee for review of the program and limits are set on the distribution of the funds.

Section 3. The bill has an immediate effective date.

SENATE BILL NO. 168

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE BY REQUEST

Introduced: 3/27/09
Referred: Health and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to state certification and designation of trauma centers; creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers; and providing for an effective date."

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

*** Section 1.** AS 18.08.082 is amended by adding a new subsection to read:

(c) The commissioner shall establish special designations in regulation for varying levels of trauma care provided by a certified trauma center that shall be used to set compensation eligibility and amounts under AS 18.08.085. The designations shall be based on nationally recognized standards and procedures.

*** Sec. 2.** AS 18.08 is amended by adding a new section to read:

Sec. 18.08.085. Uncompensated trauma care fund; creation. (a) The uncompensated trauma care fund is created. The purpose of the fund is to compensate certified trauma centers in the state that receive a special designation under AS 18.08.082(c) for care uncompensated by the person receiving the care or by any

other source.

(b) The fund consists of money appropriated to it by the legislature, including donations, recoveries of or reimbursements for awards made from the fund, income from the fund, and other program receipts from activities under this chapter. Appropriations to the fund do not lapse.

(c) The commissioner shall administer the fund in accordance with the provisions of this chapter. The commissioner shall spend money from the uncompensated trauma care fund for the purpose established in (a) of this section. The commissioner may establish and seek the advice of a special committee for review of statewide trauma care and compensation standards.

(d) The commissioner may not provide more than 25 percent of the total assets, including earnings, of the fund in a fiscal year to one trauma center.

* **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

26th Legislature(2009-2010)

Bill History/Action for 26 Legislature

BILL: SB 168 **SHORT TITLE:** TRAUMA CARE CENTERS/FUND

BILL VERSION:

CURRENT STATUS: (S) HSS **STATUS DATE:** 03/27/09

THEN FIN

SPONSOR(s): HEALTH & SOCIAL SERVICES BY REQUEST

HEARING: (S) HSS Feb 10 1:30 PM BUTROVICH 205 TELECONFERENCE

TITLE: "An Act relating to state certification and designation of trauma centers; creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers; and providing for an effective date."

Bill Number: [ ] Search Bills | Next Bill

Full Text | Minutes | Documents

Display Bill History

Jrn-Date	Jrn-Page	Action
03/27/09	0670	(S) READ THE FIRST TIME - REFERRALS
03/27/09	0670	(S) HSS, FIN
03/27/09	0670	(S) REFERRED TO HEALTH & SOCIAL SERVICES
04/08/09	Text	(S) HSS AT 1:30 PM BELTZ 211
04/08/09	Text	(S) Heard & Held
04/08/09	Text	(S) MINUTE(HSS)
04/08/09	Text	(S) MINUTE(HSS)
02/10/10	Text	(S) HSS AT 1:30 PM BUTROVICH 205

Similar Subject Match or Exact Subject Match

FUNDS
HEALTH & SOCIAL SERVICES
HOSPITALS
LICENSING
MEDICAL CARE

Bill Number: [ ] Display Bill

Next Bill

Return to Basis Main Menu (26 Legislature)

trauma centers must complete an application to ACSCOT and have a verification visit by a team from ACSCOT. Using ACSCOT criteria, Level IV trauma centers are verified by a state team, appointed by the Alaska Division of Public Health.

• **Level I – Regional Resource Center** - Level I Trauma Centers generally serve large cities or population-dense areas. A Level I Trauma Center is responsible for providing leadership in research, professional and community education. There are no Level I Trauma Centers in Alaska because, there are no trauma research and teaching facilities in Alaska.

• **Level II – Regional Trauma Centers** - A Level II Trauma Center provides comprehensive trauma care and serves as a lead trauma facility for a geographical area. A Level II Trauma Center provides educational outreach and prevention programs and assumes responsibility for trauma system leadership. There are emergency physicians and nurses in-house to initiate resuscitation and stabilization, with surgical teams on call and promptly available.

• **Level III – Area Trauma Center** - The Level III Trauma Center provides assessment, resuscitation, emergency surgery, and stabilization and, for the most critically injured patients, arranges for transfer to a Level I or Level II trauma center that can provide further definitive care. A general surgeon must be promptly available and the facility must be involved with prevention and have an active outreach program for its referring communities.

• **Level IV – Local Trauma Stabilization Center** - Level IV Trauma Centers are small rural facilities that provide initial evaluation and assessment of injured patients prior to transfer to a larger referral facility.

For more information, you can download a brochure about Trauma Center Certification in Alaska.

Below are documents/links to assist hospitals interested in seeking Trauma Center Designation.

For the American College of Surgeons, Committee on Trauma (ACSCOT) Level I, II, III verification program visit:
http://www.facs.org/trauma/verificationhosp.html

For the pre-review questionnaire for Level I, II, and III verification visit:
http://www.facs.org/trauma/prq.doc

To request for a verification visit from ACSCOT visit:
http://www.facs.org/trauma/sitevisitapplication1006.doc

source of data through our Alaska Trauma Registry.

Links:

American College of Surgeons is a scientific and educational association of surgeons founded to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. The Committee on Trauma works to improve the care of injured and critically ill patients – before, en route to, and during hospitalization. Their web site has information on trauma center designation and Advanced Trauma Life Support courses.

American Trauma Society is dedicated to the prevention of trauma and improvement of trauma care. The society is a strong advocate for injury care and prevention and have numerous programs.

American College of Emergency Physicians promotes the highest standards of patient care through its advocacy and leadership efforts. Their web site has numerous resources on a variety of topics.

TRAUMA.ORG provides global education, information and communication resources for professionals in trauma and critical care.

Alaska Trauma/EMS List Server

Alaska Trauma/EMS program is pleased to announce the list server that we have developed to disseminate information from the federal and state Trauma/EMS programs. This forum can also be used to improve communication between the facilities and open opportunities for sharing. Please be advised that if you send a message via the list serve it will go to everyone that is a member.

To join this free list, send an e-mail message to:

list.manager@list.state.ak.us

The body of the message should be:

Subscribe ak-trauma

- Level IV Trauma center information
  - Pre-review Questionnaire (Level IV Trauma Center Checklist) [coming soon]
  - Level IV, Desirable and Expected Resources/Services
  - Level IV Request for a verification visit
  - Performance Improvement for Small Rural Hospitals in Alaska
  - Performance Improvements Sample meeting minutes

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Emergency Medical Services | Injury Surveillance & Prevention
Webmaster | News | Contact Information
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alaska
brain injury
network

Every 15 seconds someone sustains a traumatic brain injury (TBI) in the U.S.

Thirty years ago, only half of all people with brain injury survived; now 78% survive. This means that many individuals now live with significant disability requiring a full range of services.

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% higher than the national average. The TBI rate in rural Alaska is one of the highest in the nation.

It is estimated that at least 10,000 Alaskans are living with brain injury today. The number keeps accumulating. Brain Injury can be a life-long disability

The Alaska Brain Injury Network, Inc. (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury.

ABIN's Board of Directors represent all regions of Alaska and the extended brain injury community – survivors, family members, service providers, health educators, researchers and those who write laws and policy.

ABIN works with the Alaska Mental Health Trust Authority, Department of Health and Social Services, and partner boards to advocate for policy changes, programs, and facilities to better serve the brain injury population.

ABIN connects survivors and family members with others. Please contact us to learn about brain injury programs in your region.

The goal for every brain injury survivor is the best possible recovery for a fulfilling and productive life. Achieving that goal requires full range of services close to home. This includes...

- Prevention
- Early identification and intervention
- Access to skilled specialists
- Community-based post injury services
- Continuing rehabilitation
- Brain injury support groups and in-state resources

What you can do...

- **Be aware of the fiscal and social burden of brain injury nationally and to the state of Alaska**
- **Become familiar with ABIN Priorities in the Governor's FY09 GF/MH Budget: Brain Injury Training for Providers.**
- **Support the Housing Trust,** www.akhousingtrust.com
- **Join Alaska Brain Matters listserve to meet Alaskans who have been touched by traumatic brain injury.**

ABIN Priorities

In-state rehab facility – many Alaskans are left in a hospital setting because there is no post-acute rehabilitation option in the State. Others are sent out of State. It is time for Alaskans to have treatment for their brain injury. Research shows outcomes improve with quality rehabilitation.

Brain Injury Waiver - recommendations for the current Medicaid waiver system to accommodate the services needed by brain injury survivors: neuropsychological assessment, cognitive and functional therapy, case management, counseling, home modifications, transportation, respite care, and more.

alaska brain injury network

www.alaskabraininjury.net
3745 Community Park Loop, Ste 240
Anchorage, AK 99508
(907) 274-2824

Alaska Brain Injury Network, Inc. helps identify, develop, implement, and sustain needed programs and resources that promote prevention and expand treatment and service delivery to Alaskans who experience TBI and their families.

You KNOW us...

The Public Health Burden of Brain Injury (prevalence)

5.3 million Brain Injuries

5 million persistent Mental Illness
4 million Alzheimer's
3 million Stroke
2 million Epilepsy
900,000 HIV/AIDS
500,000 Cerebral Palsy
400,000 Spinal Cord Injury

Brain injury accounts for more years of lost productivity than any other injury.

The Financial Burden of Brain Injury

- It is estimated that over a lifetime, it can cost between $600,000 and $1,875,000 to care for a survivor of severe TBI.
- Direct medical costs and indirect costs of TBI such as lost productivity totaled an estimated 60 billion dollars in the United States in 2000. *(Centers for Disease Control and Prevention)*
- Every dollar used for brain injury rehabilitation saves up to $35 in future medical costs. (Rhode Island Brain Injury Association)

Prevention is the only cure for Brain Injury

- The three leading causes of brain injury nationally and in Alaska are:
  1) motor vehicle crashes 2) falls and 3) assaults.
- One-third of all TBIs recorded in the Alaska Trauma Registry were alcohol related.
- The use of safety belts is the single most effective measure to prevent traumatic brain injuries.
- Helmets are estimated to be 37% effective in preventing fatal injuries to motorcyclists. *(National Highway Traffic Safety Administration)*
- Bicycle helmets are 85-88 percent effective in mitigating head and brain injuries. Every dollar spent on a bike helmet saves $40 in direct medical costs and other costs to society. *(National Highway Traffic Safety Administration)*
- 60-67% of injured U.S. soldiers sent from Iraq to Walter Reed Army Medical Center have a TBI from blasts, severe falls and motor vehicle accidents. *(United Press International, July 2004).* These soldiers are now returning home to Alaska for continuing treatment and rehabilitation.

Traumatic Brain Injury is a beneficiary group participating in the Alaska Mental Health Trust Authority "You Know Me" Anti-Stigma Campaign.

Alaska Brain Injury Network

Alaska Scorecard and TBI Dashboard – (DRAFT)

DRAFT #1 – May 22, 2008

○ Getting worse ⟺ Not changing ● Improving

	5-year Trend	Current Data	Source
SCORECARD: A "scorecard" provides a snapshot of the status of TBI issues in the State of Alaska			
Traumatic Brain Injury Non-fatal Incidence Rates			
TBI rate per 100,000	●	98.6	[redacted]
Causes			
Falls	○	28.7	[redacted]
Motor Vehicle Transportation Occupant	●	24.7	[redacted]
Assault	●	12.2	[redacted]
ATV	○	6.5	[redacted]
Bicycle	●	4.5	[redacted]
Snowmachine	●	4.4	[redacted]
Pedestrian	●	3.6	[redacted]
Sports	●	1.8	[redacted]
Water Transport	⟺	1.3	[redacted]
Suicide Attempt	●	.8	[redacted]
Gender			
TBI percentage among males		65.4 %	[redacted]
TBI percentage among females	⟺	33.2 %	[redacted]
Ethnicity			
Percentage of TBI population that is Alaska Native		34%	[redacted]
Percentage of TBI population that is White		53%	[redacted]
Percentage of TBI population that is Other; unknown, Pacific Islander, Hispanic, Black, American Indian, Asian		22%	[redacted]
Those at highest risk for hospitalization due to TBI (rate per 100,000)			
Males age 80+		301.3	[redacted]
Females age 80+		217.2	[redacted]
Males age 70-79		215.7	[redacted]
Males age 15-19		200.9	[redacted]
Traumatic Brain Injury Numbers			
TBI hospitalizations/year		640	1.b
TBI deaths/year		150	1.b
Est. TBI-related Emergency Department Visits		2953	2

1 Alaska Trauma Registry 2001-2005 – Non-fatal TBI hospitalizations
1.a Alaska Trauma Registry 1996-2005 – Non-fatal TBI hospitalizations
1.b Alaska Trauma Registry 2006 – Non-fatal TBI hospitalizations
2 HRSA TBI Implementation Grant

Alaska Trauma Registry records those who are hospitalized for more than 24 hours. This does not include the number of people who visit the emergency department and are sent home in the same day. This does not include the number of returning service members with traumatic brain injury.

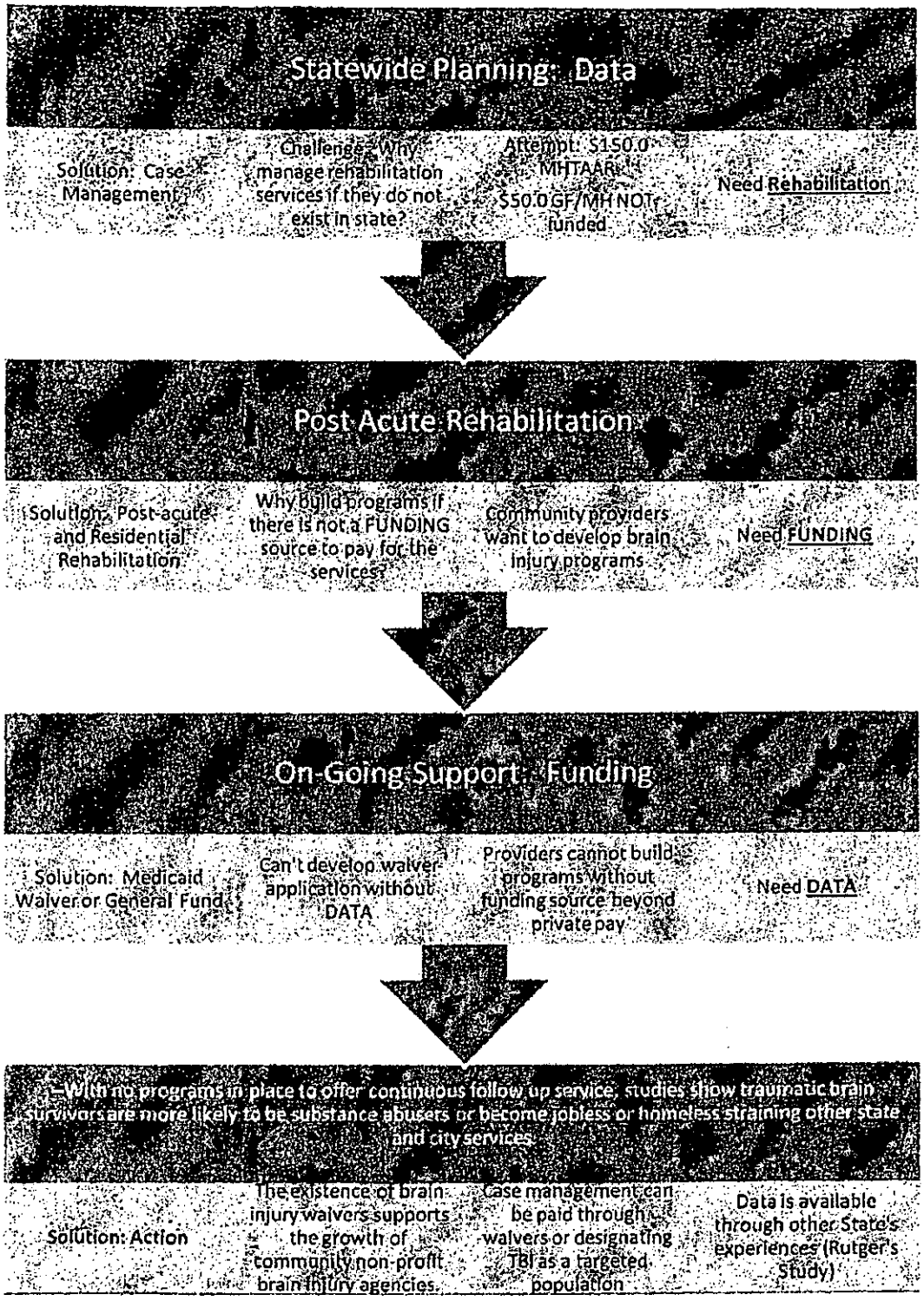
DASHBOARD: A "dashboard" provides a way to see how well an activity is working to affect the TBI population

Getting worse | No change | Improving

	Spot look trend	Current Data	Source
Dashboard: Behavioral Health			
TBI and Mental Health			
Percentage BH clients screening positive for TBI	⇔	32%	3
TBI and Substance Use			
Alcohol-related TBI 100,000		33%	4
TBI and Suicide			
Percentage of suicide victims with history of TBI		32%	4
Dashboard: Education			
Special Education			
Number of children in Special Education statewide with TBI diagnosis (2007)	⇔	66	5
Dashboard: Justice			
Corrections			
Percent of incarcerated Alaskans (adults) who are Trust beneficiaries, including those with cognitive disabilities		42%	6
Dashboard: Employment			
Vocational Rehabilitation			
Number of TBI cases		167	7
Number of TBI cases closed employed		17	7
Number of TBI cases closed with plan for employment		11	7
Average wage at closure		$12.54	7
Dashboard: Providence			
ImPACT Program			
Number of baselines (ImPACT)		57	8
Number of student/athletes seen in program (ImPACT)		25	8
Emergency Department			
Patients given the diagnosis of "head injury" or "concussion in Emergency Department in 2006		547	8
% of TBI-related ED visits that led to hospitalizations		1%	8
% of ED visits that are Pediatric		15%	8
Dashboard: Alaska Brain Injury Network			
TBI Advisory Board			
Est. Board Member Volunteer hours/year	↑	1054	9
Board Member Participation in Quarterly Board Meetings		83%	9
Ex-officio participation in quarterly board meetings		65-80%	9
% of survivors/family members on TBI board		55%	9
% Board Members who give a financial contribution		100%	9
TBI Resource Navigation			
Average new consumer contacts per month	↑	30	9
Average unique visitors/month to ABIN website	↑	750	9
Number of people on Alaska Brain Matters Listserve	↑	100+	9

3 AKAIMS
4 Suicide Follow-back Study
5 http://www.eed.state.ak.us/stats/
6 Trust/DOC Study 07
7 Division of Vocational Rehabilitation (FY07)
8 Providence Neuroservices
9 Alaska Brain Injury Network

For more information view the "10 Year Plan for TBI in Alaska" at www.alaskabraininjury.net



Alaska Trauma Hospitals as of April 2009

Name	Designation	Certification date	Certification due
Alaska Native Medical Center (Anchorage)	Level II	November 2006	2009
Mt. Edgecumbe Hospital (Sitka)	Level IV	April 2007	2010
Yukon-Kuskokwim Delta Regional Hospital (Bethel)	Level IV		2010
Sitka Community Hospital (Sitka)	Level IV	January 2007	2010
Norton Sound Regional Hospital (Nome)	Level IV	October 2006	2010

ALASKA COUNCIL ON EMERGENCY MEDICAL SERVICES

ACEMS
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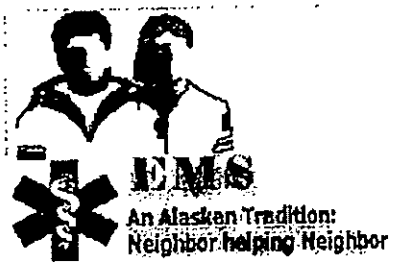

April 9, 2009

Representative Coghill
Juneau, Alaska

Representative Coghill,

Trauma is any bodily injury from an external force. Trauma puts a tremendous burden on families and communities in Alaska. An average of 400 Alaskans die each year from trauma. For every death, 11 people are hospitalized. One in four hospital admissions is uncompensated which puts an additional burden on the State's health care system. HB 168 is offered to assist in this dilemma.

House Bill 168 provides the DHSS Commissioner authority to establish special designations in regulation for varying levels of trauma care so that a 'Certified Trauma Center' would be eligible to recoup expenses as a result of uncompensated care being rendered. The purpose of the fund is to reimburse certified trauma centers in the state for care uncompensated by the person receiving the treatment or by any other source. HB 169 would then set up the uncompensated trauma care fund that would help cover some of the losses suffered by the trauma center rendering the care.

The Alaska Council on EMS seeks your support for a fully functioning trauma system, including funding for the development of trauma centers and legislation addressing the issue of incentives for trauma center designation and uncompensated care of trauma patients. The added benefit of HB 168, we believe, would be an incentive for more hospitals in the state to become 'Certified Trauma Centers' thereby assisting in the development in a state wide trauma care system.

The American College of Surgeons met 11/08 in Anchorage to assess the States trauma system. The passage of HB 168 & 169 would provide support to address some of the areas that were noted in the report.

Thank you for your support of this critical issue.

David Hull

David Hull, Chair
Alaska Council on Emergency Medical Services

cc Bill Hogan, DHSS Commissioner
Dr. Jay Butler, Chief Medical Officer
Tim Bundy, Section Chief IPEMS

Alaska Native
Tribal Health Consortium

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POSITION PAPER

CONTACT: Valerie Davidson, Senior Director
Legal and Intergovernmental Affairs
Through Pat Jackson, State Liaison for Alaska Native Health
523-0363 – pajackson@anthc.org

DATE: April 8, 2009

RE: HB 168 – State certification and designation of trauma centers and creating the uncompensated trauma care fund
HB 169 – Appropriating $5,000,000 to the uncompensated trauma care fund

POSITION: Support

ANTHC supports HB 168 and HB 169 as important steps in increasing the trauma care capacity in the state.

The Alaska Native Tribal Health Consortium (ANTHC) is a tribally controlled, non-profit statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. It is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally-recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. ANMC is the only Level II Trauma Center in the Indian Health Service/tribal health system nationally. ANMC is also the only Level II Trauma Center in Alaska. The nearest Level I Trauma Center is in Seattle.

Trauma system development is a public health priority. A comprehensive system of trauma care is an essential part of the public safety net. Regionalized trauma systems based on a network of coordinated Trauma Centers designated at the appropriate level improves health outcomes and reduces costs. ANMC, as the highest level designated Trauma Center in the State of Alaska, is the lynchpin for the state's trauma system, and provides the foundation for continued statewide system development.

Trauma Center designations were created as a way to improve outcomes for patients who face extraordinary medical issues. On balance, early and appropriate medical attention to life-threatening health issues reduces overall length of stay in the hospital and reduced complications for many patients. Without trauma care, the costs of health care for trauma patients will be greater, including trauma patients who are Medicaid eligible.

The cost of providing trauma care at ANMC has more than doubled over the past four years and funding has not kept pace. ANMC's Trauma Center simply cannot be maintained at current revenue levels. If ANMC's Trauma Center designation is discontinued because funding levels have rendered the service unsustainable, the hospital faces reductions in staffing. Diversions of patients to non-tribal providers would increase, and because the federal government reimburses 100% of the cost of services provided for Native clients at Native facilities but a smaller percentage at non-tribal providers, there would be an increased cost to the state's general fund budget.

ANTHC supports HB 168 and HB 169 as important steps by the State to encourage and support appropriate trauma care options for Alaskans. Because we are Alaska's only Level II Trauma Center we recommend removing the language in section (d) on Page 2, Line 11, that limits appropriations to any one facility to 25%.

Thank you for your consideration.

Rynnieva Moss

From: Christopher Clark [cgcalaska@yahoo.com]
Sent: Wednesday, March 11, 2009 8:44 AM
To: Tim Barry; John Bitney; Shannon Devon; Peter Fellman; Linda Hay; Paul Labolle; Karen Lidster; Tom Maher; John Manly; Rynnieva Moss; Jane Pierson; Chris Wyatt
Subject: Daily News editorial: Attracting doctors - Legislature can raise Alaska's stake in competition for docs; Obama right to nix mileage tax

Attracting doctors

Legislature can raise Alaska's stake in competition for docs

Published: March 10th, 2009 06:54 PM
Last Modified: March 10th, 2009 06:54 PM

Alaska's shortage of primary care doctors has been described as grim. A study two years ago found **we needed 400 more doctors to provide the same level of care as is available elsewhere in the country.** One result is that few doctors will accept the low rates paid by Medicare, the government insurance for those 65 and older. **It's a horrible situation for Alaska's senior citizens.**

Two bills introduced during this legislative session would help relieve the shortage of doctors and other health care workers, and both are worth passing.

Senate Bill 18 would increase the number of state-subsidized medical students in each class of the WWAMI program operated through the University of Washington. Alaska WWAMI students spend their first year of study at UAA.

These students offer an excellent return -- according to the Alaska Physician Supply Task Force study in late 2006, half of Alaska WWAMI students end up practicing in the state, and a few WWAMI students from other states join them.

The state raised the number of Alaska WWAMI students in each class to 20 in 2007.

SB 18 would increase the number by a modest amount, to 24. That's the most UAA can accommodate without incurring expensive overhead costs, said Sen. Bill Wielechowski of Anchorage, the bill's sponsor.

Adding the four students would cost the state little to no money the first year. But by the fourth year, when we would have an additional 16 Alaska students in med school, the state cost is estimated at $550,000 per year.

A second bill, SB 139 [by Sen. Donny Olson], calls for the state to pay financial incentives to already-qualified doctors, nurses or other health workers if they take certain jobs in Alaska.

The bill, with a bipartisan group of sponsors, would carry out a plan developed by a group of health care professionals including representatives of the Alaska Primary Care Association and the Alaska State Hospital and Nursing Home Association.

The state would offer financial incentives to as many as 90 workers, from physicians to nurses, to come work in Alaska. Those who take hard-to-fill jobs, or treat a share of uninsured patients or those on Medicare or Medicaid, would get priority.

3/12/2009

Each person would be guaranteed the incentive for three years as long as they kept working here.

The state would either repay part of their student loans or, if the health worker didn't have loans, simply pay them directly. The individual payments would range from $20,000 per year for nurses, physicians assistants and some others, to $35,000 for doctors, pharmacists and dentists, to $47,000 for doctors who accept the hardest-to-fill positions.

The state's cost for three years' worth of incentives would be $7.5 million.

That sum is large enough to cause concern this year, with a big drop in state revenues anticipated.

But consider this: Forty-four of the 50 states already offer financial incentives to lure health workers. Alaska is not competitive for health care jobs, and people are suffering because of it.

BOTTOM LINE: **The Legislature should pass two bills to relieve a critical shortage of health care workers in Alaska.**

Not now

Obama right to nix mileage tax

States and the federal government rightly worry that they'll see less revenue to pay for road work as Americans turn to more fuel-efficient vehicles and future technology takes us further from the internal combustion engine.

One solution is a **mileage tax, whereby vehicles would be equipped with GPS tracking devices and people would be taxed according to the miles they drive rather than the gallons of gasoline they purchase.**

Oregon has already run a pilot program for such a tax, and a federal mileage tax has gained favor in the Democratic Congress despite the opposition of President Obama.

Concerns for revenue and how to pay for road building and maintenance are valid. But the mileage tax is the wrong solution, at least for now.

First, a major shift in transportation tax policy shouldn't be done on the fly in the middle of an economic crisis. There are too many unanswered questions. Among them:

• Is the ability to track people's driving one we want governments to have?

• How does such a tax encourage the use of higher-mileage vehicles? Is the owner of a hybrid getting 35 mpg going to pay the same tax as the owner of a gas-guzzling Hummer?

• Do we really want to charge people more for miles driven during rush hours, a premium that's been suggested in some states?

Raise the gasoline tax if necessary, but let's not be talking about a mileage tax until we've done a lot more research.

BOTTOM LINE: Mileage tax? Maybe down the road. Maybe.

More Funding Needed To Fight Brain Injuries In Alaska

By Corey Allen-Young, CBS 11 News Reporter
KTVA

Posted:02/26/2009 05:34:33 PM AKST

Known as the silent epidemic, traumatic brain injury here in Alaska is the highest in the country. That's why partnerships are being made statewide to come up with solutions. The key word is solutions as leaders are looking for a permanent fix to decreasing traumatic brain injuries in Alaska. Experiencing a traumatic brain injury can change a life forever. "The recovery process after traumatic brain injury is journey that happens daily and it will continue," said Jill Hodges, of the Alaska Brain Injury Network. With 800 Alaskans being hospitalized or dying and over 10,000 Alaskans currently living with traumatic brain injuries, the consequences could be devastating.

"Yeah it will change your life and everybody else's around you," said Frank Box, who experienced a traumatic brain injury. "It can happen to you while you are walking across the street, you can fall and slip on the ice, or if you are playing a sport or riding a bicycle especially without a helmet, you can also suffer traumatic brain injury," said Christie Artuso, who is the director of the Providence Neuroscience Center. "My brother was a such a vibrant, outgoing person, and for this to happen to him is just unreal," said Duain White, whose brother suffered a traumatic brain injury in an ATV accident.

Taking into account that traumatic brain injuries are the leading cause of death and disability among children and young adults in Alaska, the need to be aware of what exactly can cause an injury is crucial. "We can't do that without the prevention needed and the education needed of our population to tell them about TBI (traumatic brain injury) and to also tell them on how to be healthy," said Don Kashevaroff, who is the CEO of the Alaska Native Tribal Health Consortium. "What we don't have in the state of Alaska is an effective rehabilitative program for people who have been afflicted with a traumatic brain injury can be helped with cognitive therapies, thru rehabilitative therapies to return to a normal functioning life," said Artuso.

Thirty years ago, one half of people who experienced a brain injury survived. Now the number has increased to 78 percent. But officials say the problem in our state is that traumatic brain injury survivors are not getting the services needed for life long living. While people who are victims of traumatic brain injuries do receive initial help there are many questions of what happens next for them. And with money in low supply to provide any additional support, officials say other agencies could be feeling the burden.

With over 10,000 Alaskans currently living with traumatic brain injuries, getting additional care and support is badly needed. "We were just released from the hospital and that was it there was no long term therapy, there was no where to go to offer cognitive therapy, long term physical therapy," said White. "We want to help them maintain their relationships, maintain their families, maintain their lifestyles," said Artuso. "What we need are community and governmental support to do that because currently there is no resources."

Adding more resources is what folks are banking on in helping their loved ones live normal functioning lives. "Is that all we can offer him, is that the best he's going to be doing the rest of his life, its very frustrating," said White. "Treatment, rehabilitation services are essential, they are the key to recovery and sometimes eventual abilities for our brothers or sisters, and family members," said Hodges.With no programs in place to offer continuous follow up service, studies show traumatic brain survivors are more likely to be substance abusers or become jobless or homeless straining other state and city services.

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TRAUMA FACT SHEET

Alaska Statewide Trauma System

Fact Sheet

What is Trauma?
Trauma is any bodily injury from external force. Although many people think of trauma as "accidents", it is better thought of as a disease. Like heart disease and cancer, trauma has identifiable causes and risk factors; and like these conditions, prevention is the best strategy. However, even with the best prevention efforts we still need to be able to take care of the seriously injured. We need to show the same commitment that we brought to cardiac and cancer treatment to trauma care. The seriously injured require timely diagnosis and treatment by health care professionals who are appropriately trained and provided with the necessary resources to reduce the risk of death or permanent disability.

Impact of Trauma in Alaska
Trauma is a tremendous burden on families and communities. In the 1990s, nearly 5,000 Alaskans died from trauma.

- For Alaskans, ages 1 to 44, trauma is the leading cause of death.
- On average, more than 400 Alaskans die from trauma each year. For every injury death, eleven people are hospitalized for trauma-related injuries. For every trauma death that occurs in the hospital, there are an estimated 3 people discharged with permanent disability.
- On average, more than 800 Alaskans are hospitalized each year for central nervous system injury (spinal cord and brain injuries).
- In 2004, motor vehicles were the leading cause of injury death (117), followed by firearm-related injuries (116).
- In 2004, the economic cost of hospital stay alone for trauma patients in Alaska was estimated at over $73 million. One in four hospital admissions were uncompensated.

Years of Potential Life Lost to Trauma
Death from trauma is tragic at any age. Society's loss is especially great because so many young people die from trauma. The impact can be measured in "years of potential life lost:" the number of years between early death from injury and the average age of death at age 70. Using years of potential life lost, trauma is the leading cause of potential life lost for all Alaskans followed by cancer and heart disease.

What is a Trauma System?
A trauma system is a predetermined, organized, multidisciplinary response to managing the care and treatment of severely injured people. It spans the full spectrum of care; from prevention and emergency care to recovery and rehabilitation. Best practice standards guide each stage of care to ensure that injured patients are promptly transported to and treated at facilities appropriate to their severity of injury and that they receive optimal care at each stage of their treatment.

A statewide trauma system also provides a framework for disaster preparedness and response. As part of its activities, a trauma system coordinates and monitors the

movement and care of severely injured people. Ideally, the trauma system identifies the needs and resources available at any moment and responds to insure optimal care.

Why Have a Trauma System?
For a severely injured person, the time between an injury and receiving definitive care is the most important predictor of survival—the "golden hour." The chance of survival diminishes with time, despite of the availability of resources and modern technology. A trauma system enhances the chance of survival by making sure that patients are brought to the most appropriate facility in the most efficient manner and that they receive optimal care each step of the way. Trauma systems benefit everybody regardless of income, race, party affiliation or locale. States with mature, comprehensive statewide trauma systems have experienced:

- A 9 percent decrease in motor vehicle crash deaths.
- A 15-20 percent increase in the survival rates of seriously injured patients.
- An increase in productive working years.
- An improvement in statewide disaster preparedness.

Disaster Preparedness
Trauma systems play a vital role in the community response to natural disasters or manmade incidents. Despite concerns over bioterrorism, experience has shown that the vast majority of terrorist attacks will involve explosive devices. We also do know that Alaska will experience major earthquakes in the future. A functioning trauma system is the framework for developing an organized coherent response to these incidents

Alaska's Trauma System
In 1990, state authority for designating trauma centers was created in Alaska. Under this statute hospital participation is entirely voluntary. Criteria were established and the process for designation at Levels I-IV outlined. Since the original legislation there have been only three hospitals that have been designated by the state. One level II and four level IV centers. Clearly to fully realize the benefits of a trauma system more widespread participation is needed. Alaska's trauma system is ideally an inclusive system, recognizing the vital role that rural communities, hospitals and health care professionals play in the care and management of the trauma patient. Wide-scale involvement is critical to get optimal outcomes for the seriously injured.

Review of Alaska Trauma Care by the American College of Surgeons November 2008

The Alaska Department of Health and Social Services (DHSS) recently contracted with the Committee on Trauma of the American College of Surgeons to review trauma care in Alaska. The full report is available on the DHSS website (www.chems.alaska.gov). It notes our strengths and weaknesses and makes recommendations for improving trauma care in our state.

Strengths include: well established injury prevention programs; extensive and creative networks for ground and air medical transport; medical subspecialty availability at three

Anchorage hospitals; and a good relationship with Harborview Medical Center (Level I trauma center) in Seattle.

Deficiencies include the lack of an additional Level II trauma center in Anchorage and the existence of two patterns of trauma care, one for Alaska natives that follows national standards and one for the rest of the state. The review team members noted that among the nontribal hospitals " few of the facilities serving the majority population have made a similar commitment to achieving nationally recognized standards of trauma care". They also noted that there is no statewide trauma plan and no incentive or requirements for hospitals to participate in the system. Additionally, there are few resources at the state level for trauma system management and coordination. Perhaps as important as any of the above, they noted that there seemed to be very little public awareness of trauma system issues.

The review team made 15 priority recommendations. Several involve better organization of state resources and development of a comprehensive statewide trauma plan. The most sweeping recommendation was that all acute care hospitals be required to become designated trauma centers at a level appropriate to their resources and size within two years. They further stated that there should be a second level II trauma center in Anchorage as soon as possible. In addition, an assessment of pediatric trauma care needs should be completed with the goal of developing at least one pediatric trauma center of excellence.

The Alaska Trauma Systems Review Committee oversees the statewide trauma system in Alaska. The system addresses four primary components: trauma hospital designation criteria; trauma registry (monitors system performance and provides feedback for improvement); EMS/pre-hospital triage and transport guidelines; and inter-facility (hospital to hospital) transfer guidelines.

Where To Go From Here

- Increased hospital participation is necessary for the statewide trauma system to function optimally.
- There need to be incentives for hospitals to provide the staff and resources required for trauma center designation.
- Legislation to cover the cost of uncompensated trauma care and to limit the medical
  liability for care given at designated trauma centers are two incentives that have been successful in other states.

  House Bills 168 and 169 have been introduced by John Coghill to encourage hospitals to participate in the trauma system by covering some of the cost of uncompensated trauma care when it is given at designated trauma centers.

The goal of the statewide trauma system is to see every hospital in Alaska designated at an appropriate level.

- *Surveys show that the general public overwhelmingly supports having a hospital in their community that is prepared for and capable of effectively managing a seriously injured patient—and are willing to pay for it!

*2005 Harris Interactive poll, "The American Public's Views of and Support for Trauma Systems: A Congressional Briefing."

Alaska Statewide Trauma System contact information:

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3

TRAUMA CARE IN ALASKA 2009 SLIDES

TRAUMA CARE IN ALASKA 2010

Goals

- Trauma as a public health problem here in the US and Alaska.
- Trauma systems- Treating the severely injured.
- American College of Surgeons Review: Trauma Care in Alaska.
- The Future.

Introduction

"If a disease were killing our children at the rate unintentional injuries are, the public would be outraged and demand that this killer be stopped."

C. Everett Koop, MD, ScDC, SCD
Former US Surgeon General
Former Honorary Chairman, The National Safekids Campaign

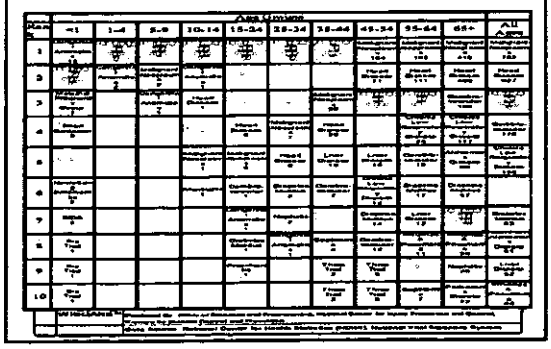
Introduction

- Injury is a major public health problem
  - Leading cause of death in 1st 4 decades of life
  - Leading cause of loss of productivity
- Despite the magnitude little public focus
- The "neglected disease" since 1966
- Significant progress in individual patient care
- Trauma systems shown to save lives

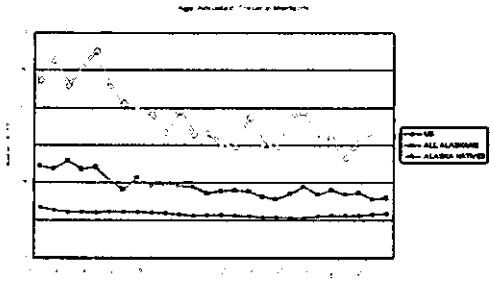
Trauma in Alaska

- Second highest trauma mortality in the US
- Leading cause of death age 1-44.
- 400-500 alaskans die each year.
- Over 5000 hospital admissions
- Over 1000 with permanent disability.

All Cause Mortality Alaska



Trauma Mortality in Alaska



Trauma in Alaska

- Motor vehicle crashes leading cause of death.
- Firearm related injuries, second.
- 2004 hospital cost for Alaska trauma patients over $73 million.
- ~ 25% over trauma admissions uncompensated.

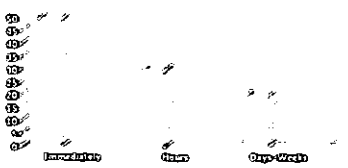
Trauma Systems

- Wounded in the remote jungle or rice paddy of Vietnam, an American citizen has a better chance for quick definitive surgical care by board certified specialists than were he hit on a highway near his home in the continental United States. Even if he were struck immediately outside the emergency room of most United States hospitals rarely would he be given such prompt, expert operative care as routinely is furnished from the site of combat wounding in Vietnam."
- Eiseman, Journal of Trauma, 1967

Trauma Systems

◇A trauma system consists of hospitals, personnel, and public service agencies with a preplanned response to caring for the injured patient.

Death from Trauma



Trauma Systems: Military Experience

- "The only victor in war is medicine"
  Mayo brothers WWII

Vietnam and Iraq development of systems of care to ensure optimal care from injury to rehab.

Trauma Systems

"Getting the right patient to the right place in the right amount of time."

- ◇Facilities (trauma center designation)
- ◇Personnel (training)
- ◇Patient transport
- ◇Triage

Facilities-Trauma Centers

- Level I -Definitive subspecialty care, research.
- Level II – Definitive subspecialty care, surgery, orthopedics, neurosurgery.
- Level III- General surgery, orthopedics, no neurosurgery
- Level IV- Stabilization, limited or no surgical capacity

Trained Personnel

- ATLS
- TNCC
- PHTLS
- ETT first responders
- RTTDC

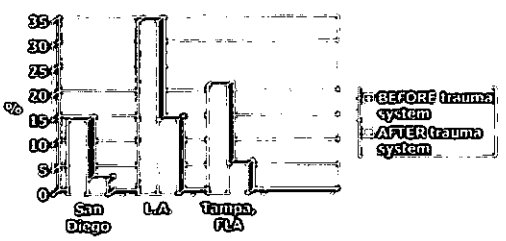
Transport and triage

- Guidelines that take into account local resources and capabilities.
- Head Injury Guidelines.
- Burn Triage.

Trauma Systems

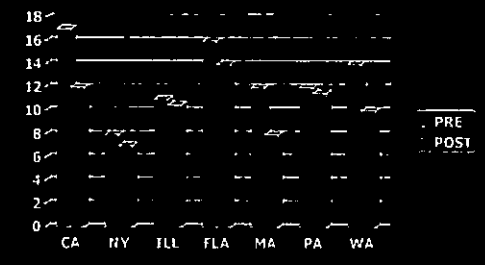
- 15-25% improvement in survival of the seriously injured.
- Increase productive working years
- Improve statewide disaster preparedness.
- Inclusive systems -best

Preventable Deaths: The impact of trauma systems



Trauma Systems & crash mortality

Nathens et.al. 2000



Trauma systems & crash mortality

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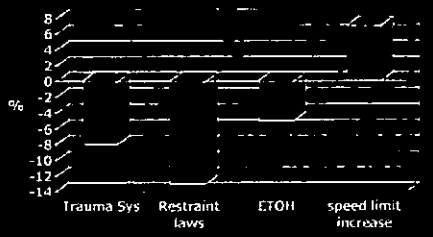
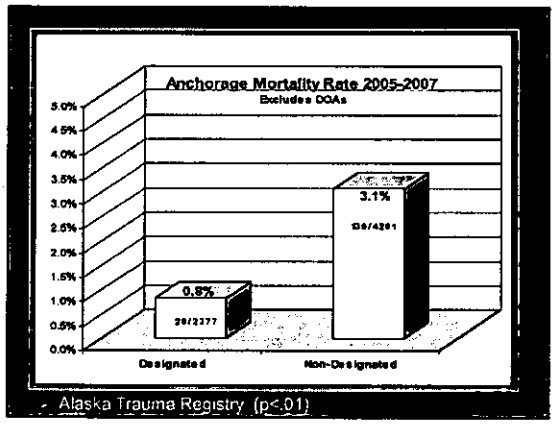
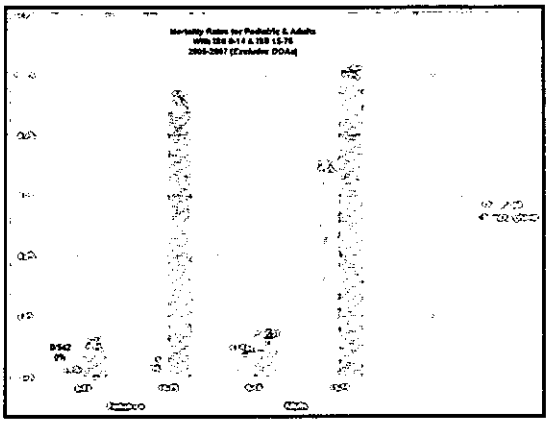




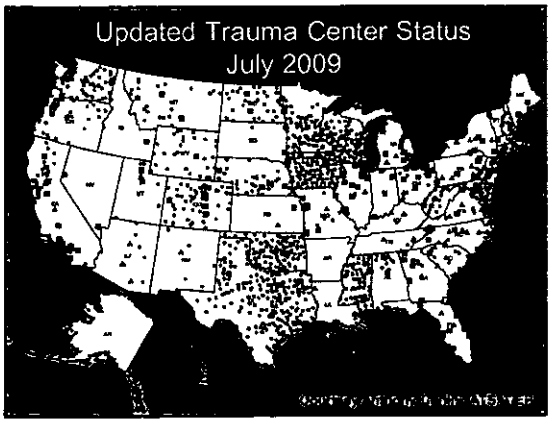


Trauma Center Growth Over Time

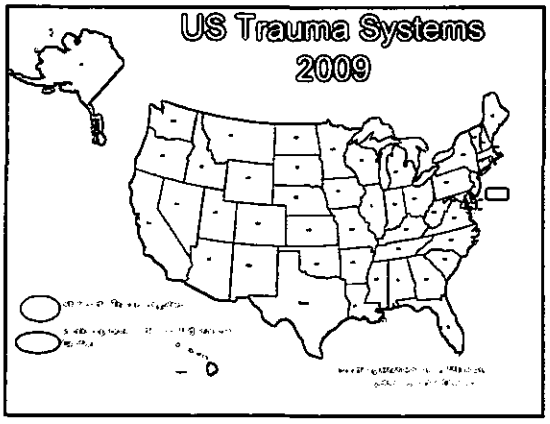
	1991	2002	2009
Level I	165	190	199
Level II	209	263	269
Level III	76	251	362
Level IV-V	21	450	748
Total	471	1,154	1,578
Pediatric Only			41

Courtesy Anthony Carlini ATS TIEP

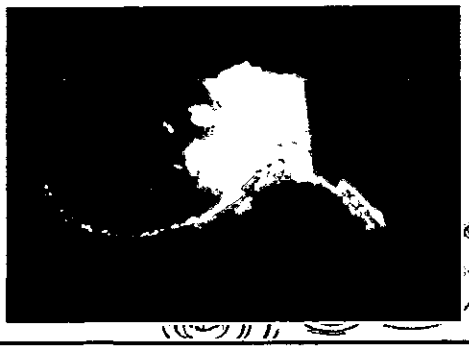
Updated Trauma Center Status July 2009



US Trauma Systems 2009



ALASKA The Great Land



Trauma Systems and the Public

- 2004 Harris poll to assess public Knowledge and perceptions on trauma and trauma care.
- Most Americans are not aware that injury is the leading cause of death for children, youth, and adults under the age of 34.

Harris Poll

- After hearing a description of a trauma center, almost all Americans feel it is extremely or very important to be treated at a trauma center in the event of a life-threatening injury.

Harris Poll

- Almost 9 out of 10 of Americans feel that having a trauma center nearby is as important as or more important than having a Fire Department or Police Department.

Harris Poll

- At the time of the survey although 75% thought there was a trauma system where they lived only about 20% actually lived in an area covered by a trauma system.
- Nearly all Americans *believe* that if they had a serious or life-threatening injury, they *would* be taken to the hospital that is best equipped to handle their specific injury in less than 1 hour.

Harris Survey- Conclusions

- The majority of the public thinks it is important to have a trauma system. (It is a nonpartisan issue.)
- Most people think they have it already.
- Many who think they are covered by a regional system are not.

Alaska Trauma System

- 1993 statute- EMS authority for designating trauma centers created.
- Hospital participation voluntary.
- Standards for trauma center designation follow American College of Surgeons criteria.

Alaska Trauma System

Verification of compliance by outside reviewers for Level I, II, III

◇In-state review for Level IV

Current Status -16 Years Later

- 24 hospitals in Alaska

Verified / Certified

- 1 Level II ANMC
- 4 Level IV centers- NSH -MEH - YKHC -SCH
- 9 other facilities with reviews or consultations.

Non-Verified

- 2 centers providing care for multiple trauma patients
- 6 centers that provide surgical capabilities
- 2 military hospitals

Alaska Trauma Facilities

- Alaska -Only state without a designated Level I/II trauma center that serves the majority of the population.
- Anchorage is the largest city in the US without a designated Level I/II center for the majority of the population.

Insanity

"Insanity is doing the same thing in the same way and expecting a different outcome"

- Old Chinese Proverb

State of Alaska DHSS
Trauma System Consultation
November 2-5 2008

ACS-COT Site Visit Team

- Reginald A Burton, MD FACS — Team Leader, Trauma Surgeon
- Jane Ball, RN, DrPH — ACS Committee
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- Drexel Pell, CEM — State EMS Director
- Nels Sandal, PhDc, REMT-B — ACS Consultant
- James D. Upchurch, MD — Emergency Physician

Objective

- To help promote a sustainable effort in the graduated development of an inclusive trauma system for Alaska
- Multidisciplinary review of the trauma system
- 17 states have been reviewed

Executive Summary

Advantages & Assets

- Committed individuals who use their time and expertise every day to serve Alaska citizens
- Extensive networks for transport
- 3 large medical centers with extensive subspecialty expertise within the state
- Large Level I trauma center in Seattle which freely accepts adult and pediatric trauma patients

Advantages & Assets

- One center maintains ACS Level II verification standards and others have obtained consultations and are working toward verification.
- Alaska Trauma Registry- all 24 acute care hospitals provide data.
- Injury prevention activities are well established.
- Initial efforts at legislative change.

Challenges and Vulnerabilities

- No trauma system plan
- Geography / Weather / Remote and isolated communities
- No standards for scene trauma triage or trauma inter-facility transfers
- Trauma system issues have limited visibility within state government.

Challenges and Vulnerabilities

Public not aware of trauma system issues.

Limited human resources.

Few incentives for hospitals to participate.

No statewide evaluation of system performance.

Trauma Care in Alaska 2009

- "There are two healthcare systems for injured patients. One for Alaska natives that adheres to national standards and another for the majority of the population"

Executive Summary

- "Several Alaska Native facilities have sought and achieved verification and designation as trauma centers. . . . . To date few of the facilities serving the majority population have made a similar commitment to achieving nationally recognized standards of trauma care."

ACS-CO" Alaska "Trauma System Review
"2010

Recommendations: Coalition Building and Community Support

- Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for all Alaskans.

Recommendations: Definitive Care Facilities

- Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with ACS criteria to meet the existing volume and acuity demands.
- Mandate participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center designation appropriate to their capabilities.

Recommendations: Definitive Care Facilities

- Study pediatric trauma care needs and establish one or more in-state centers of excellence in pediatric trauma care.
- Determine a method of providing financial support for hospitals designated/certified by the state as trauma centers to assist with uncompensated care and the cost of readiness

Recommendations: System Coordination and Patient Flow

- Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).

Recommendations: Financing

- Provide state funding to hire a fulltime trauma system manager.
- Determine a method of providing financial support for hospitals designated/certified by the state as trauma centers to assist with uncompensated care and the cost of readiness.

Themes

- You are closer than you think – many of the components are already in place.
- Alaska is a unique environment different from anywhere else
- You have developed innovative solutions to your unique challenges.
- Despite differences amongst stakeholders, all agree with the need for a consensus developed and integrated trauma system.

ACS Recommendations- Actions

- Commitment by DHSS to create a trauma manager position and develop a statewide trauma plan.
- Trauma Systems Review Committee working to develop metrics to measure trauma system performance.
- Legislation to create incentives for facilities to participate.

Alaska Trauma Systems Review Committee

- MDs, nurses, administrative, and prehospital representation
- Oversight- Trauma Registry
  - -Level IV Trauma verification
  - EMS triage and interfacility transfer guidelines
  - -Trauma system performance improvement

Alaska Trauma System: Facility Participation

- Increasing facility participation is essential.
- "Carrots and/or sticks"
- ACS recommends both
- Mandatory participation and payment for uncompensated care.

House and Senate Bills 168 and 169

- Introduced by Representative John Coghill(R) and Senator Bettye Davis(D) March 2009.
- Creates a fund to pay for uncompensated trauma care given at designated trauma centers.

Barriers

Hospital Administration concerns
- Extra cost especially at Level IIs
- Lack of physician support.
- Lack of demand from the community.

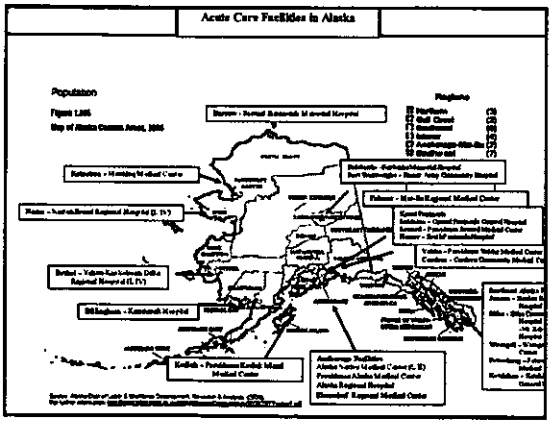
Provider Concerns
- Not needed " we do fine"
- No financial incentive to do it.
- More rules and regulations.

Social Change

- Pearl Harbor: A sudden crisis causes fundamental change.
- The Tipping Point: Pressure builds to an inflection point of change.
- Glacial Erosion: A steady growth or pressure that is hard to resist or ignore.

How can you help?

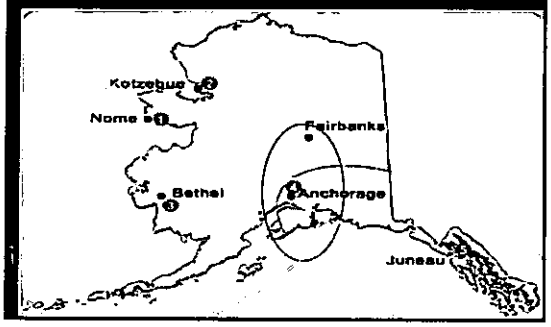
The Tipping Point
- Letters/emails to your legislators H.B. and S. 168 and 169.
- Letters/emails to your your hospital administration
- Ballot initiative?. (ie Arizona)



Vision

- An integrated system that addresses trauma from injury prevention through acute care and rehabilitation.

The Future: Alaska Trauma System(s)

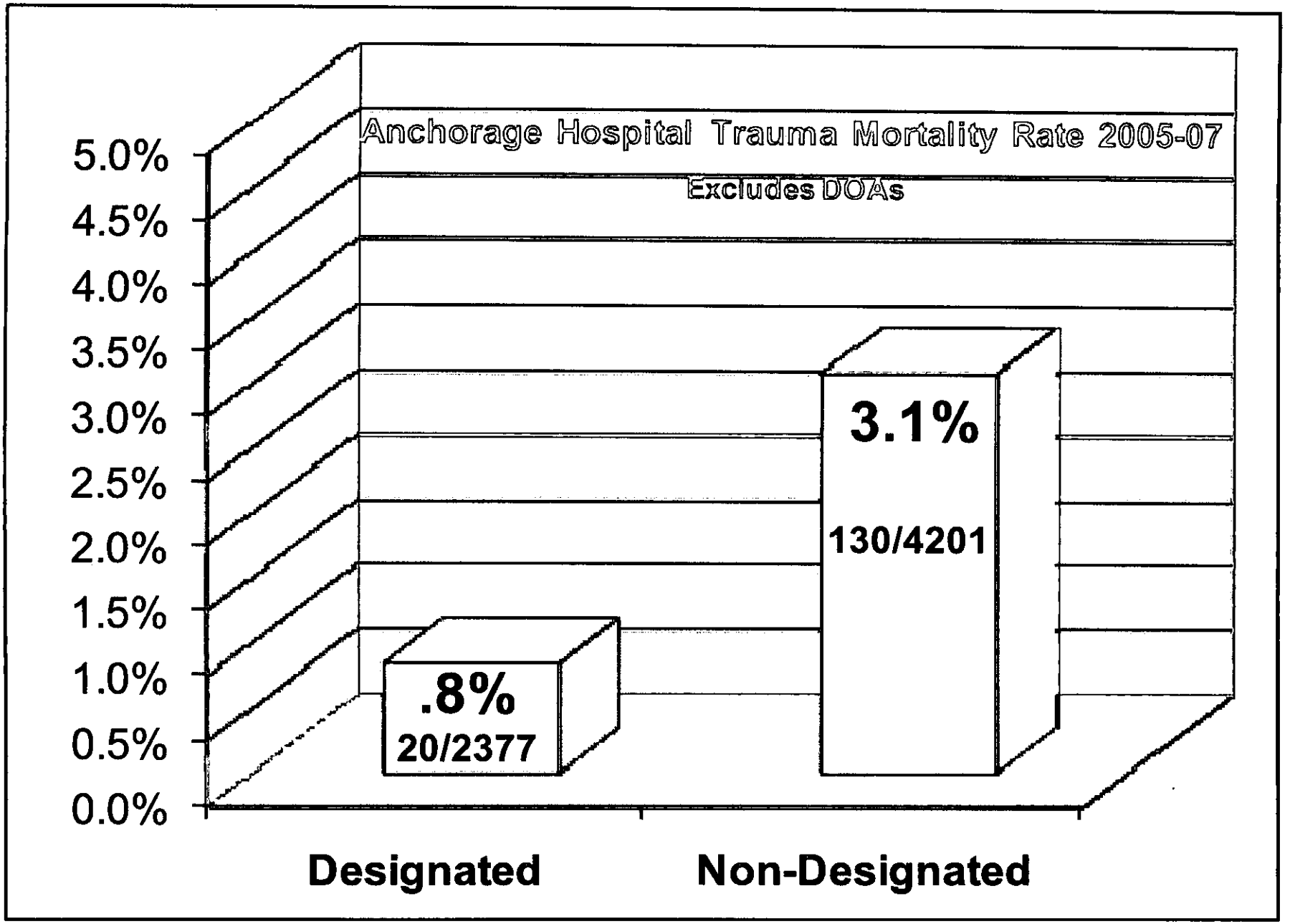


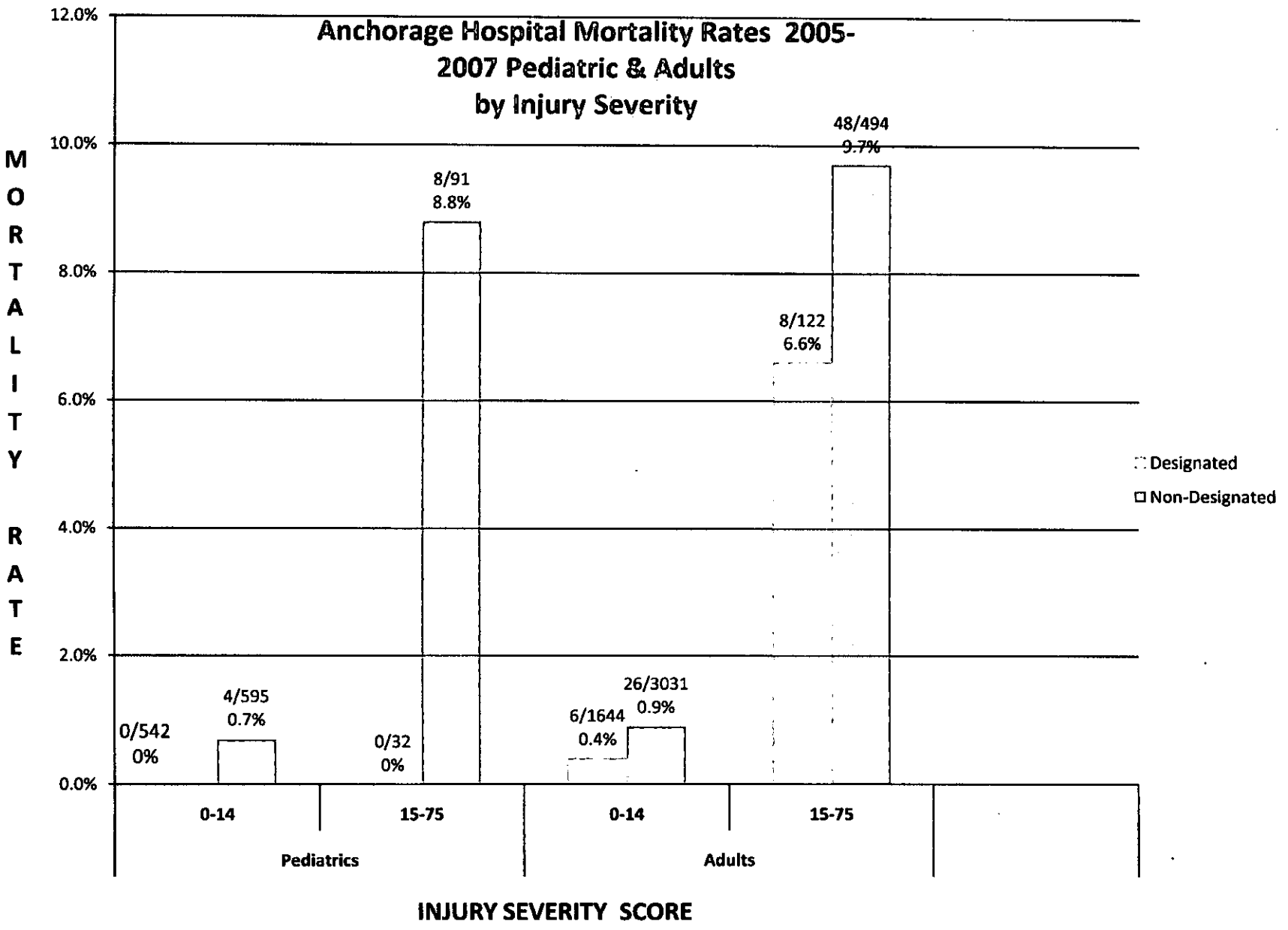
Why is this important?

Because it makes a difference and it is the care you want for your family and neighbors if they are seriously injured.

4

TRAUMA MORTALITY RATES ANCHORAGE


Anchorage Hospital Trauma Mortality Rate 2005-07
Excludes DOAs
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
.8%
20/2377
3.1%
130/4201
Designated
Non-Designated


Anchorage Hospital Mortality Rates 2005-2007 Pediatric & Adults by Injury Severity
MORTALITY RATE
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
0/542
0%
4/595
0.7%
0/32
0%
8/91
8.8%
6/1644
0.4%
26/3031
0.9%
8/122
6.6%
48/494
9.7%
Designated
Non-Designated
0-14
15-75
0-14
15-75
Pediatrics
Adults
INJURY SEVERITY SCORE

5
EMERGENCY TRAUMA CARE NEEDS IMPROVEMENT IN ALASKA LETTER

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Daily News Opinion

COMPASS: *Other points of view*

Emergency trauma care needs improvement in Alaska

By MARK S. JOHNSON and FRANK SACCO, M.D.

Johnson

You can be confident that you will receive emergency trauma care that compares favorably with care virtually anywhere else in the nation. Right? Maybe, but maybe not.

Sacco

Imagine you and your family driving across Anchorage. As you pass through a major intersection, a drunk driver runs a red light and hits your vehicle broadside. In an instant, you and your passengers face a life or death situation. If you're still conscious, you may think, thank God this happened in Anchorage where we have state of the art emergency medical services.

The Anchorage Fire Department has exceptional ambulance services, staffed with well-trained paramedics. Local hospitals have sophisticated emergency departments staffed 24 hours a day with qualified emergency medicine physicians, nurses and support personnel.

You can be confident that you will receive emergency trauma care that compares favorably with care virtually anywhere else in the nation. Right?

Maybe, but maybe not.

Though Alaskans die from injury at the second highest rate in the U.S., there is no statewide system of trauma care. In Anchorage, only the Alaska Native Medical Center has been verified by the American College of Surgeons and certified by the State of Alaska as a trauma center (Level II). Neither Providence nor Alaska Regional Hospital has achieved this national standard.

Trauma center certification means that a hospital has surgical teams readily available to take care of the most seriously injured patients at all times. Backup teams are available and outcomes are continuously reviewed to improve care.

Serious traumatic injuries can produce internal bleeding in the brain, spinal cord or internal organs. Often, this bleeding can be stopped only by surgeons in hospital operating rooms. Studies have verified the "golden hour of trauma," meaning that critically injured persons have increased chances of survival if treated within that time. Trauma centers, as part of a system of care, have been shown to decrease the mortality of the seriously injured 15 percent to 25 percent. Although rural areas may not meet the golden-hour standard, improvements in the statewide systems have been shown to achieve better outcomes for patients seriously injured in remote areas as well.

The Alaska Department of Health and Social Services recently contracted with the Committee on Trauma of the American College of Surgeons (ACS) to review Alaska's trauma care. That review notes Alaska has excellent injury prevention programs, extensive and creative networks for ground and air medical transport, medical specialists in Anchorage and a good relationship with Harborview Trauma Center (Level I) in Seattle.

Among Alaska's deficiencies: Anchorage does not have another Level II trauma center, so there are two systems of trauma care, one for Alaska Natives that follows national standards and another for non-Natives. The team identified no statewide trauma plan and no incentives or requirements for hospitals to participate in the system. State government devotes few resources to coordinating trauma care, and there seems to be very little public awareness of these issues.

The review team recommended requiring all acute-care hospitals to become designated as trauma centers at a level appropriate to their resources and size within two years (Levels II, III or IV). They recommended getting a second level II trauma center in Anchorage as soon as possible, along with a pediatric trauma center. Currently, due to a shortage of Anchorage surgeons willing to take care of children, some seriously injured non-Native children may need to be treated at the Alaska Native Medical Center.

Representative John Coghill Jr. recently introduced House Bills 168 and 169 to create incentives for hospitals to become trauma centers and to offset some of the cost of uncompensated trauma care. The Department of Health and Social Services should be commended for this comprehensive and impartial review of trauma care in Alaska. We urge Alaskans to support these bills and encourage the legislature and Gov. Palin to carefully consider the recommendations in the ACS report.

We hope the scenario above never happens to you but, if it does, let's make sure that the care we expect for our loved ones is available for all Alaskans when we need it.

Mark S. Johnson, MPA, retired as chief of Community Health and Emergency Medical Services for the State of Alaska in 2004. Frank Sacco, M.D., is chairman of the Alaska Trauma Systems Review Committee. The full report on Alaska's trauma care system is available at www.chems.alaska.gov.

Daily News

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Norman C. Brown
ne Fanning, Editor and Publisher, 1971-1983
ce Fanning, Editor and Publisher, 1967-1971

OPINION

COMPASS: *Points of view from the community*

Alaska needs a better trauma system

By FRANK SACCO and MARK S. JOHNSON

Alaska is much safer than it was a generation ago. From 1980 to 2004, the unintentional injury death rate dropped more than 50 percent. Without this improvement, an additional 300 Alaskans would have died in 2004. However, Alaska's 2004 rate remained 30 percent above the national average.

We are all aware of the terrible toll of cancer and cardiovascular diseases, but the leading cause of death for people younger than 44 is injury. It remains a major cause of death and disability for all age groups. For every death approximately three people are left with permanent disabilities.

As with other diseases, prevention is preferable to treatment. Alaska's dramatic reduction in injury deaths is largely attributable to prevention, including use of child restraints and safety belts, reduced rates of drunken driving, and increased use of personal flotation devices. Though prevention is paramount, we also must be prepared to provide the best possible care for those who become injured.

A trauma system is an organized, state-coordinated effort to deliver the full spectrum of care to injured people. The integration of EMS systems, public safety agencies, air medical services and health care facilities ensures that patients receive the most efficient, effective care possible from time of injury through rehabilitation. Trauma systems have been shown to reduce death from injury by as much as 25 percent and are recognized as an integral part of a state's EMS and disaster response system.

According to a 2004 Harris poll, most people want a comprehensive trauma system in their area. Throughout the United States, 83 percent of those surveyed felt a trauma system was as essential as having a fire department and 80 percent were willing to pay extra for it. Interestingly, though 75 percent thought there was a trauma system in their state, only eight states have fully functioning systems and 15 states have no system.

Sacco

Alaska is blessed with exceptional physicians and quality medical resources, but lack of an organized trauma system means that access to timely, quality care cannot be assured.

Johnson

Where do we stand? In 1993, the Alaska Legislature provided authority to the Department of Health and Social Services to verify and certify trauma centers. The statute does not require, or provide incentives for, hospital participation. It does state that no hospital can represent itself as a trauma center unless certified by the state.

Regulations adopted in 1996 require trauma centers to meet standards developed by the American College of Surgeons. Four levels are recognized, from Level I (highest) to Level IV (trauma stabilization facility). There are adequate medical resources to establish Level II trauma centers in Anchorage. In addition, it is feasible to establish Level III and IV centers throughout the state. Because of long transport times, centers of all levels are essential for improving outcomes.

Since the statute and regulations were enacted, only three of 24 eligible hospitals have successfully completed the verification and certification process. (Alaska Native Medical Center — Level II, Yukon Kuskokwim Regional and Norton Sound Regional Hospitals — Level IV).

Alaska is blessed with exceptional physicians and quality medical resources, but lack of an organized trauma system means that access to timely, quality care cannot be assured. In recent years there have been times when critical specialties such as neurosurgery and vascular surgery have been unavailable for emergencies, necessitating transfer of some critical patients to Seattle.

Here are four steps to improve trauma care in Alaska:

1. Residents need to let legislators know that quality trauma care is important.

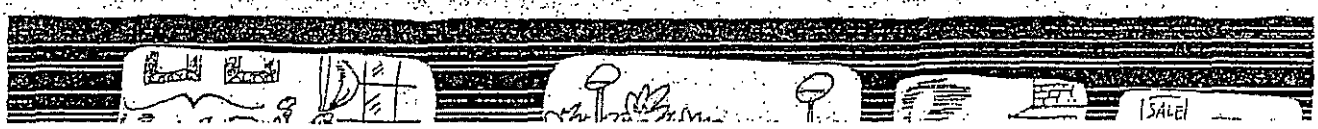
2. The Legislature should put teeth and incentives in the current statute. Successful approaches in other states include requiring trauma center certification at some level as a condition for hospital licensing and limiting medical liability for injuries treated at trauma centers.

3. Tertiary hospitals should ensure availability of critical sub-specialists 24 hours a day, seven days a week.

4. Local EMS and medical providers should organize regional trauma systems and integrate them with the statewide system.

Developing a comprehensive statewide trauma system, and expanding injury prevention efforts, will make Alaska a safer, healthier place to live.

■ Dr. Frank Sacco is chief of surgery at the Alaska Native Medical Center and chairman of the Alaska Chapter of American College of Surgeons Committee on Trauma. Mark S. Johnson was chief of Emergency Medical Services in the Department of Health and Social Services from 1979 until he retired in 2004.



6

AMERCIAN COLLEGE OF SURGEONS RECOMMENDATIONS

Trauma System Consultation
State of Alaska
Anchorage, Alaska

November 2nd -5th , 2008
American College of Surgeons
Committee on Trauma

PRIORITY RECOMMENDATIONS AMERICAN COLLEGE OF SURGEONS ALASKA TRAUMA SYSTEM REVIEW

November 2-5 2008

Definitive Care Facilities

- Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with American College of Surgeons Committee on Trauma (ACS-COT) verification criteria to meet the existing volume and acuity demands.
- Mandate participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center certification/designation appropriate to their capabilities.
  - o Facilities should seek trauma center designation at a level appropriate for their capabilities.
  - o Other facilities, such as remote health care clinics, should participate with rapid patient assessment and stabilization and by following guidelines for trauma triage and transfer.
- Study pediatric trauma care needs with the goal of establishing one or more centers of excellence in pediatric trauma care.

Coalition Building and Community Support

- Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.

Lead Agency and Human Resources Within the Lead Agency

Develop an appropriate position classification and duty statement for a 1.0 full time equivalent (FTE), permanent trauma system manager that specifies education as a health professional, experience in trauma or emergency health care, and the administrative skills and clinical understanding necessary to support trauma system development.

Trauma System Plan

- Develop a comprehensive trauma system strategic plan consistent with the Health Resources and Services Administration (HRSA) *Model Trauma System Planning and Evaluation* document.

Coalition Building and Community Support

- Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.

System Integration

- Ensure that the Injury Prevention and Emergency Medical Services

(IPEMS) Section is engaged in planning with disaster preparedness, emergency management, and public health functions for integration of the trauma system.

Financing

• Provide state funding to hire a fulltime trauma system manager.

Emergency Medical Services

• Develop a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (e.g., load capacity, instrument rating, landing requirements, etc); and to monitor the availability and location of air resources in near real-time.

System Coordination and Patient Flow

• Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).

Disaster Preparedness

• Integrate all components of the trauma system into state and local disaster planning activities.

System-wide Evaluation and Quality Assurance

• Develop an initial set of 3-5 statewide system performance indicators from among the list of nine provided in the Pre-Review Questionnaire.

Trauma Management Information Systems

• Ensure that all elements considered essential to system development, evaluation and performance improvement in the State of Alaska are included and functional in the new trauma registry and are consistent with the National Trauma Data Standard definitions.

Statutory Authority and Administrative Rules

System Leadership

• Form an Alaska Technical Advisory Committee (ATAC) and task it with providing the Alaska Council on Emergency Medical Services (ACEMS) with recommendations regarding the following functions: data systems, trauma system planning, system-wide performance improvement and patient safety, trauma education (Advanced Trauma Life Support [ATLS], Trauma Nurse Core Curriculum [TNCC], Prehospital Trauma Life Support [PHTLS], etc), trauma center review and certification, injury prevention and control, public policy, and research.

- Enact legislation to expand the membership of the ACEMS to represent the trauma system and to include the following members appointed as follows:

  - One member, appointed by the Governor, shall represent the Alaska Chapter of the American College of Surgeons Committee on Trauma.
  - One member, appointed by the Governor, shall be a general surgeon who routinely participates in the care of injured patients.
  - One member, appointed by the Governor, shall represent the Alaska Chapter of the American Academy of Pediatrics.
  - One member, appointed by the Alaska Legislature, upon the recommendation of the Speaker of the House of Representatives.
  - One member, appointed by the Alaska Legislature, upon the recommendation of the President of the Senate.

7

TRAUMA SYSTEM CONSULTATION STATE OF ALASKA NOVEMBER 2008

Trauma System Consultation

State of Alaska

Anchorage, Alaska

November 2nd-5th, 2008

American College of Surgeons

Committee on Trauma

4703

A multidisciplinary working group prepared this document based on the consultation visit that took place on November 2nd-5th, 2008 in Anchorage, Alaska and included the following members:

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Executive Summary

American College of Surgeons
Trauma System Consultation Visit
Alaska Department of Health and Social Services
November 2nd-5th, 2008

The American College of Surgeons, Trauma Systems Evaluation and Planning Committee (TSEPC) is honored to have been invited to the largest state in the nation and to have listened as the state's impassioned health care providers and public servants discussed their success and remaining challenges. We are pleased to provide this report and to encourage you to implement the key recommendations to improve the system of trauma care for all Alaskans and visitors, regardless of where that injury may occur.

It is clear that Alaska recognizes the significance of its injury problem as witnessed both by epidemiological descriptions of fatal and non-fatal injury and by the extensive focus on injury prevention programs across the state. Alaska's current trauma system is a testament to the adage that "necessity is the mother of invention". Clearly the "Last Frontier" is challenged with issues of geography, remoteness, inclement weather and limited health care resources. State and regional leaders, along with a wide ranging cadre of health care providers are to be congratulated for their efforts to achieve the trauma system mantra of "getting the right patient to the right place in the right amount of time". Whether this has involved training a hunting buddy to be an Emergency Trauma Technician, or a local aviation service has figured out how to carry a litter in a small aircraft, or a rural Critical Access Hospital has strived to become certified or designated as a Level IV trauma center, clear progress has been demonstrated toward the betterment of trauma care in Alaska.

The achievements to date have largely been unplanned with limited coordination. As a result, incongruity exists within the current trauma system. Several Alaska Native facilities have sought and achieved verification/designation as trauma centers. These facilities are to be commended for their dedication and commitment to trauma care and the trauma system. To date, few of the facilities serving the majority population have made a similar commitment to achieving nationally recognized standards of trauma care.

4707

The current leadership of the Alaska Department of Health and Social Services recently made a commitment to trauma system development by making this a priority project in the 2009 work plan. This represents an opportunity to begin the process to coordinate, systematize and institutionalize these efforts so that, regardless of where someone is injured in Alaska or what their racial and ethnic heritage might be, all have equal access to optimal trauma care.
Alaska must make a commitment of resources, both fiscal and human, to achieve the recommendations outlined in this document. The consultation team encourages the state to retain the opportunity for system ingenuity when addressing the challenges that Alaska's geography and environment impose when increasing the standardization of trauma system processes.

Advantages and Assets of the Alaska Trauma System

- The lead agency for trauma is identified. Statute designates the Alaska Council on EMS (ACEMS) as an advisory group with responsibility for trauma.
- The state has very committed individuals who use their time and expertise every day to serve Alaska citizens.
- The state has extensive and creative networks for transport.
- Three large medical centers with extensive subspecialty expertise exist within the state.
- A large Level I trauma center in Seattle freely accepts adult and pediatric trauma patients.
- One medical center maintains ACS Level II verification standards and other facilities have obtained consultation and are working toward verification.
- All 24 acute care hospitals provide data to the Alaska trauma registry.
- Injury prevention activities are well established.
- The EMS Goals document categorizes communities by size and remoteness and identifies the resources that should be available for health care and trauma care.
- The state created the Emergency Trauma Technician program to prepare community members to provide initial trauma care.

- Initial efforts have been made to obtain legislative change.

Challenges and Vulnerabilities of the Alaska Trauma System

- The state has many challenges due to geography, weather, and remote and isolated communities.
- No trauma system strategic plan has been developed.
- No standards exist for scene trauma triage or trauma inter-facility transfers.
- Trauma system issues receive limited attention by the Alaska Council on EMS, and thus little visibility within the Department of Health and Social Services.
- The general public is not aware of trauma system issues.
- The state has limited human resources for the provision of trauma care. The lead agency also has limited human resources for trauma system management.
- The ACEMS has no formal trauma representatives.
- There are two healthcare systems for trauma care, one for Native Alaskans and one for other Alaskans.
- Few incentives exist for hospitals to participate in the trauma system.
- No statewide evaluation of system performance is conducted.
- The trauma registry data are not current.

4709

Priority Recommendations Summary

This report contains more than seventy recommendations. Of these, the TSEPC team felt that the following were the most critical to the system's short and long-term success.

Statutory Authority and Administrative Rules

- **Enact legislation to expand the membership of the ACEMS to represent the trauma system and to include the following members appointed as follows:**
    - **One member, appointed by the Governor, shall represent the Alaska Chapter of the American College of Surgeons Committee on Trauma.**
    - **One member, appointed by the Governor, shall be a general surgeon who routinely participates in the care of injured patients.**
    - **One member, appointed by the Governor, shall represent the Alaska Chapter of the American Academy of Pediatrics.**
    - **One member, appointed by the Alaska Legislature, upon the recommendation of the Speaker of the House of Representatives.**
    - **One member, appointed by the Alaska Legislature, upon the recommendation of the President of the Senate.**
- **Require participation of all acute care hospitals in the trauma system within a 2 year time frame.**
    - **Facilities should seek trauma center designation at a level appropriate for their capabilities.**
    - **Other facilities, such as remote health care clinics, should participate with rapid patient assessment and stabilization and by following guidelines for trauma triage and transfer.**

System Leadership

- **Form an Alaska Technical Advisory Committee (ATAC) and task it with providing the Alaska Council on Emergency Medical Services (ACEMS) with recommendations regarding the following functions: data systems, trauma system planning, system-wide performance improvement and patient safety, trauma education (Advanced Trauma Life Support [ATLS], Trauma Nurse Core Curriculum [TNCC], Prehospital Trauma Life Support [PHTLS], etc), trauma center review and certification, injury prevention and control, public policy, and research.**

Coalition Building and Community Support

- **Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.**

Lead Agency and Human Resources Within the Lead Agency

Develop an appropriate position classification and duty statement for a 1.0 full time equivalent (FTE), permanent trauma system manager that specifies education as a health professional, experience in trauma or emergency health care, and the administrative skills and clinical understanding necessary to support trauma system development.

Trauma System Plan

- **Develop a comprehensive trauma system strategic plan consistent with the Health Resources and Services Administration (HRSA) *Model Trauma System Planning and Evaluation* document.**

System Integration

- **Ensure that the Injury Prevention and Emergency Medical Services (IPEMS) Section is engaged in planning with disaster preparedness, emergency management, and public health functions for integration of the trauma system.**

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Financing

- **Provide state funding to hire a fulltime trauma system manager.**

Emergency Medical Services

- **Develop a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (e.g., load capacity, instrument rating, landing requirements, etc); and to monitor the availability and location of air resources in near real-time.**

Definitive Care Facilities

- **Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with American College of Surgeons Committee on Trauma (ACS-COT) verification criteria to meet the existing volume and acuity demands.**
- **Mandate participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center certification/designation appropriate to their capabilities.**
- **Study pediatric trauma care needs with the goal of establishing one or more centers of excellence in pediatric trauma care.**

System Coordination and Patient Flow

- **Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).**

Disaster Preparedness

- **Integrate all components of the trauma system into state and local disaster planning activities.**

System-wide Evaluation and Quality Assurance

- **Develop an initial set of 3-5 statewide system performance indicators from among the list of nine provided in the Pre-Review Questionnaire.**

Trauma Management Information Systems

- **Ensure that all elements considered essential to system development, evaluation and performance improvement in the State of Alaska are included and functional in the new trauma registry and are consistent with the National Trauma Data Standard definitions.**

Trauma System Assessment

Injury Epidemiology

Purpose and Rationale

Injury epidemiology is concerned with the evaluation of the frequency, rates, and pattern of injury events in a population. Injury pattern refers to the occurrence of injury-related events by time, place, and personal characteristics (for example, demographic factors such as age, race, and sex) and behavior and environmental exposures, and, thus, it provides a relatively simple form of risk-factor assessment.

The descriptive epidemiology of injury among the whole jurisdictional population (geographic area served) within a trauma system should be studied and reported. Injury epidemiology provides the data for public health action and becomes an important link between injury prevention and control and trauma system design and development. Within the trauma system, injury epidemiology has an integral role in describing the root causes of injury and identifying patterns of injury so that public health policy and programs can be implemented. Knowledge of a region's injury epidemiology enables the identification of priorities for directing better allocation of resources, the nature and distribution of injury prevention activities, financing of the system, and health policy initiatives.

The epidemiology of injury is obtained by analyzing data from multiple sources. These sources might include vital statistics, hospital administrative discharge databases, and data from emergency medical services (EMS), emergency departments (EDs), and trauma registries. Motor-vehicle crash data might also prove useful, as would data from the criminal justice system focusing on interpersonal conflict. It is important to assess the burden of injury across specific population groups (for example, children, elderly people and ethnic groups) to ensure that specific needs or risk factors are identified. It is critical to assess rates of injury appropriately and, thus, to identify the appropriate denominator (for example, admissions per 100,000 population). Without such a measure, it becomes difficult to provide valid comparisons across geographic regions and over time.

To establish injury policy and develop an injury prevention and control plan, the trauma system, in conjunction with the state or regional epidemiologist, should complete a risk assessment and gap analysis using all available data. These data allow for an assessment of the "injury health" of the population (community, state, or region) and will allow for the assessment of whether injury prevention programs are available, accessible, effective, and efficient.

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An ongoing part of injury epidemiology is public health surveillance. In the case of injury surveillance, the trauma system provides routine and systematic data collection and, along with its partners in public health, uses the data to complete injury analysis, interpretation, and dissemination of the injury information. Public health officials and trauma leaders should use injury surveillance data to describe and monitor injury events and emerging injury trends in their jurisdictions; to identify emerging threats that will call for a reassessment of priorities and/or reallocation of resources; and to assist in the planning, implementation, and evaluation of public health interventions and programs.

OPTIMAL ELEMENTS

I. There is a thorough description of the epidemiology of injury in the system jurisdiction using population-based data and clinical databases. **(B-101)**

a. There is a through description of the epidemiology of injury mortality in the system jurisdiction using population-based data. **(I-101.1)**

b. There is a description of injuries within the trauma system jurisdiction, including the distribution by geographic area, high-risk populations (pediatric, elderly, distinct cultural/ethnic, rural, and others), incidence, prevalence, mechanism, manner, intent, mortality, contributing factors, determinants, morbidity, injury severity (including death), and patient distribution using any or all the following: vital statistics, ED data, EMS data, hospital discharge data, state police data (data from law enforcement agencies), medical examiner data, trauma registry, and other data sources. The description is updated at regular intervals. **(I-101.2)**
Note: Injury severity should be determined through the consistent and system-wide application of one of the existing injury scoring methods, for example, Injury Severity Score (ISS).

c. There is comparison of injury mortality using local, regional, statewide, and national data. **(I-101.3)**

d. Collaboration exists among EMS, public health officials, and trauma system leaders to complete injury risk assessments. **(I-101.4)**

e. The trauma system works with EMS and public health agencies to identify special at-risk populations. **(I-101.7)**

II. Collected data are used to evaluate system performance and to develop public policy. **(B-205)**

a. Injury prevention programs use trauma management information system data to develop intervention strategies. **(I-205.4)**

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III. The trauma, public health, and emergency preparedness systems are closely linked. **(B-208)**

a. The trauma system and the public health system have established linkages, including programs with an emphasis on population based public health surveillance and evaluation for acute and chronic traumatic injury and injury prevention. **(I-208.1)**

IV. The jurisdictional lead agency, in cooperation with the other agencies and organizations, uses analytic tools to monitor the performance of population based prevention and trauma care services. **(B-304)**

a. The lead agency, along with partner organizations, prepares annual reports on the status on injury prevention and trauma care in the state, regional, or local areas. **(I-304.1)**

b. The trauma system management information system database is available for routine public health surveillance. There is concurrent access to the databases (ED, trauma, prehospital, medical examiner, and public health epidemiology) for the purpose of routine surveillance and monitoring of health status that occurs regularly and is a shared responsibility. **(I-304.2)**

CURRENT STATUS

Injury is the leading cause of death for Native Alaskans of all ages. Injury is the third leading cause of death for all Alaskans. Like the remainder of the United States, injury is the leading cause of death for the population between 1 and 44 years of age. Leading mechanisms for unintentional injury include the following: motor vehicle crash, falls, airplane crash, fire, all terrain vehicles, snow machine, and firearms. Suicide is a leading cause of injury death for ages 15 to 64 years. Injury mortality is significantly higher in Alaska than in the remainder of the United States where injury is the fifth leading cause of death; however it was reported that the state's injury mortality rate has decreased significantly over the last 30 years.

Healthy Alaskans 2010 describes significant injury prevention objectives for the state, with indicators identified for unintentional injury, occupational fatalities, attempted suicide, nonfatal, hospitalized traumatic brain injury, prenatal physical abuse, population using seatbelts, and households keeping firearms locked and loaded. A strategic plan for addressing these injury prevention objectives was not identified.

A dedicated staff working on epidemiology is assigned to the Department of Health and Social Services (DHSS) Injury Prevention and EMS (IPEMS) Section to coordinate the data analysis for various injury focus areas. Additionally, the Native Alaska Epidemiology Center analyzes data related to injury among the native population. A report on Native Alaskan injury morbidity and mortality was published in 2008.

Access to numerous population-based databases (e.g., vital statistics, fatal analysis reporting system, public safety information system, civilian fire fatality statistics, uniform crime reporting, medical examiner case database, and hospital discharge data system) are readily available for study of the injury problem.

Funding from grants and other state agencies has been obtained and creatively used to support injury surveillance. The state has many population-based injury databases used to describe the injury problem. Numerous injury surveillance activities are ongoing, such as the violent deaths reporting, occupational injuries, motor vehicle crashes, and traumatic brain injuries. The Alaska trauma registry which has data from all 24 acute care hospitals has been used extensively to describe the patterns of injury in the state.

The state had a State and Territorial Injury Prevention Directors Association (STIPDA) assessment conducted in 2003. Work was reported to be still in progress to address many of the recommendations included in the report.

The state has a wealth of data about the injury problem. Primary injury prevention has been the priority focus of information shared with the public and members of the injury coalition. The data have been used to compete successfully for numerous federal grants and state agency projects.

The state website has fairly recent information and reports about injury trends for selected injuries, particularly regarding injury mechanisms for which the state has grant funding. Several publications were reported to be in draft stage related to grant funded activities, but no general description of the injury problem in the state has been published since *Healthy Alaskans 2010*.

No apparent linkage has been made between injury prevention and injury control, which would integrate secondary and tertiary prevention (or the care provided after the patient is injured) in the injury epidemiology focus. Alaskans have not been informed about the injury problem, its relationship to trauma care, and the need for a trauma system.

RECOMMENDATIONS

- Develop fact sheets for public education regarding injuries that require hospitalization and a trauma system.
- Expand the focus of injury epidemiology to report on trauma patient outcomes and the relationship to the trauma system.

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Purpose and Rationale

In the absence of validated national benchmarks, or norms, the benchmarks, indicators and scoring (BIS) process included in the Health Resources and Services Administration's *Model Trauma System Planning and Evaluation* document provides a tool for each trauma system to define its system-specific health status benchmarks and performance indicators and to use a variety of community health and public health interventions to improve the community's health status. The tool also addresses reducing the burden of injury as a community-wide public health problem, not strictly as a trauma patient care issue.

This BIS tool provides the instrument and process for a relatively objective state and sub-state (regional) trauma system self-assessment. The BIS process allows for the use of state, regional, and local data and assets to drive consensus responses to the BIS. It is essential that the BIS process be completed by a multidisciplinary stakeholder group, most often the equivalent of a state trauma advisory committee. The BIS process can help focus the discussion on various system strengths and weaknesses, can be used to set goals or benchmarks, and provides the opportunity to target often limited resources and energies to the areas identified as most critical during the consensus process. The BIS process is useful to develop a snapshot of any given system at a moment in time. However, its true usefulness is in repeated assessments that reveal progress toward achieving various benchmarks identified in the previous application of the BIS. This process further permits the trauma system to refine goals to be attained before future reassessments using the tool.

OPTIMAL ELEMENT

I. Assurance to constituents that services necessary to achieve agreed-on goals are provided by encouraging actions of others (public or private), requiring action through regulation, or providing services directly. **(B-300)**

CURRENT STATUS

In early 2007, the Benchmark, Indicators and Scoring (BIS) document from the *Model Trauma System Planning and Evaluation* document was distributed to the Trauma System Review Committee (TSRC). Seven of the sixteen members completed the BIS scoring. Results were compiled and means were calculated for each indicator. Those summary scores were presented to the TSRC at their May, 2007, meeting. The TSRC selected benchmarks 205, 206 and 208 for improvement over the succeeding year.

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Specifically, the TSRC identified three tactics to improve scores for identified benchmarks. These tactics included:

1. Select three measures of patient care that can be reviewed by the committee.
2. Compare and contrast transfers from designated Level IV facilities with those from non-designated facilities.
3. Review deaths in transport and deaths within 24 hours of admission.

When queried about the status of these tactical objectives, the TSRC members noted that little progress has been made in completing those processes. Initial data were reviewed from the state trauma registry to begin the process. However, the consensus was that the data needed additional cleaning, so the project was placed on hold and has not been revisited.

Those who had participated in the BIS review relayed some frustration about the process, stating that they did not have sufficient information to answer each of the indicators. Other states that have completed the BIS process in the same individual process have had similar experiences; however, when states have completed the BIS in a facilitated group process, individuals from across the trauma system spectrum learn a great deal about other areas of the trauma system. These facilitated processes have been conducted in many different formats, including audio teleconferencing, segmentation of the BIS by section, and in face-to-face retreats.

When participants were asked about whether the BIS might be revisited, little enthusiasm was expressed for undertaking the process, probably due to the frustration associated with the initial process and the low perceived value of the outcome.

RECOMMENDATIONS

- Select and complete one of the three tactical objectives identified in the May, 2007, TSRC meeting.
- Secure funding to support a facilitated trauma system assessment utilizing the Benchmark, Indicators and Scoring (BIS) process with the newly formed Alaska Trauma Advisory Committee (ATAC) and other trauma system stakeholders and state partners.
- Repeat the BIS process at regular intervals (e.g., every two years) as a means of establishing and monitoring system benchmarks

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Trauma System Policy Development

Statutory Authority and Administrative Rules

Purpose and Rationale

Reducing morbidity and mortality due to injury is the measure of success of a trauma system. A key element to this success is having the legal authority necessary to improve and enhance care of injured people through comprehensive legislation and through implementing regulations and administrative code, including the ability to regularly update laws, policies, procedures, and protocols. In the context of the trauma system, comprehensive legislation means the statutes, regulations, or administrative codes necessary to meet or exceed a predescribed set of standards of care. It also refers to the operating procedures necessary to continually improve the care of injured patients from injury prevention and control programs through post injury rehabilitation. The ability to enforce laws and rules guides the care and treatment of injured patients throughout the continuum of care.

There must be sufficient legal authority to establish a lead trauma agency and to plan, develop, maintain, and evaluate the trauma system during all phases of care. In addition, it is essential that as the development of the trauma system progresses, included in the legislative mandate are provisions for collaboration, coordination, and integration with other entities also engaged in providing care, treatment, or surveillance activities related to injured people. A broad approach to policy development should include the building of system infrastructure that can ensure system oversight and future development, enforcement, and routine monitoring of system performance; the updating of laws, regulations or rules, and policies and procedures; and the establishment of best practices across all phases of intervention. The success of the system in reducing morbidity and mortality due to traumatic injury improves when all service providers and system participants consistently comply with the rules, have the ability to evaluate performance in a confidential manner, and work together to improve and enhance the trauma system through defined policies.

OPTIMAL ELEMENTS

I. Comprehensive state statutory authority and administrative rules support trauma system leaders and maintain trauma system infrastructure, planning, oversight, and future development. **(B-201)**

a. The legislative authority states that all the trauma system components, emergency medical services (EMS), injury control, incident management, and planning documents work together for the effective implementation of the trauma system (infrastructure is in place). **(I-201.2)**

b. Administrative rules and regulations direct the development of operational policies and procedures at the state, regional, and local levels. **(I-201.3)**

II. The lead agency acts to protect the public welfare by enforcing various laws, rules, and regulations as they pertain to the trauma system. **(B-311)**

a. Laws, rules, and regulations are routinely reviewed and revised to continually strengthen and improve the trauma system. **(I-311.4)**

CURRENT STATUS

The IPEMS Section has served as the administrative unit for trauma and emergency medical services (EMS) since 1977. The Alaska State Statutes (AS 18.08.010), related to EMS and Trauma as revised in 1993, provide the agency with authority for the development, implementation, and maintenance of a statewide comprehensive EMS system. Historically the IPEMS has provided leadership with dedicated individuals who have committed themselves to the improvement of trauma and emergency care for the state. Leadership within the IPEMS has experienced changes beginning in 2004 due to the retirement of its Chief and reorganization within the DHSS.

A significant strength for the IPEMS Section is that it currently has support from the senior leadership within the DHSS to provide for the development and regulatory oversight of the state's EMS and trauma system. The statutory authority and departmental support provide an opportunity for the IPEMS Section to identify and collaborate with the numerous stakeholders for trauma and EMS to include the Alaska Hospital Association, the Native Alaskan healthcare providers, prehospital provider organizations, health professional organizations, and numerous governmental and non-governmental entities.

The Alaska Council on Emergency Medical Services (ACEMS) was established in statute (AS 18.08.020). The council has eleven members appointed by the Governor, and it is charged with advising the Commissioner of DHSS and Governor regarding the planning and implementation of a statewide EMS system. Membership of the council includes prehospital professionals, other healthcare professionals, an EMS administrator, a hospital administrator and members of the public. The ACEMS currently has no required surgical, pediatric, or legislative representation on the council.

The Trauma System Review Committee (TSRC) is appointed by the Commissioner of DHSS. It is comprised of physicians and other healthcare professionals tasked to review the trauma system data. The committee is a legal medical review organization under statute AS 18.23.010-070, and membership is approved by the State Medical Board.

The TSRC's work in reviewing the trauma registry data and monitoring the care being delivered to the state's citizens and visitors is provided confidentiality and liability protection in statute AS 18.23.020. This represents another significant strength in the state's EMS and trauma system. The committee's role beyond the review of trauma registry data is not clearly defined and no direct connection to the ACEMS currently exists.

Recently the TSRC proposed a legislative effort titled the Alaska Trauma Improvement Act, but insufficient legislative support was obtained for passage in the last (2006) legislative session. The efforts and success of the TSRC to promote improvements in trauma care for all Alaskans is commendable and can be attributed to the vision and leadership provided by its chair Dr. Frank Sacco and to the dedication of its membership. Currently hospital participation in the statewide trauma system is voluntary and no incentives are provided to promote participation. For an inclusive trauma system approach and to improve trauma care statewide all hospitals should be required to participate, not only by submission of trauma data, but at some level of trauma system participation.

The state EMS medical director's current role does not include medical oversight of the trauma system. The state does not have a trauma medical director or advisor identified to provide the IPEMS Section with guidance in the development and oversight of the trauma system. The designation of a trauma surgeon to such a role would increase the state's ability to fully integrate all phases of care, including prehospital, into a statewide inclusive trauma system.

RECOMMENDATIONS

- **Enact legislation to expand the membership of the ACEMS to represent the trauma system and include the following members appointed as follows:**
  - **One member, appointed by the Governor, shall represent the Alaska Chapter of the American College of Surgeons Committee on Trauma.**
  - **One member, appointed by the Governor, shall be a general surgeon who routinely participates in the care of injured patients.**
  - **One member, appointed by the Governor, shall represent the Alaska Chapter of the American Academy of Pediatrics.**
  - **One member, appointed by the Alaska Legislature upon the recommendation of the Speaker of the House of Representatives.**
  - **One member, appointed by the Alaska legislature upon the recommendation of the President of the Senate.**
- **Require participation of all acute care hospitals in the trauma system within a 2 year time frame.**

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- **Facilities should seek trauma center designation at a level appropriate for their capabilities.**
- **Other facilities, such as remote health care clinics, should participate with rapid patient assessment and stabilization and by following guidelines for trauma triage and transfer.**

- Require all hospitals and clinics to submit data to the state trauma registry.
- Amend the Alaska Administrative Code (AAC) to give the IPEMS Section responsibility for development of a statewide plan for the implementation and monitoring of an inclusive trauma system.

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Purpose and Rationale

In addition to lead agency staff and consultants (for example, trauma system medical director), there are other significant leadership roles essential to developing mature trauma systems. A broad constituency of trauma leaders includes trauma center medical directors and nurse coordinators, prehospital personnel, injury prevention advocates, and others. This broad group of trauma leaders works with the lead agency to inform and educate others about the trauma system, implements trauma prevention programs, and assists in trauma system evaluation and research to ensure that the right patient, right hospital, and right time goals are met. There is a strong role for the trauma system leadership in conveying trauma system messages, building communication pathways, building coalitions, and collaborating with relevant individuals and groups. The marketing communication component of trauma system development and maintenance begins with a consensus-built public information and education plan. The plan should emphasize the need for close collaboration between coalitions and constituency groups and increased public awareness of trauma as a disease. The plan should be part of the ongoing and regular assessment of the trauma system and be updated as frequently as necessary to meet the changing environment of the trauma system.

When there are challenges to providing the optimal care to trauma patients within the system, the leadership needs to effect change to produce the desired results. Broad system improvements require the ability to identify challenges and the resources and authority to make changes to improve system performance. However, system evaluation is a shared responsibility. Although the leadership will have a key role in the acquisition and analysis of system performance data, the multidisciplinary trauma oversight committee will share the responsibility of interpreting those data from a broad systems perspective to help determine the efficiency and effectiveness of the system in meeting its stated performance goals and benchmarks. All stakeholders have the responsibility of identifying opportunities for system improvement and bringing them to the attention of the multidisciplinary committee or the lead agency. Often, subtle changes in system performance are noticed by clinical care providers long before they become apparent through more formal evaluation processes.

Perhaps the biggest challenge facing the lead agency is to synergize the diversity, complexity, and uniqueness of individuals and organizations into a finely tuned system for prevention of injury and for the provision of quality care for injured patients. To meet this challenge, leaders in all phases of trauma care must demonstrate a strong desire to work together to improve care provided to injured victims.

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OPTIMAL ELEMENTS

I. Trauma system leaders (lead agency, trauma center personnel, and other stakeholders) use a process to establish, maintain, and constantly evaluate and improve a comprehensive trauma system in cooperation with medical, professional, governmental, and other citizen organizations. **(B-202)**

II. Collected data are used to evaluate system performance and to develop public policy. **(B-205)**

III. Trauma system leaders, including a trauma-specific statewide multidisciplinary, multiagency advisory committee, regularly review system performance reports. **(B-206)**

IV. The lead agency informs and educates state, regional, and local, constituencies and policy makers to foster collaboration and cooperation for system enhancement and injury control. **(B-207)**

CURRENT STATUS

The IPEMS Section of the DHSS is the lead agency charged with development, implementation, and maintenance of a statewide comprehensive EMS system, including trauma care. The DHSS has identified the development of a statewide trauma system as one of its 2009 priorities. Both the DHSS Commissioner and Chief Medical Officer were supportive of obtaining an American College of Surgeons (ACS) Trauma Systems Consultation, and both attended. Alaska has not established a clear process for developing, maintaining and continually evaluating a comprehensive trauma system, and this, in part, was the impetus for this consultative visit.

The Alaska Trauma Registry Review Committee was created to review registry data, provide guidance for trauma registry improvement, and review and approve requests for release of registry data. The TSRC role has broadened over the years to include reviewing trauma registry data, making recommendations for trauma system improvement, and reviewing facilities for Level IV trauma center designation. The name has also changed, to become the Trauma Systems Review Committee (TSRC). The TSRC has multidisciplinary membership appointed by the IPEMS Section and approved by the Alaska Medical Board. The chairperson of the Alaska Chapter of the American College of Surgeons Committee on Trauma (ACS-COT) is currently a member of the TSRC.

The TSRC has been attempting to effect change by conducting selected studies from the trauma registry to evaluate trauma care, and then developing care guidelines, such as the head injury management guidelines for rural facilities.

Recommendations from the TSRC that have been transmitted to the lead agency have not always resulted in action or change, and the TSRC is not empowered to make changes in the trauma system. Individuals from the committee are also active in proposing new trauma system improvement legislation.

By statute the ACEMS is charged with advising the Governor and the Commissioner of DHSS with regard to the planning and implementation of a statewide EMS system that by definition includes trauma. From a review of ACEMS minutes, this council has primarily addressed prehospital issues with little focus on issues related to the broader trauma system. The Chair of the Alaska Chapter of the ACS-COT regularly attends meetings of ACEMS, and he has reported trauma system issues and advances to the council. The Alaska COT has been active in proposing trauma system improvements and change.

While the surgeons of the Alaska Native Healthcare System are very active in trauma systems development and performance improvement, other community surgeons in Anchorage are not as actively engaged. The trauma nurse coordinators from the hospitals throughout the state appear to be experienced, knowledgeable, and active in trying to improve the trauma system.

The state does not have a group of multidisciplinary trauma stakeholders; however the large number of participants present at the trauma system consultation (TSC) demonstrates that the state has interested stakeholders. No forum exists for trauma system problem resolution. A state trauma advisory body that serves as a subcommittee of the ACEMS is a recommended strategy for giving stakeholders an opportunity to participate in trauma system development.

RECOMMENDATIONS

- **Form the Alaska Trauma Advisory Committee (ATAC) and task it with providing the Alaska Council on Emergency Medical Services (ACEMS) with recommendations regarding the following functions of the trauma system: trauma system planning, data systems, systemwide performance improvement and patient safety, trauma education (Advanced Trauma Life Support [ATLS], Trauma Nurse Core Curriculum [TNCC], Prehospital Trauma Life Support [PHTLS], etc), trauma center review and designation, injury prevention and control, public policy, and research.**
- Ensure that the Alaska Trauma Advisory Committee (ATAC) has a broad multidisciplinary membership that might include legislative personnel and representation from the Alaska Native Healthcare System, the public sector hospital systems, the Alaska Hospital Association, emergency nurses, prehospital providers, and the media.
- Develop trauma stakeholder discussion groups (e.g., trauma medical directors, trauma coordinators, trauma registrars) to provide direction and

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broad-based, multidisciplinary and multi-committee support for trauma system development.

- Make the existing TSRC a subcommittee of the ATAC, sanctioned by the Alaska Medical Board and narrow its focus to specifically concentrate on issues of system performance and improvement.

Purpose and Rationale

Coalition building is a continuous process of cultivating and maintaining relationships with constituents (interested citizens) in a state or region who agree to collaborate on injury control and trauma system development. Key constituents include health professionals, trauma center administrators, prehospital care providers, health insurers and payers, data experts, consumers and advocates, policy makers, and media representatives. The coalition of key constituents comprises the trauma system's stakeholders. The involvement of these key constituents is important for the following:

- Trauma system plan development
- Regionalization: promoting collaboration rather than competition between trauma centers
- System integration
- State policy development: authorizing legislation and regulations
- Financing initiatives
- Disaster preparedness

The coalition should be effectively organized through the formation of multidisciplinary state and regional advisory groups to coordinate trauma system planning and implementation efforts. Constituents also communicate with elected officials and policy leaders regarding the development and sustainability of the trauma system. Information and education are needed by constituents to be effective partners in policy development for trauma system planning. Regular communication about the status of the trauma system helps these key partners to recognize needs and progress made with trauma system implementation.

One of the most effective ways to educate elected officials and the public is through an organized public information and education effort that may involve a media campaign about the burden of injury in the state and the need for trauma system development. Information and education are important to reduce the incidence of injury in all age groups and to demonstrate the value of an effective trauma system when a serious injury occurs.

OPTIMAL ELEMENT

I. The lead agency informs and educates state, regional, and local constituencies and policy makers to foster collaboration and cooperation for system enhancement and injury control. **(B-207)**

CURRENT STATUS

Alaska does not currently have a coalition of trauma stakeholders who meet or communicate about the trauma system. It was reported that a prior trauma stakeholder group, associated with federal grant funding, had met but was disbanded when federal funding ended. This trauma system consultation was one of the first opportunities for health professionals, acute care facility administrators, state agency representatives, prehospital providers, and data managers to meet and focus on aspects of the trauma system.

The most significant barrier to sustaining a trauma stakeholder group was identified as geography and the high cost associated with travel to a central location. Alternate mechanisms of communication such as an electronic listserv or web-based conferencing have not been investigated. Another barrier is the lack of a state trauma manager with adequate time to facilitate communication among stakeholders interested in trauma care issues.

Developing a trauma system has only recently become a priority goal of the DHSS. It was reported that Alaskans have an expectation that they will be cared for in the event of injury, and they believe the resources of a trauma system are in place. No public education regarding trauma care and the need for a trauma system has yet been initiated. Some education of elected state officials has been initiated, but it may be challenging to make the trauma system a priority without strong public support.

RECOMMENDATIONS

- **Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.**
- Establish a mechanism of communication (e.g., electronic listserv or discussion group) for stakeholders with an interest in trauma system development.
    - Ensure that information about planning meetings is posted and accessible to stakeholders in a timely manner.
- Identify mechanisms for interested individuals to participate in trauma system planning from remote locations (e.g., web-based teleconferencing).

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Lead Agency and Human Resources within the Lead Agency

Purpose and Rationale

Each trauma system (state, regional, local, as defined in state statute) should have a lead agency with a strong program manager who is responsible for leading the trauma system. The lead agency, usually a government agency, should have the authority, responsibility, and resources to lead the planning, development, operations, and evaluation of the trauma system throughout the continuum of care. The lead agency, empowered through legislation, ensures system integrity and provides for program integration with other health care and community-based entities, namely, public health, EMS, disaster preparedness, emergency management, law enforcement, social services, and other community-based organizations.

The lead agency works through a variety of groups to accomplish the goals of trauma system planning, implementation, and evaluation. The ability to bring multidisciplinary, multiagency advisory groups together to accomplish trauma system goals is essential in developing and maintaining the trauma system and is part of providing leadership to evolving and mature systems.

The lead agency's trauma system program manager coordinates trauma system design, the adoption of minimum standards (prehospital and in-hospital), and provides for overall system evaluation through performance indicator assessment and assurance. In addition to a trauma program manager, the lead agency must be sufficiently staffed to actively participate in each phase of development and in maintaining the system through a clearly defined structure for decision making (policies and procedures) and through proactive surveillance and evaluation. *Minimum* staffing usually consists of a trauma system program manager, data entry and analysis personnel, and monitoring and compliance personnel. Additional staff resources include administrative support and a part-time commitment from the public health epidemiology service to provide system evaluation and research support.

Within the leadership and governance structure of the trauma system, there is a role for strong physician leadership. This role is usually fulfilled by a full- or part-time trauma medical director within the lead agency.

OPTIMAL ELEMENTS

I. Comprehensive state statutory authority and administrative rules support trauma system leaders and maintain trauma system infrastructure, planning, oversight, and future development. **(B-201)**

a. The legislative authority (statutes and regulations) plans, develops, implements, manages, and evaluates the trauma system and its component parts, including the identification of the lead agency and the designation of trauma facilities. **(I-201.1)**

b. The lead agency has adopted clearly defined trauma system standards (for example, facility standards, triage and transfer guidelines, and data collection standards) and has sufficient legal authority to ensure and enforce compliance. **(I-201.4)**.

II. Sufficient resources, including financial and infrastructure-related, support system planning, implementation, and maintenance. **(B-204)**

CURRENT STATUS

The role of the IPEMS Section in trauma system development is clearly stated in state statutes; however, better definition of how the agency integrates trauma care into the overall EMS program is needed, such as through the development of a statewide trauma strategic plan (See Trauma System Plan).

The trauma system is currently managed by a trauma system manager (0.2 full-time equivalent [FTE]) and a trauma registrar (1.0 FTE). The trauma registrar is supported by two contracted positions. The trauma registrar also has computer and epidemiology support from the National Institute for Occupational Safety and Health (NIOSH) Field Station staff. The IPEMS Section also has an impressive injury prevention program and staffing. However, the lead agency is not adequately staffed to meet the demands of developing and maintaining a statewide trauma system through trauma program assessment, policy development, and performance improvement activities.

The present job classification for the trauma manager is a Public Health Specialist II position which does not specify any education or experience requirements related to emergency health care. The present job description identifies the additional duties and responsibilities for the state trauma manager to include serving as the state Emergency Medical Services for Children (EMSC) program manager and the manager of grants for the state rural automated external defibrillator program. Additional duties and responsibilities for this position include analyzing the continuing education needs and soliciting

educational sessions for the annual EMS Symposium. It was reported that the EMSC responsibilities have now been shifted to another position. However, the remaining responsibilities would significantly impact the individual's ability to focus on trauma system development.

Staffing is currently insufficient within the lead agency to encourage and support trauma stakeholders in building a statewide inclusive trauma system. A qualified trauma manager is needed to facilitate the development of a statewide trauma system plan. As the position is currently vacant, the timing is optimal to revise the job description and job classification to enable recruitment of an individual who is a health professional (e.g., nurse with a BSN or MSN) with experience in trauma or emergency health care.

Additionally, the trauma system has no designated physician to provide medical oversight. The IPEMS Section has a designated emergency physician serving as the State EMS Medical Director, but this individual has no responsibilities for trauma system medical control and oversight. If a Trauma Medical Director can not be recruited and hired, potentially a Trauma Medical Oversight Subcommittee of the ATAC could be created to fulfill this responsibility and support the State EMS Medical Director.

RECOMMENDATIONS

- **Develop an appropriate position classification and duty statement for a 1.0 full time equivalent (FTE), permanent trauma system manager that specifies education as a health professional, experience in trauma or emergency health care, and the administrative skills and clinical understanding necessary to support trauma system development.**
- Recruit a trauma manager.
- Develop a mechanism for trauma system medical oversight (e.g., hire a Trauma Medical Director, develop a subcommittee of the Alaska Trauma Advisory Committee).
- Ensure that the trauma system has trauma medical direction.

Purpose and Rationale

Each trauma system, as defined in statute, should have a clearly articulated trauma system planning process resulting in a written trauma system plan. The plan should be built on a completed inventory of trauma system resources identifying gaps in services or resources and the location of assets. It should also include an assessment of population demographics, topography, or other access enhancements (location of hospital and prehospital resources) or barriers to access. It is important that the plan identify special populations (for example, pediatric, elderly, in need of burn care, ethnic groups, rural) within the geographic area served and address the needs of those populations within the planning process. A needs assessment (or other method of identifying injury patterns, patient care review/preventable death study) should also be completed for initial trauma system planning and updated periodically as needed to assess system changes over time.

The trauma system plan is developed by the lead trauma agency based on the results of a needs assessment and other data resources available for review. It describes the system design, integrated and inclusive, with adopted standards of care for prehospital and hospital personnel and a process to regularly review the plan over time. The plan is built on input from trauma advisory committees (or stakeholder groups) that assist in analyzing data, identifying resources, and developing system standards of care, including system policies and procedures and overall system design. Ideally, although every stakeholder group may not be satisfied with the plan or system design, the plan, to the extent possible, should be based on consensus of the advisory committees and stakeholder groups. These advisory groups should be able to review the plan before final adoption and approve the plan before it is submitted to the lead agency with authority for plan approval.

The trauma system plan is used to guide system development, implementation, and management. Each component of the trauma system (for example, prehospital, hospital, communications, and transportation) is clearly defined and an established service level identified (baseline) with goals for enhancement (benchmark). Within the plan are incorporated other planning documents used to ensure integration of similar services and build collaboration and cooperation with those services. Service plans for emergency preparedness, EMS, injury prevention and control, public health, social services, and mental health are examples of services for which the trauma system plan should include an interface between agencies and services.

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OPTIMAL ELEMENT

I. The state lead agency has a comprehensive written trauma system plan based on national guidelines. The plan integrates the trauma system with EMS, public health, emergency preparedness, and incident management. The written trauma system plan is developed in collaboration with community partners and stakeholders. **(B-203)**

a. The trauma system plan clearly describes the system design (including the components necessary to have an integrated and inclusive trauma system) and is used to guide system implementation and management. For example, the plan includes references to regulatory standards and documents and includes methods of data collection and analysis. **(I-203.4)**

CURRENT STATUS

In 1993, Alaska secured funding from HRSA to develop a statewide trauma system plan. A task force was created to draft a trauma plan within the existing *Alaska EMS Goals* document. The 1992 Health Resources and Services Administration (HRSA) *Model Trauma Care System Plan* draft was utilized as the basis for the development of this trauma system plan. The grant funding also enabled the state to develop two additional documents: Trauma Triage, Transport and Transfer Guidelines and a Guide on Rehabilitation Services. No mention was made of work performed during federal trauma grant funding from 2002 to 2004.

The *Alaska EMS Goals* document is a guide for the development of EMS and trauma systems by categorizing communities throughout the state by remoteness and resources that should be available. The document identifies specific challenges that Alaska communities face such as access and availability of care, limited road access, availability of training, and recruitment and retention of EMS volunteers. The classifications of communities can also be used to identify levels of care and capabilities to manage the trauma patient.

The *Alaska EMS Goals* document provides a brief overview of EMS system needs in Alaska and lists the state's priorities for grant funding. The integration and consideration of special organizations such as rural health networks, critical incident stress management teams, community injury prevention organizations and local emergency preparedness councils are reflected in the document, along with topics such as seasonal impacts, special populations, hazardous materials, injury prevention, air medical transportation, communications, trauma care, and quality assurance.

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An assessment tool called the EMS Community Checklist is available to communities in order to determine their current status in meeting EMS and Trauma system goals within a specified community classification. It is unclear if the data from the assessment tools have been collated and utilized for state system planning.

The community classification in the goals document references classification levels from rural to urban using a 1-5 numbering system. This numbering system is inconsistent with the ACS standards for level of trauma center verification which are in reverse order by facility capabilities.

The TSRC has adopted the *ACS Resources for Optimal Care of the Injured Patient for Acute Care Facilities*, as the standard for trauma center certification (the term used by Alaska for designation). The *Alaska EMS Goals* document clearly specifies the adoption of these standards within each community categorization. The document also promotes the utilization of the various triage and treatment guidelines for the trauma patient. In addition, the guide specifies the importance of establishing an inclusive trauma system and the utilization of trauma registry data to assess the effectiveness of the system.

The *Alaska EMS Goals* document was last updated in 2003, making it consistent with planning and evaluation standards of the time. The guide does not incorporate the 2006 *HRSA Model Trauma System Planning and Evaluation* document that promotes a public health approach to trauma system development.

Overall, the *Alaska EMS Goals* document provides the necessary and comprehensive guidelines for the development and enhancement of the components of a state trauma system. A state assessment to determine at what level the communities have met the goals, has not been accomplished to determine the current needs or trauma resources and assets available.

The IPEMS Section has established five reasonable goals for the trauma system with the limited state resources that are available. Though the goals appear to be achievable, it is unclear how the needs for these goals were determined and how they will be measured and accomplished.

The state has seven EMS regions and EMS Councils. Specific areas of the *Alaska EMS Goals* document recognize the importance of these regional and local assets. However, utilization of these resources for trauma system assessment and strategic planning has not been clearly demonstrated.

RECOMMENDATIONS

- **Develop a comprehensive trauma system strategic plan based on the Health Resources and Services Administration (HRSA) *Model Trauma System Planning and Evaluation* document.**
- Consider revising the *Alaska EMS Goals* document by reversing the community classification numbering system to be consistent with the American College of Surgeons Committee on Trauma (ACS-COT) trauma center verification levels (e.g., urban is 1 and isolated community is 5).
- Ensure that the comprehensive trauma system plan is integrated and made consistent with the 2003 *Alaska EMS Goals* document, the state health plan, the injury prevention plan, the rural health plan and disaster preparedness plans.

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System Integration

Purpose and Rationale

Trauma system integration is essential for the daily care of injured people and includes such services as mental health, social services, child protective services, and public safety. The trauma system should use the public health approach to injury prevention to contribute to reducing the entire burden of injury in a state or region. This approach enables the trauma system to address primary, secondary, and tertiary injury prevention through closer integration with community health programs and mobilizing community partnerships. The partnerships also include mental health, social services, child protection, and public safety services. Collaboration with the public health community also provides access to health data that can be used for system assessment, development of public policy, and informing and educating the community.

Integration with EMS is essential because this system is linked with the emergency response and communication infrastructure and transports severely injured patients to trauma centers. Triage protocols should exist for treatment and patient delivery decisions. Regulations and procedures should exist for online and off-line medical direction. In the event of a disaster affecting local trauma centers, EMS would have a major role in evacuating patients from trauma centers to safety or to other facilities or to make beds available for patients in greater need.

The trauma system is a significant state and regional resource for the response to mass casualty incidents (MCIs). The trauma system and its trauma centers are essential for the rapid mobilization of resources during MCIs. Preplanning and integration of the trauma system with related systems (public health, EMS, and emergency preparedness) are critical for rapid mobilization when a disaster or MCI occurs. The extensive impact of disasters and MCIs on the functioning of trauma centers and the EMS and public health systems within the affected region or state must be considered, and joint planning for optimal use of all resources must occur to enable a coordinated response to an MCI. Trauma system leaders need to be actively involved in emergency management planning to ensure that trauma centers are integrated into the local, regional, and state disaster response plans.

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OPTIMAL ELEMENTS

I. The state lead agency has a comprehensive written trauma system plan based on national guidelines. The plan integrates the trauma system with EMS, public health, emergency preparedness, and incident management. The written trauma system plan is developed in collaboration with community partners and stakeholders. **(B-203)**

a. The trauma system plan has established clearly defined methods of integrating the trauma system plan with the EMS, emergency, and public health preparedness plans. **(I-203.7)**

II. The trauma, public health, and emergency preparedness systems are closely linked. **(B-208)**

CURRENT STATUS

The two groups involved with EMS and trauma are the ACEMS and the TSRC. Membership on the ACEMS is dictated in statute and consists of two physicians with experience in either emergency medicine or trauma, emergency nurses, prehospital providers, an EMS administrator, a hospital administrator, and consumers. Currently the only formal trauma involvement is the Chair of the ACS-COT who serves in a liaison capacity. TSRC membership includes a trauma registrar, epidemiologist, surgeon, emergency physician, hospital administrator, hospital trauma director, all Anchorage trauma nurse coordinators, two prehospital EMS personnel, a pediatrician, and six other miscellaneous members.

Little apparent integration occurs between other trauma stakeholders. Even with EMS representation on the TSRC and a trauma liaison on ACEMS, an EMS participant reported continuing issues regarding communications with the hospitals providing trauma care in Anchorage. Issues were said to involve diversion status and availability of specialty care providers, stemming from the differing level of commitment to trauma care by the facilities.

No integration was reported between the state trauma system and other related services, such as public safety or law enforcement agencies, mental health services, and social services. While psychiatric and social services consultations are available within the verified trauma care center and remaining two hospitals providing trauma care, there was no evidence of ongoing discussions regarding ways to improve interactions or for planning better system integration in the future.

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Integration with the Office of Rural Health to support trauma education across the state was described. Integration with numerous other agencies was demonstrated by the transfer of funds for specific program support (see the Financing Section).

The membership of the future ATAC should include representation from fire, law enforcement, social services, injury prevention, mental health, and protective services, in addition to health professionals involved in trauma care. Having a consumer of trauma care or their family member would also bring the public perspective to issues. Legislative representatives would bring much needed insight into legal methods of change. Agencies that could also be included as formal or liaison members include the Office of Rural Health, the Alaska Native Healthcare System, and disaster preparedness agencies. The broader the representation working on the trauma system, the broader the attack base for resolution.

RECOMMENDATIONS

- **Ensure that the Injury Prevention and Emergency Medical Services (IPEMS) Section is engaged in planning with disaster preparedness, emergency management, and public health functions for integration of the trauma system.**

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Financing

Purpose and Rationale

Trauma systems need sufficient funding to plan, implement, and evaluate a statewide or regional system of care. All components of the trauma system need funding, including prehospital, acute care facilities, rehabilitation, and prevention programs. Lead agency trauma system management requires adequate funding for daily operations and other important activities such as advisory committee meetings, development of regulations, data collection, performance improvement, and public awareness and education. Adequate funding to support the operation of trauma centers and their state of readiness to care for seriously injured patients within the state or region is essential. The financial health of the trauma system is essential for ensuring its integrity and its improvement over time.

The trauma system lead agency needs a process for assessing its own financial health, as well as that of the trauma system. A trauma system budget should be prepared, and costs should be reported by each component, if possible. Routine collection of financial data from all participating health care facilities is encouraged to fully identify the costs and revenues of the trauma system, including costs and revenues pertaining to patient care, administrative, and trauma center operations. When possible, the lead agency financial planning should integrate with the budgets and costs of the EMS system and disaster, rehabilitation, and prevention programs to enable development of a comprehensive financial health report.

Trauma system financial planning should be related to the trauma plan outcome measures (for example, patient outcome measures such as mortality rates, length of stay, and quality-of-life indicators). Such information may demonstrate the value added by having a trauma system in place.

OPTIMAL ELEMENTS

I. Sufficient resources, including financial and infrastructure-related, support system planning, implementation, and maintenance. **(B-204)**

a. Financial resources exist that support the planning, implementation, and ongoing management of the administrative and clinical care components of the trauma system. **(I 204.2)**

b. Designated funding for trauma system infrastructure support (lead agency) is legislatively appropriated. **(I-204.3)**

c. Operational budgets (system administration and operations, facilities administration and operations, and EMS administration and operations) are aligned with the trauma system plan and priorities. **(I-204.4)**

II. The financial aspects of the trauma systems are integrated into the overall performance improvement system to ensure ongoing fine tuning and cost-effectiveness. **(B-309)**

a. Collection and reimbursement data are submitted by each agency or institution on at least an annual basis. Common definitions exist for collection and reimbursement data and are submitted by each agency. **(I-309.2)**

CURRENT STATUS

Although Alaska has no designated state funding for the development and maintenance of a statewide trauma system, the IPEMS Section has been creative in leveraging funding to support various aspects of the trauma system. The IPEMS Section receives significant funding from several sources (primarily federal grants and other state allocations) that is being used to support the state's efforts to maintain the trauma system. However, many of these funding sources will only provide short term assistance. The current funding sources include the following:

- Community Health Grants to support Community Health Aide Training and medical supervision of the community health aides throughout the state based on a formula defined in AS 18.28.010.
- Rural Health Flexibility Funding is used to provide trauma training to Critical Access Hospitals and emergency services.
- The state provides capital project funding to support the communication needs of emergency responders for the maintenance and replacement of communications equipment.
- HRSA's Emergency Medical Services for Children program funding pays a portion of the salary support for the individual filling the part-time trauma manager position.
- Centers for Disease Control (CDC) Disaster Preparedness funds were used to pay for the ACS-COT trauma system consultation visit.
- NIOSH provides funding for one FTE and two contractors to support the trauma registry.

- Federal Emergency Preparedness Grants are pass-through funds used to develop and implement fire and burn injury prevention strategies. Recipients include the Municipality of Anchorage, the Alaska Native Tribal Health Consortium, and the Alaska State Hospital and Nursing Home Association.
- The state also provides funding to local agencies from the Code Blue Project Funds to provide EMS equipment and ambulances for local communities. With the assistance of the Department of Agriculture (USDA), the Rasmusson Foundation, and the Denali Commission, approximately $14 million was received to provide new EMS equipment in 2008. A local match is required for the foundation funding and is key to the success of the project.
- The state also provides resources to regional EMS agencies to develop a comprehensive EMS system as outlined in the Alaska EMS Goals document.

Currently, the state does not employ either the State EMS Medical Director or a Trauma Medical Director. However, they contract with an MD, on a part-time basis to, serve as the State EMS Medical Director. State funding to support EMS and trauma system medical direction is critical to the development and maintenance of a statewide inclusive trauma system.

The state does not charge fees for the designation of trauma center site visits. However, charging a fee for trauma center certification/designation would likely go directly to the state general fund due to the state's constitutional requirement prohibiting dedicated funds for program support. In addition, given the fact that trauma center certification/designation is currently voluntary, charging fees may be an impediment to implementing the state's inclusive trauma system.

Levels I-III trauma centers are verified by the ACS after which the state certifies/designates them as trauma centers at these levels. Level IV certifications/designations are conducted by the IPEMS based on meeting the criteria of the ACS Committee on Trauma. No state funding is available to support trauma center readiness or uncompensated care.

The trauma registry includes a mechanism to collect financial data regarding trauma patients, and all the hospitals participate in the registry. The data are not submitted from all hospitals in a timely manner, and the information is not currently being used for financial planning or evaluation of the statewide system.

RECOMMENDATIONS

- **Provide state funding to hire a fulltime trauma system manager.**
- Provide state funding to ensure sufficient medical direction for the trauma and EMS programs.
- Determine a method of providing financial support for hospitals certified/designated by the state as trauma centers to assist with uncompensated care and the cost of readiness.
- Encourage the use of FLEX grant funding for the preparation of eligible facilities to become certified/designated as Level IV trauma centers.

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Trauma System Assurance

Prevention and Outreach

Purpose and Rationale

Trauma systems must develop prevention strategies that help control injury as part of an integrated, coordinated, and inclusive trauma system. The lead agency and providers throughout the system should be working with business organizations, community groups, and the public to enact prevention programs and prevention strategies that are based on epidemiologic data gleaned from the system.

Efforts at prevention must be targeted for the intended audience, well defined, and structured, so that the impact of prevention efforts is systemwide. The implementation of injury control and prevention requires the same priority as other aspects of the trauma system, including adequate staffing, partnering with the community, and taking advantage of outreach opportunities. Many systems focus information, education, and prevention efforts directly to the general public (for example, restraint use, driving while intoxicated). However, a portion of these efforts should be directed toward emergency medical services (EMS) and trauma care personnel safety (for example, securing the scene, infection control). Collaboration with public service agencies, such as the department of health is essential to successful prevention program implementation. Such partnerships can serve to synergize and increase the efficiency of individual efforts. Alliances with multiple agencies within the system, hospitals, and professional associations, working toward the formation of an injury control network, are beneficial.

Activities that are essential to the development and implementation of injury control and prevention programs include the following:

- A needs assessment focusing on the public information needed for media relations, public officials, general public, and third-party payers, thus ensuring a better understanding of injury control and prevention
- A needs assessment for the general medical community, including physicians, nurses, prehospital care providers, and others concerning trauma system and injury control information
- Preparation of annual reports on the status of injury prevention and trauma care in the system
- Trauma system databases that are available and usable for routine public health surveillance

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OPTIMAL ELEMENTS

I. The lead agency informs and educates state, regional, and local constituencies and policy makers to foster collaboration and cooperation for system enhancement and injury control. **(B-207)**

a. The trauma system leaders (lead agency, advisory committees, and others) inform and educate constituencies and policy makers through community development activities, targeted media messaging, and active collaborations aimed at injury prevention and trauma system development. **(I-207.2)**

II. The jurisdictional lead agency, in cooperation with other agencies and organizations, uses analytic tools to monitor the performance of population based prevention and trauma care services. **(B-304)**

a. The lead agency, along with partner organizations, prepares annual reports on the status of injury prevention and trauma care in state, regional, or local areas. **(I-304.1)**

III. The lead agency ensures that the trauma system demonstrates prevention and medical outreach activities within its defined service area. **(B-306)**

a. The trauma system is active within its jurisdiction in the evaluation of community based activities and injury prevention and response programs. **(I-306.2)**

b. The effect or impact of outreach programs (medical and community training and support and prevention activities) is evaluated as part of a system performance improvement process. **(I-306.3)**

CURRENT STATUS

The state is to be commended for recognizing the significant problem and impact of injury on Alaskans. The IPEMS Section within DHSS is the primary focus area for injury epidemiology and injury prevention in the state. Numerous programs and sources of funding from other agencies and from grant funding (e.g., NIOSH, Maternal and Child Health, Department of Highway Safety, Medicaid, and CDC) support injury program efforts. Documents provided to the consultant team identified an injury program manager and 8 additional staff members in IPEMS.

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The state has numerous groups with which it works successfully to implement injury prevention programs. The Alaska Native Tribal Health Consortium Injury Prevention Program works to develop and disseminate culturally appropriate injury prevention programs. Acute care facilities were reported to be implementing brief alcohol screening and intervention programs.
The Alaska Injury Prevention Center is an example of a coalition formed to promote injury prevention outreach by the Anchorage acute care facilities. This center has progressed beyond its original Anchorage outreach focus to become a nonprofit organization that can develop, implement, and evaluate injury program interventions across the entire state.

The state has been an acknowledged leader in the development of injury prevention programs, such as the Kids Don't Float program that has reduced drowning deaths among children. This program is now sustained through partnerships with the Coast Guard and SafeKids. The state often serves as a facilitator for injury program implementation through its many partnerships, such as Injury Prevention in a Bag with EMTs in small communities. Information about 16 injury mechanisms, their prevention strategies, and resources for injury prevention programs are available on the IPEMS website.

Several state agencies collaborate with IPEMS in conducting injury surveillance and in implementing injury prevention strategies, such as the Alaska Marine Safety and Education Association, Alaska Highway Safety Office, Alaska Division of Fire and Life Safety.

The EMS Goals document describes the importance of implementing injury prevention programs in all communities across the state. Injury prevention education is targeted to prehospital providers during the annual EMS conference, and continuing medical education units are provided. Prehospital providers have been engaged in implementing the Injury in a Bag program as well as other injury prevention programs.

The focus of the state and its extensive programming for primary injury prevention is exemplary. Injury prevention is an important component of the trauma system. An opportunity now exists to expand the primary injury prevention focus to the broader concept of injury control so that this emphasis can be integrated with the future state trauma system.

RECOMMENDATIONS

- Ensure representation of an injury prevention representative on the Alaska Trauma Advisory Council (ATAC).

- Incorporate the concept of "injury control" into the prevention activities to raise awareness of the need for a comprehensive and integrated trauma system.

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Purpose and Rationale

The trauma system includes, and/or interacts with, many different agencies, institutions, and systems. The EMS system is one of the most important of these relationships. EMS is often the critical link between the injury-producing event and definitive care at a trauma center. Even though at its inception the EMS system was a very broad system concept, over time, EMS has come to be recognized as the prehospital care component of the larger emergency health care system. It is a complex system that not only transports patients, but also includes public access, communications, personnel, triage, data collection, and quality improvement activities.

The EMS system medical director must have statutory authority to develop protocols, oversee practice, and establish a means of ongoing quality assessment to ensure the optimal provision of prehospital care. If not the same individual, the EMS system medical director must work closely with the trauma system medical director to ensure that protocols and goals are mutually aligned. The EMS system medical director must also have ongoing interaction with EMS agency medical directors at local levels, as well as the state EMS for Children program, to ensure that there is understanding of and compliance with trauma triage and destination protocols.

Ideally, a system should have some means of ensuring whether resources meet the needs of the population. To achieve this end, a resource and needs assessment evaluating the availability and geographic distribution of EMS personnel and physical resources is important to ensure a rapid and appropriate response. This assessment includes a detailed description of the distribution of ground ambulance and air medical locations across the region. Resource allocations must be assessed on a periodic basis as needs dictate a redistribution of resources. In communities with full-time paid EMS agencies, ambulances should be positioned according to predictable geographic or temporal demands to optimize response efficiencies. Such positioning schemes require strong prehospital data collection systems that can track the location of occurrences over time. Periodic assessment of dispatch and transport times will also provide insight into whether resources are consistent with needs.

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Each region should have objective criteria dictating the level of response (advanced life support [ALS], basic life support [BLS]), the mode of transport, and the disposition of the patient based on the location of the incident and the severity of injury. A mechanism for case-based review of trauma patients that involves prehospital and hospital providers allows bidirectional information sharing and continuing education, ensuring that expectations are met at both ends. Ongoing review of triage and treatment decisions allows for continuing quality improvement of the triage and prehospital care protocols. A more detailed discussion of in-field (primary) triage criteria is provided in the section titled: System Coordination and Patient Flow.

Human Resources

Periodic workforce assessments of EMS should be conducted to ensure adequate numbers and distribution of personnel. EMS, not unlike other health care professions, experiences shortages and misdistribution of personnel. Some means of addressing recruitment, retention, and engagement of qualified personnel should be a priority. It is critical that trauma system leaders work to ensure that prehospital care providers at all levels attain and maintain competence in trauma care. Maintenance of competence should be ensured by requiring standards for credentialing and certification and specifying continuing educational requirements for all prehospital personnel involved in trauma care. The core curricula for First Responder, Emergency Medical Technician (EMT) Basic, EMT-Intermediate, EMT Paramedic, and other levels of prehospital personnel have an essential orientation to trauma care for all ages. However, trauma care knowledge and skills need to be continuously updated, refined, and expanded through targeted trauma care training such as Prehospital Trauma Life Support®, Basic Trauma Life Support®, and age-specific courses. Mechanisms for the periodic assessment of competence, educational needs, and education availability within the system should be incorporated into the trauma system plan.

Systems of excellence also encourage EMS providers to go beyond meeting state standards for agency licensure and to seek national accreditation. National accreditation standards exist for ground-based and air medical agencies, as well as for EMS educational programs. In some states, agency licensure requirements are waived or substantially simplified if the EMS agency maintains national accreditation.

EMS is the only component of the emergency health care and trauma system that depends on a large cadre of volunteers. In some states, substantially more than half of all EMS agencies are staffed by volunteers. These agencies typically serve rural areas and are essential to the provision of immediate care to trauma patients, in addition to provision of efficient transportation to the appropriate facility. In some smaller facilities, EMS personnel also become part of the emergency resuscitation team, augmenting hospital personnel. The trauma care system program should reach out to these volunteer agencies to help them achieve their vital role in the outcome of care of trauma patients. However, it

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must be noted that there is a delicate balance between expecting quality performance in these agencies and placing unrealistic demands on their response capacity. In many cases, it is better to ensure that there is an optimal BLS response available at all times rather than a sporadic or less timely response involving ALS personnel. Support to volunteer EMS systems may be in the form of quality improvement activities, training, clinical opportunities, and support to the system medical director.

Owing to the multidisciplinary nature of trauma system response to injury, conferences that include all levels of providers (for example, prehospital personnel, nurses, and physicians) need to occur regularly with each level of personnel respected for its role in the care and outcome of trauma patients. Communication with and respect for prehospital providers is particularly important, especially in rural areas where exposure to major trauma patients might be relatively rare.

Integration of EMS Within the Trauma System

In addition to its critical role in the prehospital treatment and transportation of injured patients, EMS must also be engaged in assessment and integration functions that include the trauma system and also public health and other public safety agencies. EMS agencies should have a critical role in ensuring that communication systems are available and have sufficient redundancy so that trauma system stakeholders will be able to assess and act to limit death and disability at the single patient level and at the population level in the case of mass casualty incidents (MCIs). Enhanced 911 services and a central communication system for the EMS/trauma system to ensure field-to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications among all system participants are important for integrating a system's response. Wireless communications capabilities, including automatic crash notification, hold great promise for quickly identifying trauma-producing events, thereby reducing delays in discovery and decreasing prehospital response intervals.

Further integration might be accomplished through the use of EMS data to help define high-risk geographic and demographic characteristics of injuries within a response area. EMS should assist with the identification of injury prevention program needs and in the delivery of prevention messages. EMS also serves a critical role in the development of all-hazards response plans and in the implementation of those plans during a crisis. This integration should be provided by the state and regional trauma plan and overseen by the lead agency. EMS should participate through its leadership in all aspects of trauma system design, evaluation, and operation, including policy development, public education, and strategic planning.

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OPTIMAL ELEMENTS

I. The trauma system is supported by an EMS system that includes communications, medical oversight, prehospital triage, and transportation; the trauma system, EMS system, and public health agency are well integrated. **(B-302)**

a. There is well-defined trauma system medical oversight integrating the specialty needs of the trauma system with the medical oversight for the overall EMS system. **(I-302.1)**

b. There is a clearly defined, cooperative, and ongoing relationship between the trauma specialty physician leaders (for example, trauma medical director within each trauma center) and the EMS system medical director. **(I-302.2)**

c. There is clear-cut legal authority and responsibility for the EMS system medical director, including the authority to adopt protocols, to implement a performance improvement system, to restrict the practice of prehospital care providers, and to generally ensure medical appropriateness of the EMS system. **(I-302.3)**

d. The trauma system medical director is actively involved with the development, implementation, and ongoing evaluation of system dispatch protocols to ensure they are congruent with the trauma system design. These protocols include, but are not limited to, which resources to dispatch, for example, ALS versus BLS, air ground coordination, early notification of the trauma care facility, pre-arrival instructions, and other procedures necessary to ensure that resources dispatched are consistent with the needs of injured patients. **(I-302.4)**

e. The retrospective medical oversight of the EMS system for trauma triage, communications, treatment, and transport is closely coordinated with the established performance improvement processes of the trauma system. **(I-302.5)**

f. There is a universal access number for citizens to access the EMS/trauma system, with dispatch of appropriate medical resources. There is a central communication system for the EMS/trauma system to ensure field- to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications among all system participants. **(I-302.7)**

g. There are sufficient and well-coordinated transportation resources to ensure that EMS providers arrive at the scene promptly and expeditiously transport the patient to the correct hospital by the correct transportation mode. **(I-302.8)**

II. The lead trauma authority ensures a competent workforce. **(B-310)**

a. In cooperation with the prehospital certification and licensure authority, set guidelines for prehospital personnel for initial and ongoing trauma training, including trauma-specific courses and courses that are readily available throughout the state. **(I-310.1)**

b. In cooperation with the prehospital certification and licensure authority, ensure that prehospital personnel who routinely provide care to trauma patients have a current trauma training certificate, for example, Prehospital Trauma Life Support or Basic Trauma Life Support and others, or that trauma training needs are driven by the performance improvement process. **(I-310.2)**

c. Conduct at least 1 multidisciplinary trauma conference annually that encourages system and team approaches to trauma care. **(I-310.9)**

III. The lead agency acts to protect the public welfare by enforcing various laws, rules, and regulations as they pertain to the trauma system. **(B-311)**

a. Incentives are provided to individual agencies and institutions to seek state or nationally recognized accreditation in areas that will contribute to overall improvement across the trauma system, for example, Commission on Accreditation of Ambulance Services for prehospital agencies, Council on Allied Health Education Accreditation for training programs, and American College of Surgeons (ACS) verification for trauma facilities. **(I-311.6)**

CURRENT STATUS

The lead agency for Alaska EMS is the IPEMS Section under the authority of the DHSS. The EMS system is comprised of seven EMS regions that span a huge geographic area with extreme terrain and weather variations. These regions receive varying degrees of funding from the state. The state has approximately 3,300 Emergency Medical Technicians (EMTs), 175 Mobile Intensive Care Paramedics (MICPs) and unknown numbers of first responders.

When injured or ill patients require treatment not available locally, they may be transported by ground (ambulance, privately owned vehicle, snow machine, dog sled), by water (U.S. Coast Guard, fishing boat) or air (rotor or fixed wing, medical private or commercial). EMS ground services in Alaska include five BLS, 39 ALS with occasional BLS, and 33 ALS services. Air medical services include eight Medevac and 10 Critical Care Air Ambulance services with one service also certified as a Perinatal Specialty Air Medical Transport Service. Each of the regional hub cities has at least one air medical service. There are approximately

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180 certified and uncertified first responder services across the state, however not all communities are covered.

EMT levels are as follows:

- EMT I (EMT Basic, 1994 U.S. Department of Transportation (DOT) National Standard Curriculum (NSC) with medication module but not manual defibrillation or advanced airway module);

- EMT II (EMT I plus 50 additional hours of training; exceeds EMT Intermediate 85, can administer intravenous fluids (5% dextrose in water, crystalloid volume-replacement solutions) and selected medications (50% dextrose in water and naloxone hydrochloride);

- EMT III (EMT I plus EMT II plus 50 hours of additional training; can administer EMT II medications plus lidocaine, atropine, morphine, and epinephrine 1:1000/1:10,000; apply electrodes, monitor cardiac activity and provide countershock for ventricular fibrillation and pulseless ventricular tachycardia).

- Defibrillator Technician training is available for EMT I and II levels that allows them to perform manual defibrillation.

EMT levels II and III function under direct or indirect supervision of a physician, and if they do not have a medical director they must function at the EMT I level. EMT I, II and III personnel are certified by the IPEMS Section. The local medical director may expand the scope of an EMT I, II or III after approval by the IPEMS Section and submission of a training and evaluation plan. The local medical director is responsible for the expanded care provided.

The Mobile Intensive Care Paramedic (MICP) is licensed by the Alaska State Medical Board which requires completion of training that follows the U.S. DOT NSC for paramedics, successful completion of the National Registry paramedic examination, and obtaining a physician sponsor approved by the Alaska State Medical Board.

First Responders are not certified by the state, including the Alaska Emergency Trauma Technician (ETT). The ETT is trained via a 44 hour course developed by the Public Safety Academy to cover emergency trauma care, medical communication, and Medevac preparations.

Most isolated communities have Community Health Aids (CHA) who are trained and function as the primary care provider either under the distant supervision of a physician or the direct supervision of a nurse practitioner or physician assistant located in the community. CHA's are First Responder or ETT trained with many at the EMT I level or higher. Due to the limited access to roads and a transportation system that depends on air or water and good weather, the injured

patient may be in the care of the CHA for up to 72 hours. It is essential that these communities have optimal communications capabilities for access to physicians and regional medical facilities. Due to the high turnover rate of the CHAs, the state will need to continue to make training programs available so this level of care can continue to be provided in these isolated communities.

The state contracts with an emergency physician on an as needed basis to perform selected duties of the state EMS medical director, and a federally-funded Alaska Native Health Service Medical Director oversees the Indian Health Service/Public Health Service medical directors. Regional and local physician medical directors are largely volunteers. A regional or local medical director for state certified EMT II or III personnel, training programs or courses (EMT II, EMT III or manual defibrillator technician training) or for a service (basic life support (BLS), advanced life support (ALS) or air medical) must be an Alaska licensed physician or a physician working in the regular medical service of the U.S. Armed Services or the U.S. Public Health Service. The medical director must participate in an orientation provided by the IPEMS Section within one year after accepting the responsibility of medical direction. Medical directors of an ALS ground service or air medical service have additional requirements.

Medical director responsibilities for the certified EMT include the following:

- supervise the medical care,
- establish and annually review treatment protocols,
- approve advanced life support standing orders for each state-certified EMT,
- provide quarterly critiques of patient care,
- schedule quarterly on-site supervision, and
- approve a program of continuing medical education for each state-certified EMT supervised.

The licensed MICP functions under a physician sponsor as noted above. While the responsibilities of the medical director of an MICP service are defined, the responsibility of the physician sponsor for the individual MICP is not. The IPEMS Section suggests that the MICP physician sponsor should follow the guidelines outlined for medical directors of certified EMTs. Local and regional EMS medical directors are provided liability coverage for their EMS duties, but their time is not compensated by the state.

Resources for regional and local EMS medical directors include an Alaska Medical Director's Handbook, a physician track during the annual State EMS Symposium, and an EMS Medical Directors' meeting during the symposium, both facilitated by the state EMS medical director.

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Online medical direction for EMS providers in rural and remote locations is provided by the hospital or clinic in that region via phone (some locations have limited telemedicine capability). Often the communications system is solely dependent on satellite access. The regional facility will decide on patient disposition and help arrange transport to the most appropriate health care facility. Patient transport may involve multiple transfers requiring various modes of travel.

Alaska's 27 largest communities have Enhanced 911 services. Wireless E-911 is available in Anchorage and Juneau with limited availability in Fairbanks and Kenai. The service is Phase II compliant (Phase II rules require wireless carriers to begin providing more precise Automatic Location Identification). Alaska has uniform minimum standards for training and certification of Emergency Medical Dispatchers.

RECOMMENDATIONS

- **Develop a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (i.e. load capacity, instrument rating, landing requirements, etc); and to monitor the availability and location of air resources.**
- Continue to support the Emergency Trauma Technician training and maximize course availability.
- Develop a program of prehospital continuing education for trauma that includes special populations such as geriatrics and pediatrics.
- Develop a medical director's listserv as a method to disseminate information in a timely manner and encourage interaction among medical directors.
- Continue to develop a National EMS Information System (NEMSIS) - compliant electronic EMS database to support evaluation of the EMS system and as a quality improvement tool for patient care.

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Purpose and Rationale

Inclusive trauma systems are the systems that include all acute health care facilities, to the extent that their resources and capabilities allow and in which the patient's needs are matched to hospital resources and capabilities. Thus, as the core of a regional trauma system, acute care facilities operating within an inclusive trauma system provide definitive care to the entire spectrum of patients with traumatic injuries. Acute care facilities must be well integrated into the continuum of care, including prevention and rehabilitation, and operate as part of a network of trauma-receiving hospitals within the public health framework. All acute care facilities should participate in the essential activities of a trauma system, including performance improvement, data submission to state or regional registries, representation on regional trauma advisory committees, and mutual operational agreements with other regional hospitals to address interfacility transfer, educational support, and outreach. The roles of all definitive care facilities, including specialty hospitals (for example, pediatric, burn, severe traumatic brain injury [TBI], spinal cord injury [SCI]) within the system should be clearly outlined in the regional trauma plan and monitored by the lead agency. Facilities providing the highest level of trauma care are expected to provide leadership in education, outreach, patient care, and research and to participate in the design, development, evaluation, and operation of the regional trauma system.

In an inclusive system, patients should be triaged to the appropriate facility based on their needs and facility resources. Patients with the least severe injuries might be cared for at appropriately designated facilities within their community, whereas the most severe should be triaged to a level I or II trauma center. In rural and frontier systems, smaller facilities must be ready to resuscitate and initiate treatment of the major injuries and have a system in place that will allow for the fastest, safest transfer to a higher level of care.

Trauma receiving facilities providing definitive care to patients with other than minor injuries must be specifically designated by the state or regional lead agency and equipped and qualified to do so at a level commensurate with injury severity. To assess and ensure that injury type and severity are matched to the qualifications of the facilities and personnel providing definitive care, the lead agency should have a process in place that reviews and verifies the qualifications of a particular facility according to a specific set of resource and quality standards. This criteria-based process for review and verification should be consistent with national standards and be conducted on a periodic cycle as determined by the lead agency. When centers do not meet set standards, there should be a process for suspension, probation, revocation, or dedesignation.

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Designation by the lead agency should be restricted to facilities meeting criteria or statewide resource and quality standards and based on patient care needs of the regional trauma system. There should be a well-defined regulatory relationship between the lead agency and designated trauma facilities in the form of a contract, guidelines, or memorandum of understanding. This legally binding document should define the relationships, roles, and responsibilities between the lead agency and the medical leadership from each designated trauma facility. The number of trauma centers by level of designation and location of acute care facilities must be periodically assessed by the lead agency with respect to patient care needs and timely access to definitive trauma care. There should be a process in place for augmenting and restricting, if necessary, the number and/or level of acute care facilities based on these periodic assessments. The trauma system plan should address means for improving acute care facility participation in the trauma system, particularly in systems in which there has been difficulty addressing needs.

Human Resources

The ability to deliver high-quality trauma care is highly dependent on the availability of skilled human resources. Therefore, it is critical to assess the availability and educational needs of providers on a periodic basis. Because availability, particularly of subspecialty resources, is often limited, some means of addressing recruitment, retention, and engagement of qualified personnel should be a priority. At this time, there are no fellowship trained trauma surgeons in Alaska. Periodic workforce assessments should be conducted. Maintenance of competence should be ensured by requiring standards for credentialing and certification and specifying continuing educational requirements for physicians and nurses providing care to trauma patients. Mechanisms for the periodic assessment of ancillary and subspecialty competence, educational needs, and availability within the system for all designated facilities should be incorporated into the trauma system plan. The lead trauma centers in rural areas will need to consider teleconferencing and telemedicine to assist smaller facilities in providing education on regionally identified needs. In addition, lead trauma centers within the region should assist in meeting educational needs while fostering a team approach to care through annual educational multidisciplinary trauma conferences. These activities will do much to foster a sense of teamwork and a functionally inclusive system.

Integration of Designated Trauma Facilities Within the Trauma System

Designated trauma facilities must be well integrated into all other facets of an organized system of trauma care, including public health systems and injury surveillance, prevention, EMS and prehospital care, disaster preparedness, rehabilitation, and system performance improvement. This integration should be provided by the state and/or regional trauma plan and overseen by the lead agency.

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Each designated acute care facility should participate, through its trauma program leadership, in all aspects of trauma system design, evaluation, and operation. This participation should include policy and legislative development, legislative and public education, and strategic planning. In addition, the trauma program and subspecialty leaders should provide direction and oversight to the development, implementation, and monitoring of integrated protocols for patient care used throughout the system (for example, TBI guidelines used by prehospital providers and nondesignated transferring centers), including region specific primary (field) and secondary (early transfer) triage protocols. The highest level trauma facilities should provide leadership of the regional trauma committees through their trauma program medical leadership. These medical leaders, through their activities on these committees, can assist the lead agency and help ensure that deficiencies in the quality of care within the system, relative to national standards, are recognized and corrected. Educational outreach by these higher level centers should be used when appropriate to help achieve this goal.

OPTIMAL ELEMENTS

I. Acute care facilities are integrated into a resource efficient, inclusive network that meets required standards and that provides optimal care for all injured patients. **(B-303)**

a. The trauma system plan has clearly defined the roles and responsibilities of all acute care facilities treating trauma and of facilities that provide care to specialty populations (for example, burn, pediatric, SCI, and others). **(I-303.1)**

II. To maintain its state, regional, or local designation, each hospital will continually work to improve the trauma care as measured by patient outcomes. **(B-307)**

a. The trauma system engages in regular evaluation of all licensed acute care facilities that provide trauma care to trauma patients and of designated trauma hospitals. Such evaluation involves independent external reviews. **(I-307.1)**

III. The lead trauma authority ensures a competent workforce. **(B-310)**

a. As part of the established standards, set appropriate levels of trauma training for nursing personnel who routinely care for trauma patients in acute care facilities. **(I-310.3)**

b. Ensure that appropriate, approved trauma training courses are provided for nursing personnel on a regular basis. **(I-310.4)**

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c. In cooperation with the nursing licensure authority, ensure that all nursing personnel who routinely provide care to trauma patients have a trauma training certificate (for example, Advanced Trauma Care for Nurses, Trauma Nursing Core Course, or any national or state trauma nurse verification course). As an alternative after initial trauma course completion, training can be driven by the performance improvement process. **(I-310.5)**

d. In cooperation with the physician licensure authority, ensure that physicians who routinely provide care to trauma patients have a current trauma training certificate of completion, for example, Advanced Trauma Life Support® (ATLS®) and others. As an alternative, physicians may maintain trauma competence through continuing medical education programs after initial ATLS completion. **(I-310.8)**

e. Conduct at least 1 multidisciplinary trauma conference annually that encourages system and team approaches to trauma care. **(I-310.9)**

f. As new protocols and treatment approaches are instituted within the system, structured mechanisms are in place to inform all personnel about the changes in a timely manner. **(I-310-10)**

CURRENT STATUS

Facilities

Alaska has an inclusive, voluntary trauma system. There are 24 hospitals, two of which are military facilities. Five hospitals are certified/designated trauma centers:

- Level II trauma center: Alaska Native Medical Center
- Level IV trauma centers : Norton Sound Regional Hospital
  Yukon Kuskokwim Delta Regional Hospital
  Mt. Edgecumbe Hospital
  Sitka Community Hospital

Harborview Medical Center in Seattle, WA is the Level I trauma center that supports Southeast Alaska, and often patients from other areas of the state.

The hospitals caring for the largest volume of trauma patients are concentrated in Anchorage:

- Alaska Native Medical Center (certified/designated Level II)
- Providence Alaska Medical Center (not designated), private not-for-profit
- Alaska Regional Hospital (not designated), for-profit

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The only other community with more than one hospital is Sitka (Sitka Community Hospital and Mt. Edgecumbe Hospital, both level IV trauma centers).

Large portions of the state are in remote, austere areas with low population, no roads and minimal health care availability. These areas are essentially isolated in periods of bad weather and must rely on local resources for emergency care for extended periods of time.

For purposes of health care delivery, the two distinct populations in Alaska (not including the military), are Native Alaskans and all other Alaskans. Native Alaskans generally receive care via the Alaska Tribal Health System/Alaska Native Tribal Health Consortium, an integrated network of facilities and providers that deliver care to defined beneficiaries. At the local level, community clinics staffed by Community Health Aides or mid-level providers are sources of healthcare in small communities. These clinics are part of an established referral relationship that includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center (Level II trauma center), providing the entire spectrum of acute trauma care. The community clinics and Community Health Aides/mid-level providers assume a significant role for the stabilization and early management of trauma patients prior to transport, and when patients cannot be transported out to larger facilities because of weather or other conditions.

Perception of incentives for hospitals to become certified/designated as trauma centers vary. The Alaska Tribal Health System/ Alaska Native Tribal Health Consortium has recognized the burden of injury on Native Alaskans, leading to the support of trauma center certification/designation of the Alaska Native Medical Center and some level IV facilities. Despite the financial costs associated with verification and certification, participants reported collateral benefits of trauma center certification/designation, including contributing to an overall elevation of the quality of care at that institution and providing service to their community. Although the private non-profit hospitals that serve Alaskans recognize that trauma care is an important contribution to the community, these facilities are reluctant to pursue certification/designation without the support of their medical staffs.

Human Resources

Human resources are limited, and significant problems exist for recruitment and retention of physicians and nurses. The shortages of physicians and nurses will likely worsen in the coming years (Alaska Physician Supply Task Force report, 2006). Since Alaska has no medical school, the option of "growing our own" which has been somewhat successful for other states, will not work without strong collaboration with the University of Washington's WWAMI program, partnership between the University of Washington School of Medicine and the states of Wyoming, Alaska, Montana, and Idaho. For example, there are currently no trauma fellowship trained general surgeons in the state, in any facility. There are surgeons who do trauma surgery. Alaska Native Medical

Center has 3 surgery residents rotating from Phoenix. Providence Alaska Medical Center has family practice residents on rotation.

Several surgical specialties are in jeopardy including pediatric surgery and vascular surgery. One of 2 pediatric surgeons in the state has recently retired, prompting the remaining pediatric surgeon to make tentative plans to leave Alaska. The situation for neurosurgery and orthopedics appears more stable with sufficient numbers in Anchorage to support current volumes. Patients requiring re-implantation and many requiring burns are transported to centers outside Alaska. Among general surgeons taking emergency department call in non-designated hospitals with significant trauma volumes, participants expressed concern regarding the burden of trauma call and identified emerging requests for financial support for taking trauma call.

Among nurses, high turnover rates and staffing with travelers are commonplace challenges. Given the national outlook for nursing shortages, this will likely worsen with time. Critical care nurse staffing levels are especially low and contribute to bypass decisions.

Integration of Designated Trauma Facilities Within the Trauma System

Diversion or inability to accept trauma patients reportedly occurs regularly and appears most often due to emergency department capacity issues, ICU bed availability, or the lack of staffed beds secondary to nursing shortages. On occasion, all 3 emergency departments in Anchorage have closed for trauma at the same time, which prompts the automatic re-opening of all the facilities and trauma patient transports in rotation. No state data are available to describe the frequency of such closings. The impact on EMS has been significant by their report, and this is compounded by challenges in communication about the rotation schedule.

Nondesignated hospitals provide the majority of trauma care in Alaska. Significant concerns were expressed by Fire and EMS crews regarding challenges they have faced when delivering patients to high-volume, nondesignated hospitals in Anchorage. Among these concerns expressed were that the nondesignated hospitals do not have the "system" in place to bring in the personnel resources needed for optimal care in a timely and efficient manner.

RECOMMENDATIONS

- **Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with American College of Surgeons Committee on Trauma (ACS-COT) verification criteria to meet the existing volume and acuity demands.**

- **Require participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center designation appropriate to their capabilities.**
- **Study pediatric trauma care needs with the goal of establishing one or more centers of excellence in pediatric trauma care.**
- Develop a memorandum of understanding between certified/designated hospitals and the state lead agency describing mutual roles and responsibilities.
- Support designated trauma center and affiliated physician readiness/standby costs and uncompensated trauma care costs through an identified state funding mechanism.
- Establish a mechanism to routinely track data on emergency department closures or bypass, and develop notification plans that include EMS and hospital stakeholders.
- Pursue a focused, well-funded strategy to recruit trauma surgeons and trauma prepared nurses to the state.
- Increase the number of physician resident positions at Alaska hospitals to encourage potential candidates to relocate to the state.

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Purpose and Rationale

To achieve the best possible outcomes, the system must be designed so that the right patient is transported to the right facility at the right time. Although on the surface this objective seems relatively straightforward, patients, geography, and transportation systems often conspire to present significant challenges. The most critically injured trauma patient is often easy to identify at the scene by virtue of the presence of coma or hypotension. However, in some circumstances, the patients requiring the resources of a Level I or II center may not be immediately apparent to prehospital providers. Primary or field triage criteria aid providers in identifying which patients have the greatest likelihood of adverse outcomes and might benefit from the resources of a designated trauma center. Even if the need is identified, regional geography or limited air medical (or land) transport services might not allow for direct transport to an appropriate facility.

Primary triage of a patient from the field to a center capable of providing definitive care is the goal of the trauma system. However, there are circumstances (for example, airway management, rural environments, inclement weather) when triaging a patient to a closer facility for stabilization and transfer is the best option for accessing definitive care. Patients sustaining severe injuries in rural environments might need immediate assessment and stabilization before a long-distance transport to a trauma center. In addition, evaluation of the patient might bring to light severe injuries for which needed care exceeds the resources of the initial receiving facility. Some patients might have specific needs that can be addressed at relatively few centers within a region (for example, pediatric trauma, burns, severe TBI, SCI, and reimplantation). Finally, temporary resource limitations might necessitate the transfer of patients between acute care facilities.

Secondary triage at the initial receiving facility has several advantages in systems with a large rural or suburban component. The ability to assess patients at non-designated or level III to V centers provides an opportunity to limit the transfer of only the most severely injured patients to level I or II facilities, thus preserving a limited resource for patients most in need. It also provides patients with lesser injuries the possibility of being cared for within their community.

The decision to transfer a trauma patient should be based on objective, prospectively agreed-on criteria. Established transfer criteria and transfer agreements will minimize discussions about individual patient transfers, expedite the process, and ensure optimal patient care. Delays in transfer might increase mortality, complications, and length of stay. A system with an excess of transferred patients might tax the resources of the regional trauma facility. Conversely, inappropriate retention of patients at centers without adequate

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facilities or expertise might increase the risk of adverse outcomes. Given the importance of timely, appropriate interfacility transfers, the time to transfer, as well as the rates of primary and secondary overtriage and undertriage, should be evaluated on a regular basis, and corrective actions should be instituted when problems are identified. Data derived from tracking and monitoring the timeliness of access to a level of trauma care commensurate with injury type and severity should be used to help define optimal system configuration.

A central communications center with real-time access to information on system resources greatly facilitates the transfer process. Ideally, this center identifies a receiving facility, facilitates dialogue between the transferring and receiving centers, and coordinates interfacility transport.

To ensure that the system operates at the greatest efficiency, it is important that patients are repatriated back to community hospitals once the acute phase of trauma care is complete. The process of repatriation opens up the limited resources available to care for severely injured patients. In addition, it provides an opportunity to bring patients back into their local environment where their social network might help reintegrate patients into their community.

OPTIMAL ELEMENTS

I. The trauma system is supported by an EMS system that includes communications, medical oversight, prehospital triage, and transportation; the trauma system, EMS system, and public health agency are well integrated. **(B-302)**

a. There are mandatory systemwide prehospital triage criteria to ensure that trauma patients are transported to an appropriate facility based on their injuries. These triage criteria are regularly evaluated and updated to ensure acceptable and system-defined rates of sensitivity and specificity for appropriately identifying a major trauma patient. **(I-302.6)**

b. There is a universal access number for citizens to access the EMS/trauma system, with dispatch of appropriate medical resources. There is a central communications system for the EMS/trauma system to ensure field-to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications among all system participants. **(I-302.7)**

c. There is a procedure for communications among medical facilities when arranging for interfacility transfers, including contingencies for radio or telephone system failure. **(I-302.9)**

II. Acute care facilities are integrated into a resource-efficient, inclusive network that meets required standards and that provides optimal care for all injured patients. **(B-303)**

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a. When injured patients arrive at a medical facility that cannot provide the appropriate level of definitive care, there is an organized and regularly monitored system to ensure that the patients are expeditiously transferred to the appropriate system-defined trauma facility. **(I-303.4)**

CURRENT STATUS

In Alaska, prehospital trauma care and patient triage is highly variable and dependent on location of injury, regional resources and local protocols. As stated in the PRQ:

> *"There are no statewide protocols for prehospital triage. The Trauma Triage, Transport & Transfer Guidelines developed by the Trauma System Planning and Development Task Force in 1993 and revised in 2002, offers guidelines to assist local EMS agencies and hospitals in developing local protocols. The protocols themselves are developed locally and approved by their medical director."*

Trauma care delivery (as most health care in Alaska) is closely tied to geographic location which dictates resources, communication, and transportation. At least three distinct areas are identified based on models of trauma care delivery:

- *Bush area:* these remote areas are geographically isolated and have unique challenges including weather, no roads, and basic health care capabilities with few hospitals.

- *Anchorage area:* this urban environment is the major population center of the state and has several acute care hospitals, advanced infrastructure, and system redundancy in several segments. It is the primary health care referral area for the state for all Alaskans.

- *Southeast:* this area has intermediate capabilities compared to the 2 areas listed above and has a special relationship with Harborview Medical Center (Level I trauma center) in Seattle.

In addition to the geographic differentiation mentioned above, Alaska health care delivery can also be viewed in the context of populations (excluding the military):

- Native Alaskans: health care delivery to this population occurs across all geographic regions and is organized and administered by Alaska Tribal Health System/ Alaska Native Tribal Health Consortium, an integrated network of facilities and providers that deliver care to Native Alaskans as defined beneficiaries.

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- Alaskans: health care delivery to this population occurs along more typical lines and involves a variety of hospitals and providers in varying density dependent on location and funding source.

Care to Native Alaskans and other Alaskans in the bush is overlapping, as many Alaskans receive primary and emergency care in Alaska Native clinics and hospitals when they are the only resources available. To a degree, some overlapping of trauma care for Native Alaskans and other Alaskans occurs within the Anchorage hospitals when by-pass or diversion causes a trauma patient to be directed to Alaska Native Medical Center or one of the non-certified/designated hospitals.

Many remote areas of the state are faced with unique challenges in the provision of trauma care. Providers and facilities have demonstrated creativity and resourcefulness in their attempt to overcome the problems of distance, limited resources, and communication challenges. This innovation and flexibility is to be commended, and it has been valuable and necessary.

In the more urban regions, such as Anchorage, the transition to more organized, efficient and coordinated systems of patient flow has not been complete. This has been reflected in frustrations expressed by local EMS services, referring physicians from outlying facilities, and members of the local physician provider community. Physicians described the problem of making multiple calls for transfer of a patient to an Anchorage hospital. In some cases Anchorage is by-passed and the patient is sent to Seattle. While there are two pediatric intensive care units in Anchorage hospitals, beds are sometimes unavailable, and children are sometimes sent to Seattle as well.

The situation is further complicated by the co-existence in the Anchorage area of a higher level of organized trauma care at the Alaska Native Medical Center (including a pediatric ICU), while the private not-for-profit hospitals (Providence Alaska Medical Center and Alaska Regional Hospital) maintain non-certified/designated trauma care facilities. All three hospitals serve as regional referral facilities for large areas of the state with Providence Alaska Medical Center receiving the largest volume of patients, including pediatrics. Local EMS as well as referring facilities throughout the state are faced with at least two differing sets of referral guidelines and triage criteria (for Native Alaskans and other Alaskans), as well as varying abilities to provide care to special populations (including burns, pediatrics, and vascular surgery).

In addition to the lack of statewide triage protocols, the flow of patients within the major treating facilities varies greatly. Available trauma registry data from 2006 show that at the designated Level II hospital, Alaska Native Medical Center, the majority of patients are admitted to surgical services. In contrast, at hospitals serving Alaskans, such as Providence Alaska Medical Center, which has the largest trauma patient volume, substantial numbers of patients are admitted to

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non-surgical services. With the increase in hospital-based medical specialists (e.g., hospitalists), these trends are likely to have become pronounced. The care of trauma patients on non-surgical services without an organized trauma service is inconsistent with national guidelines, and it likely contributes to inferior outcomes such as longer ICU and hospital stays, higher complication and mortality rates, lower patient and provider satisfaction scores, and increased costs.

Significant divergence of opinion is apparent among providers at the private nonprofit hospitals in Anchorage regarding the need for, and value of, trauma center certification/designation and an organized trauma system. Emergency physicians expressed the opinion that they are able to deliver all aspects of initial care and obtain prompt surgical support, as well as the opinion that there were significant deficiencies in the availability and involvement of surgical specialists. As noted above, EMS services and referring physicians at outlying facilities participating in the TSC supported the latter perspective. Surgeons also expressed divided opinions regarding trauma center designation – surgeons at designated trauma centers are supportive while those at the non-designated facilities expressed serious concerns. Participants indicated that the provision of financial support for on-call responsibilities would facilitate the participation of private surgeons in meeting the certification/designation standards. The support of these groups of physicians would likely facilitate improvements in system coordination and patient flow.

It is recognized that Harborview Medical Center in Seattle provides important referral care for Alaska, especially for special populations (e.g., pediatrics, burns, reimplantation, and rehabilitation). Patient flow to Harborview appears to be relatively straightforward thanks to significant efforts by the receiving facility to treat Alaska patients preferentially and by the placement of fixed-wing aircraft in Southeast Alaska.

Within the state there are 79 ground ambulance units, 19 primarily fixed-wing air services, as well as civilian, Coast Guard, and military helicopters. Many of these units function under very difficult circumstances and succeed because of experience and innovation. No central coordinating agency or mechanism to manage these resources exists, and no easily accessible resource describing runways and equipment that can be used in each location is available.

Repatriation rarely occurs in this system, particularly for patients treated in Seattle.

RECOMMENDATIONS

- **Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).**

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- Preserve the flexibility and encourage the innovation for trauma care that exists in the remote regions of the state.
- Develop an online resource describing available patient transport resources across the state.
- Encourage the adoption of standardized, evidence-based, in-hospital trauma team activation protocols.
- Develop inter-facility transfer criteria to ensure that patients with specialized needs are sent to facilities with matching resources.
- Maintain the existing effective relationship with Harborview Medical Center and develop strategies to improve Medicaid funding for transfers.

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Purpose and Rationale

As an integral component of the trauma system, rehabilitation services in acute care and rehabilitation centers provide coordinated care for trauma patients who have sustained severe or catastrophic injuries, resulting in long-standing or permanent impairments. Patients with less severe injuries may also benefit from rehabilitative programs that enhance recovery and speed return to function and productivity. The goal of rehabilitative interventions is to allow the patient to return to the highest level of function, reducing disability and avoiding handicap whenever possible. The rehabilitation process should begin in the acute care facility as soon as possible, ideally within the first 24 hours. Inpatient and outpatient rehabilitation services should be available. Rehabilitation centers should have CARF (Commission of Accreditation of Rehabilitation Facilities) accreditation for comprehensive inpatient rehabilitation programs, and accreditation of specialty centers (SCI and TBI) should be strongly encouraged.

The trauma system should conduct a rehabilitation needs assessment (including specialized programs in SCI, TBI, and for children) to identify the number of beds needed and available for rehabilitation in the geographic region. Rehabilitation specialists should be integrated into the multidisciplinary advisory committee to ensure that rehabilitation issues are integrated into the trauma system plan. The trauma system should demonstrate strong linkages and transfer agreements between designated trauma centers and rehabilitation facilities located in its geographic region (in or out of state). Plans for repatriation of patients, especially when rehabilitation centers across state lines are used, should be part of rehabilitation system planning. Feedback on functional outcomes after rehabilitation should be made available to the trauma centers.

OPTIMAL ELEMENTS

I. The lead agency ensures that adequate rehabilitation facilities have been integrated into the trauma system and that these resources are made available to all populations requiring them. **(B-308)**

a. The lead agency has incorporated, within the trauma system plan and the trauma center standards, requirements for rehabilitation services, including interfacility transfer of trauma patients to rehabilitation centers. **(I-308.1)**

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b. Rehabilitation centers and outpatient rehabilitation services provide data on trauma patients to the central trauma system registry that include final disposition, functional outcome, and rehabilitation costs and also participate in performance improvement processes. **(I-308.2)**

II. A resource assessment for the trauma system has been completed and is regularly updated. **(B-103)**

a. The trauma system has completed a comprehensive system status inventory that identifies the availability and distribution of current capabilities and resources. **(I-103.1)**

CURRENT STATUS

While rehabilitation resources are available in Alaska, they are relatively limited in scope and capacity. The 20 inpatient rehabilitation beds in Alaska are all in the Anchorage (10 at Alaska Regional Hospital and 10 at Providence Alaska Medical Center). No pediatric rehabilitation beds for children under age 14 years exist in the state. Limited individual outpatient rehabilitation programs exist to support defined patient groups (e.g., traumatic brain injury [TBI]) at hospitals and in the community.

Patients with traumatic brain injury (adult and children 14 years and older) commonly utilize these rehabilitation beds in Anchorage, while most patients with spinal cord injury (SCI) are sent to spinal cord rehabilitation facilities in the lower 48 states. It was reported that patients wait approximately two days for an inpatient rehabilitation bed for TBI, and about 20 days for SCI; however this varies by patient status and availability of a funding source.

Harborview Medical Center in Seattle, WA provides significant support for rehabilitation services to injured patients from Alaska, including pediatric patients. This relationship is longstanding and well-developed, especially with acute care facilities in the Southeastern Alaska. Because Alaska Medicaid reimbursement rates are reportedly lower than Washington Medicaid rates, much of the care provided to patients with Alaska Medicaid transferred to Seattle is uncompensated or undercompensated.

Repatriation of patients transferred to rehabilitation centers is difficult and complicated by many variables (e.g., the cost of travel home, finding a physician to assume care responsibility). It was reported that patients transported out-of-state for rehabilitation frequently do not return to Alaska and that patients who are brought to Anchorage for rehabilitation services are likely to remain in the area.

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No state data are available to evaluate the status of rehabilitation in Alaska. No needs assessment has been conducted to identify the rehabilitation needs of trauma patients in the state. Few data describe utilization, ultimate outcomes and dispositions of trauma patients requiring rehabilitation services. It is not clear that efforts are being made to include rehabilitation data and patient outcomes in the state trauma registry.

No rehabilitation specialist (physiatrist) sits on the TSRC.

RECOMMENDATIONS

- Include rehabilitation outcomes in the trauma registry.
- Perform a needs assessment for rehabilitation of trauma patients in Alaska.
- Develop a comprehensive plan to provide a continuum of rehabilitation services from acute care settings to inpatient rehabilitation to outpatient services, especially for traumatic brain injury, spinal cord injury, and pediatric trauma.
- Appoint a rehabilitation specialist to membership in the newly formed Alaska Trauma Advisory Committee (ATAC).
- Encourage rehabilitation centers to attain CARF (Commission of Accreditation of Rehabilitation Facilities) accreditation.
- Evaluate repatriation options for patients transferred to Anchorage or out-of-state.

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Purpose and Rationale

As critically important resources for state, regional, and local responses to MCIs, the trauma system and its trauma centers are central to disaster preparedness. Trauma system leaders need to be actively involved in public health preparedness planning to ensure that trauma system resources are integrated into the state, regional, and local disaster response plans. Acute care facilities (sometimes including one or more trauma centers) within an affected community are the first line of response to an MCI. However, an MCI may result in more casualties than the local acute care facilities can handle, requiring the activation of a larger emergency response plan with support provided by state and regional assets.

For this reason, the trauma system and its trauma centers must conduct a resource assessment of its surge capacity to respond to MCIs. The resource assessment should build on and be coupled to a hazard vulnerability analysis. An assessment of the trauma system's response to simulated incident or tabletop drills must be conducted to determine the trauma system's ability to respond to MCIs. Following these assessments, a gap analysis should be conducted to develop statewide MCI response resource standards. This information is essential for the development of an emergency management plan that includes the trauma system.

Planning and integration of the trauma system with plans of related systems (public health, EMS, and emergency management) are important because of the extensive impact disasters have on the trauma system and the value of the trauma system in providing care. Relationships and working cooperation between the trauma system and public health, EMS, and emergency management agencies support the provision of assets that enable a more rapid and organized disaster response when an event occurs. For example, the EMS emergency preparedness plan needs to include the distribution of severely injured patients to trauma centers, when possible, to make optimal use of trauma center resources. This plan could optimize triage through directing less severely injured patients to lower level trauma centers or nondesignated facilities, thus allowing resources in trauma centers to be spared for patients with the most severe injuries. In addition, the trauma system and its trauma centers will be targeted to receive additional resources (personnel, equipment, and supplies) during major MCIs.

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Mass casualty events and disasters are chaotic, and only with planning and drills will a more organized response be possible. Simulation or tabletop drills provide an opportunity to test the emergency preparedness response plans for the trauma system and other systems and to train the teams that will respond. Exercises must be jointly conducted with other agencies to ensure that all aspects of the response plan have the trauma system integrated.

OPTIMAL ELEMENTS

I. An assessment of the trauma system's emergency preparedness has been completed, including coordination with the public health agency, EMS system, and the emergency management agency. **(B-104)**

a. There is a resource assessment of the trauma system's ability to expand its capacity to respond to MCIs in an all-hazards approach. **(I-104.1)**

b. There has been a consultation by external experts to assist in identifying current status and needs of the trauma system to be able to respond to MCIs. **(I-104.2)**

c. The trauma system has completed a gap analysis based on the resource assessment for trauma emergency preparedness. **(I-104.3)**

II. The lead agency ensures that its trauma system plan is integrated with, and complementary to, the comprehensive mass casualty plan for natural and manmade incidents, including an all-hazards approach to planning and operations. **(B-305)**

a. The EMS, the trauma system, and the all-hazards medical response system have operational trauma and all-hazards response plans and have established an ongoing cooperative working relationship to ensure trauma system readiness for all-hazards events. **(I-305.1)**

b. All-hazards events routinely include situations involving natural (for example, earthquake), unintentional (for example, school bus crash), and intentional (for example, terrorist explosion) trauma-producing events that test the expanded response capabilities and surge capacity of the trauma system. **(I-305-2)**

c. The trauma system, through the lead agency, has access to additional equipment, materials, and personnel for large-scale traumatic events. **(I-305.3)**

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CURRENT STATUS

Alaska has an active geological environment with frequent earthquakes, extensive volcano eruptions, huge avalanches, periodic flooding and large expanses of fresh and salt water, all of which invite potential disaster. Two-thirds of Alaska is without roads and Alaskans are dependent on air travel for routine and emergent travel. Communication capabilities and disaster resources decrease as distance from population centers increases.

The lead agency for disaster preparedness is the Division of Emergency Services which resides within the Department of Military and Veterans Affairs, Division of Homeland Security and Emergency Management. The DHSS has primary functional responsibility for mass casualty events. Both agencies recognize the need for an effective trauma system as an integral component of disaster capability.

A recent full scale exercise, Alaska Shield/Northern Edge 2007 demonstrated strengths that included effective local interoperable communications equipment. However this interoperability does not necessarily transfer to the majority of the state. Weaknesses identified were lack of coordination of air transports and local/state/military resources, as well as lack of interagency coordination for resource requests and allocation during mass casualty events.

The state has no registry for volunteer medical providers, except for the Alaska Board of Nursing that maintains a registry of nurses who would volunteer to respond to a disaster. There are two Medical Reserve Corps in Alaska, but they are not functional due to lack of funding.

Some EMS providers have received disaster training, but they are not required to obtain or maintain such training.

RECOMMENDATIONS

- **Integrate all components of the trauma system into state and local disaster planning activities.**
- Perform a detailed statewide communication assessment.
- Provide basic all-hazards disaster training for all prehospital providers that can be delivered via a variety of formats.

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Purpose and Rationale

The trauma lead agency has responsibility for instituting processes to evaluate the performance of all aspects of the trauma system. Key aspects of systemwide effectiveness include the outcomes of population based injury prevention initiatives, access to care, as well as the availability of services, the quality of services provided within the trauma care continuum from prehospital and acute care management phases through rehabilitation and community reintegration, and financial impact or cost. Intrinsic to this function is the delineation of valid, objective metrics for the ongoing quality audit of system performance and patient outcomes based on sound benchmarks and available clinical evidence. Trauma management information systems (MISs) must be available to support data collection and analysis.

The lead agency should establish forums that promote inclusive multidisciplinary and multiagency review of cases, events, concerns, regulatory issues, policies, procedures, and standards that pertain to the trauma system. The evaluation of system effectiveness must take into account the integration of these various components of the trauma care continuum and review how well personnel, agencies, and facilities perform together to achieve the desired goals and objectives. Results of customer satisfaction (patient, provider, and facility) appraisals and data indicative of community and population needs should be considered in strategic planning for system development. System improvements derived through evaluation and quality assurance activities may encompass enhancements in technology, legislative or regulatory infrastructure, clinical care, and critical resource availability.

To promote participation and sustainability, the lead agency should associate accountability for achieving defined goals and trauma system performance indicators with meaningful incentives that will act to cement the support of key constituents in the health care community and general population. For example, the costs and benefits of the trauma system as they relate to reducing mortality or decreasing years of productive life lost may make the value of promoting trauma system development more tangible. A facility that achieves trauma center verification/designation may be rewarded with monetary compensation (for example, ability to bill for trauma activation fees) and the ability to serve as a receiving center for trauma patients. The trauma lead agency should promote ongoing dialog with key stakeholders to ensure that incentives remain aligned with system needs.

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OPTIMAL ELEMENTS

I. The trauma MIS is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the trauma system, including a cost-benefit analysis. **(B-301)**

a. The lead trauma authority ensures that each member hospital of the trauma system collects and uses patient data, as well as provider data, to assess system performance and to improve quality of care. Assessment data are routinely submitted to the lead trauma authority. **(I-301.1)**

II. The jurisdictional lead agency, in cooperation with other agencies and organizations, uses analytic tools to monitor the performance of population based prevention and trauma care services. **(B-304)**

III. The financial aspects of the trauma system are integrated into the overall performance improvement system to ensure ongoing fine tuning and cost-effectiveness. **(B-309)**

a. Financial data are combined with other cost, outcome, or surrogate measures, for example, years of potential life lost, quality-adjusted life years, and disability adjusted life years; length of stay; length of intensive care unit stay; number of ventilator days; and others, to estimate and track true system costs and cost- benefits. **(I-309.4)**

CURRENT STATUS

According to the PRQ, the TSRC is charged with "ongoing monitoring and evaluating of the trauma system". Even though the actions of the TSRC are exempt from discovery, it is unclear that the TSRC has truly been empowered or authorized to perform its system evaluation and quality improvement functions. No clear line of authority could be identified in provided documentation for the TSRC to recommend or impose system change. The PRQ illustrates this challenge in the following statement:

> "The TSRC has reported findings to the Lead Agency, ACEMS and liaisons, EMS regional coordinators, and trauma care providers via the Annual EMS Symposium... In special circumstances, such as the advancement of a Trauma System Improvement Act, members of the TSRC have shared information with legislators... The TSRC may make recommendations to the Lead Agency and constituent members of the trauma system".

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The uncertainty of lines of authority is further exacerbated by the fact that the TSRC formally operates under the aegis of the Alaska State Medical Board.

When asked about specific evaluation and quality assurance processes, the stakeholders present acknowledged that they have neither determined Alaska's preventable mortality rate nor quantified the opportunities for improvement by phase of care.

The TSRC has made significant contributions to the standardization of care through the development of documents such as "Guidelines for the Management and Transfer of Head Injury Patients in Remote and Rural Alaska". However, the impact of this and other guidelines has not been monitored, and adherence to the guidelines was reported as variable. There has not been "loop closure" on these efforts.

The TSRC identified nine indicators of interest and initiated efforts to examine the data necessary to determine the status of those indicators. However, during the first pass of the data, it was reported that the data were of insufficient quality to answer the questions posed by the indicator. Additional data cleaning was needed.

While it was reported that a major impediment to system evaluation and quality assurance was either the lack or quality of data, the ACS team was able to request and receive trauma registry data (2006) that was sufficiently detailed to engage in rudimentary evaluation processes, e.g., stratification of trauma patients by facility and by ISS. While the data are aging, these data serve as a fundamental building block of a system evaluation process.

RECOMMENDATIONS

- **Develop an initial set of 3-5 statewide system performance indicators from among the list of 9 provided in the Pre-Review Questionnaire (PRQ).**
- Examine available data points and definitions, and develop indicators for performance improvement that can be determined on the basis of those data points.
- Formally review the data associated with each indicator on a quarterly to annual basis and start a benchmarking process.
- Report the results of all evaluation and quality assurance processes in an annual report that is presented to all system stakeholders, including the new Alaska Trauma Advisory Committee (ATAC) and Alaska Council on Emergency Medical Services (ACEMS).

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Purpose and Rationale

Hospital-based trauma registries developed from the idea that aggregating data from similar cases may reveal variations in care and ultimately result in a better understanding of the underlying injury and its treatment. Hospital-based registries have proven very effective in improving trauma care within an institution but provide limited information regarding how interactions with other phases of health care influence the outcome of an injured patient. To address this limitation, data from hospital-based registries should be collated into a regional registry and linked such that data from all phases of care (prehospital, hospital, and rehabilitation) are accessible in 1 data set. When possible, these data should be further linked to law enforcement, crash incident reports, ED records, administrative discharge data, medical examiner records, vital statistics data (death certificates), and financial data. The information system should be designed to provide systemwide data that allow and facilitate evaluation of the structure, process, and outcomes of the entire system; all phases of care; and their interactions. This information should be used to develop, implement, and influence public policy.

The lead agency should maintain oversight of the information system. In doing so, it must define the roles and responsibilities for agencies and institutions regarding data collection and outline processes to evaluate the quality, timeliness, and completeness of data. There must be some means to ensure patient and provider confidentiality is in keeping with federal regulations. The agency must also develop policies and procedures to facilitate and encourage injury surveillance and trauma care research using data derived from the trauma MIS. There are key features of regional trauma MISs that enhance their usefulness as a means to evaluate the quality of care provided within a system. Patient information collected within the management system must be standardized to ensure that noted variations in care can be characterized in a similar manner across differing geographic regions, facilities, and EMS agencies. The composition of patients and injuries included in local registries (inclusion criteria) should be consistent across centers, allowing for the evaluation of processes and outcomes among similar patient groups. Many regions limit their information systems to trauma centers. However, the optimal approach is to collect data from all acute care facilities within the region. Limiting required data submission to hospitals designated as trauma centers allows one to evaluate systems issues only among patients transported to appropriate facilities. It is also important to have protocols in place to ensure a uniform approach to data abstraction and collection. Research suggests that if the process of case abstraction is not routinely calibrated, practices used by abstractors begin to drift.

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Finally, every effort should be made to conform to national standards defining processes for case acquisition, case definition (that is, inclusion criteria), and registry coding conventions. Two such national standards include the National Highway Traffic Safety Administration's National Emergency Medical Services Information System (NEMSIS), which standardizes EMS data collection, and the American College of Surgeons National Trauma Data Standard, which addresses the standardization of hospital registry data collection. Strictly adhering to national standards markedly increases the value of state trauma MISs by providing national benchmarks and allowing for the use of software solutions that link data sets to enable a review of the entire injury and health care event for an injured patient.

To derive value from the tremendous amount of effort that goes into data collection, it is important that a similar focus address the process of data reporting. Dedicated staff and resources should be available to ensure rapid and consistent reporting of information to vested parties with the authority and vision to prevent injuries and improve the care of patients with injuries. An optimal information reporting process will include standardized reporting tools that allow for the assessment of temporal and/or system changes and a dynamic reporting tool, permitting anyone to tailor specific "views" of the information.

OPTIMAL ELEMENTS

I. There is an established trauma MIS for ongoing injury surveillance and system performance assessment. **(B-102)**

a. There is an established injury surveillance process that can, in part, be used as an MIS performance measure. **(I-102.1)**

b. Injury surveillance is coordinated with statewide and local community health surveillance. **(I-102.2)**

c. There is a process to evaluate the quality, timeliness, completeness, and confidentiality of data. **(I-102.4)**

d. There is an established method of collecting trauma financial data from all health care facilities and trauma agencies, including patient charges and administrative and system costs. **(I-102.5)**

II. The trauma MIS is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the trauma system, including a cost-benefit analysis. **(B-301)**

a. The lead trauma authority ensures that each member hospital of the trauma system collects and uses patient data, as well as provider data, to assess system performance and to improve quality of care. Assessment data are routinely submitted to the lead trauma authority. **(I-301.1)**

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b. Prehospital care providers collect patient care and administrative data for each episode of care and not only provide these data to the hospital, but also have a mechanism to evaluate the data within their own agency, including monitoring trends and identifying outliers. **(I-301.2)**

c. Trauma registry, ED, prehospital, rehabilitation, and other databases are linked or combined to create a trauma system registry. **(I-301.3)**

d. The lead agency has available for use the latest in computer/technology advances and analytic tools for monitoring injury prevention and control components of the trauma system. There is reporting on the outcome of implemented strategies for injury prevention and control programs within the trauma system. **(I-301.4)**

CURRENT STATUS

The State of Alaska has worked diligently over several decades to develop, maintain, and improve a systemwide trauma registry. This has meant an evolutionary process involving at least two vendors and substantial challenges in linking disparate computer languages that exist in the Native Alaskan and other Alaskan record keeping systems. The State is to be commended for its persistence in this regard.

The lead agency maintains a full-time trauma registrar which represents, in fact, the most significant personnel commitment dedicated to the trauma program. Funds to support this position come from external sources (NIOSH).

Currently all hospitals contribute to the statewide trauma registry. For the larger facilities, this involves electronic data transfer. However, for the smaller facilities, the process involves on-site abstraction of records, completion of a data abstract summary, and manual input into the system. A contract employee is assigned the responsibility of facilitating this process. She described multiple challenges at some of the smaller hospitals, such as limited personnel resources for abstracting, enormous travel distances and costs for her to visit the hospitals, a reluctance by the hospitals to ask for or accept consultative help, and persistent turnover of data registrars at the hospitals. These challenges result in a significant delay (up to 2 years) in acquiring trauma data from all acute care facilities. In some cases, the consultant performs data abstraction at some of the smaller hospitals in an effort to get data submission caught up.

A second contract employee is used to clean and validate the data. She demonstrated significant adeptness with the system registry data by fulfilling several requests of the ACS team during their deliberations. For example, she was able to easily stratify injury severity by hospital and track transfers in an out of each facility. The contract employees are responsible for an annual training of trauma registrars.

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During the discussion of the management information system, it was revealed that recently a new trauma registry vendor has received the Alaska contract. There was substantial discordance with the manner in which the vendor was selected, with the end-users (e.g., registrars, trauma managers, trauma directors, and the TSRC) having little to no input into the process. While data input into the new system is tentatively scheduled to begin January 1, 2009, concern was expressed by participants that during the transition period there was the potential for data to be delayed or, perhaps, even lost. Several participants suggested that they might maintain their current system in lieu of using the newly acquired system.

One of the perceived advantages of the new trauma system is that it can, and will, be linked with electronic prehospital data since the same vendor holds a single contract for the provision of both systems. The effectiveness of this linkage could not be fully ascertained at the time of the ACS visit since the systems were only then "coming on-line". However, it is important to note that similar efforts by other states to link the trauma registry and prehospital data systems have not been universally successful, even when the same vendor has been used for each system. The IPEMS Section will need to work closely with the vendor to monitor progress in meeting contract expectations. The state is to be commended for obtaining a grant that will enable to the lead agency to perform additional linkage with other, free standing, data sets such as the traffic crash database.

Alaska has a data rich environment. Numerous other databases exist and have been used for epidemiologic and prevention activities. However, they have only been used in a limited capacity to help steer and manage the trauma system.

Specific policies and procedures have been developed by the TSRC concerning the release of trauma registry data. Several researchers have accessed the data system following these guidelines.

RECOMMENDATIONS

- **Ensure that all elements considered essential to system development, evaluation and performance improvement in the State of Alaska are evident and working in the new trauma registry and are consistent with the National Trauma Data Standard (NTDS) definitions.**
    - This should be tasked to a peer review protected subcommittee, (e.g. the Trauma System Review Committee) of the Alaska Technical Advisory Committee (ATAC), in collaboration with the trauma registrar, trauma registrar contract employees, and the vendor.
- Safeguard the legacy data by maintaining the current software system separately and discretely from the new system until a legacy data transfer has occurred and validation queries have been completed.

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- Minimize gaps and delays in data during the trauma registry transition process by maintaining dual systems until the transfer of legacy and concurrent data has been completed and validated.
- Establish mechanisms for capturing data from remote facilities in a timely manner, e.g., provide scanners and/or encrypted methods of electronic transmission of records in lieu of travel to each facility.
- Submit statewide trauma registry data to the National Trauma Data Bank (NTDB) on an annual basis.
- Achieve linkage and integration with other data sets, specifically, prehospital and hospital discharge data (UB.92/04).
- Use existing data, beginning immediately, for system development and quality improvement activities, in spite of its acknowledged imperfections.
- Provide reports on at least a quarterly basis to all stakeholders.

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Purpose and Rationale

Overview of Research Activity

Trauma systems are remarkably diverse. This diversity is simply a reflection of authorities tailoring the system to meet the needs of the region based on the unique combination of geographic, economic, and population characteristics within their jurisdiction. In addition, trauma systems are not fixed in their organization or operation. The system evolves over years in response to lessons learned, critical review, and changes in population demographics. Given the diversity of organization and the dynamic nature of any particular system, it is valuable when research can be conducted that evaluates the effectiveness of the regional or statewide system. Research drives the system and will provide the foundation for system development and performance improvement. Research findings provide value in defining best practices and might alter system development. Thus, the system should facilitate and encourage trauma-related research through processes designed to make data available to investigators. Competitive grants or contracts made available through lead authorities or constituencies should provide funds to support research activities. All system components should contribute to the research agenda. The extent to which research activities are required should be clearly outlined in the trauma system plan and/or the criteria for trauma center designation.

The sources of data used for research might be institutional and regional trauma registries. As an alternative, population-based research might provide a broader view of trauma care within the region. Primary data collection, although desirable, is expensive but might provide insights into system performance that might not be otherwise available.

Trauma Registry–based Research

Investigators examining trauma systems can use the information recorded in trauma registries to great advantage to determine the prevalence and annual incidence rate of injuries, patterns of care that occur to injured patients in the system's region, and outcomes for the patients. These data can be compared with standards available from other trauma registries, such as the NTDB. Such comparisons can then enable investigators to determine if care within their region is within standards and can allow for benchmarking. Initiating and sustaining injury prevention initiatives is a vital goal in mature trauma systems. Investigators can take a leadership role in performing research using trauma registry data that identify emerging threats and instituting public health measures to mitigate the threats. For example, a recent surge in death and disability related to off -road

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vehicles can be identified and the scope of the problem defined in terms of who, where, and how riders are injured, and then, through presentations and publications, the public can be informed of a new threat.

Trauma system administrators have a responsibility to control investigators' access to the registry. The integrity and reliability of data in a trauma systems registry are essential if accurate research and valid conclusions are to be reached using the data. Trauma system administrators should have a process that screens data entered into the system's composite registry from individual institutions. There should be a mechanism that ensures that the information is stored in a secure manner. Investigators who seek access to the trauma registry must follow a written policy and procedure that includes approval by an authorized institutional review board. Trauma registry data may include unique identifiers, and system administrators must ensure that patient confidentiality is respected, consistent with state and federal regulations.

Population-based Trauma System Research

A major disadvantage of using only trauma registry data to conduct research that evaluates injured patients in a region is the bias resulting from missing data on patients not treated at trauma centers. Specifically, most registry data are restricted to information from hospitals that participate in the trauma system. Although ideally all facilities participate in the form of an inclusive system, many systems do not attain this goal. Thus, a population-based data set provides investigators with the full spectrum of patients, irrespective of whether they have been treated in trauma centers or nondesignated centers or were never admitted to the hospital owing to death at the scene of incident or because their injuries were insufficiently severe to require admission. The state and national hospital discharge databases are examples of population-based data. These discharge databases contain information that was abstracted from medical records for billing purposes by hospital employees who enter these data into an electronic database. For investigators seeking a wider perspective on the care of injured patients in their region, these more inclusive data sets, compared with registries, are essential tools. Other population based data that may be of help include mortality vital statistics data recorded in death certificates. Selected regions might have outpatient data to capture patients who are assessed in the ED and then released.

Investigators can use these population-based data to study the influence of a regional trauma system on the entire spectrum of patients within its catchment area.

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Participation in Research Projects and Primary Data Collection

Multi-institutional research projects are important mechanisms for learning new knowledge that can guide the care of injured patients. Investigators within trauma systems can participate as co-investigators in these projects. Investigators can participate by recruiting patients into prospective studies, being leaders in the design and administration of grants, and preparing manuscripts and reports. Evidence of this collaboration is that investigators within a trauma system are recognized in announcements of grants or awards. Lead agency personnel should identify and reach out to resources within the system with research expertise. These include academic centers and public health agencies.

Measures of Research Activity

Research can be broadly defined as hypothesis-driven data analysis. This analysis leads the investigators to a conclusion, which might become a recommendation for system change. Full manuscripts published in peer reviewed research journals are an exemplary form of research activity. Research reported in annual reviews or in public information formats intended to inform the trauma system's constituency can also be considered legitimate research activity.

OPTIMAL ELEMENTS

I. The trauma MIS is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the trauma system, including a cost-benefit analysis. **(B-301)**

a. The lead agency has available for use the latest in computer/technology advances and analytic tools for monitoring injury prevention and control components of the trauma system. There is reporting on the outcome of implemented strategies for injury prevention and control programs within the trauma system. **(I-301.4)**

II. The lead agency ensures that the trauma system demonstrates prevention and medical outreach activities within its defined service area. **(B-306)**

a. The trauma system has developed mechanisms to engage the general medical community and other system participants in their research findings and performance improvement efforts. **(I-306.1)**

b. The effect or impact of outreach programs (medical community training/support and prevention activities) is evaluated as part of a system performance improvement process. **(I-306.3)**

III. To maintain its state, regional, or local designation, each hospital will continually work to improve the trauma care as measured by patient outcomes. **(B-307)**

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a. The trauma system implements and regularly reviews a standardized report on patient care outcomes as measured against national norms. **(I-307.2)**

CURRENT STATUS

A specific research agenda has not been developed for the Alaska trauma system. However, a reasonable representation of trauma-related literature can be found using an electronic medical literature search. Several articles use the trauma registry as a basis of data. Unfortunately, most of the articles are aging. Several are published in *Alaska Medicine*, which reportedly is changing from a quarterly publication to an annual publication.

A wealth of scientific and technical publications has been produced in the Alaska injury prevention literature. Again several of these publications use trauma registry data, at least partially, as a basis for the publications.

The University of Alaska – Anchorage currently offers a Master of Public Health (MPH) degree within its Department of Health Sciences. Linkages between the MPH program and the trauma system were not discussed. The lead agency has direct access to a staff epidemiologist.

RECOMMENDATIONS

- Establish a collaborative relationship between the University of Alaska-Anchorage's public health program and the lead agency's epidemiologist and the Alaska Trauma Advisory Committee (ATAC).

- Develop, jointly, a research agenda that can build on the current trauma registry data and expand to include more rigorous research projects.

- Attempt to minimize Institutional Review Board approval challenges while still maintaining full protection of any/all subjects.

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Focus Questions

1. How can Alaska attain full participation of hospitals in the statewide trauma system?

Trauma centers and trauma systems have been demonstrated to decrease mortality following injury.[1,2,3] All of the acute care hospitals in Alaska are currently providing care for injured patients. However; trauma patients in Alaska who are not Native Alaskans do not have routine access to a verified/designated Level I or II trauma center. A trauma system will fully attain the benefits of improved patient care and superior outcomes only when all facilities institute and follow evidence-based guidelines to decrease variability in care and deviations from the standard of care. Central to this evolution is the implementation of a rigorous, multidisciplinary performance improvement program. A coordinated system of trauma care within acute care facilities accomplishes the following:

- improved communications,
- streamlined coordination of care issues,
- increased physician satisfaction,
- a sense of pride in trauma care providers throughout the facility, and
- the community is reassured that everything possible is being done to provide them state-of-the art trauma care.

Trauma systems have been well studied, and these studies form the basis for the recommendations and guidelines found in the ACS-COT *Resources for Optimal Care of the Injured Patient* document.

Hospitals, healthcare providers, and physicians in Alaska are already providing trauma care. The adoption of an inclusive trauma system with verified/ designated trauma centers would enable facilities in the state to provide trauma care to all Alaskans with less variability in care, better patient outcomes, lower resource utilization, and higher patient and provider satisfaction. In many cases, trauma care within an organized and verified trauma center also results in lower costs as evidence-based practice replaces less efficient practice patterns.

Only five hospitals are currently verified/designated trauma centers in Alaska. Reasons expressed by participants for not becoming verified and designated are varied but fall into two main categories:

- Administrator's concerns regarding increased costs to be borne by the hospital and the potential impact on the medical staff
- Lack of broad physician support

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Administrators' concerns

Administrators' concerns involve a number of issues related to trauma center verification:

- Multi-system trauma patients require an organized system of care for optimal outcomes which increases institutional readiness costs.
- "Poor" uninsured case mix of trauma patients.
- Effect on hospital operations such as disruption of operating room schedules, filling ICU beds, etc.
- Physicians tend to be reluctant to participate and may elect to abandon a hospital that seeks designation.

Lack of physician support

Medical staff support for trauma center verification tends to be lukewarm at private hospitals for a number of reasons:

- Trauma patients have higher rates of uncompensated care than "elective" patients.
- Trauma patients are more likely to sue a physician (unfounded).
- The care of trauma patients imposes undue burdens including night and weekend work, and this care is generally disruptive of elective practices.

To address the above mentioned concerns, a number of issues should be openly discussed by key representatives of the identified groups, and a variety of solutions should be considered. It is likely that no one answer fits every situation and a combination of flexibility and transparency is needed.

While it is true that verification/designation as a trauma center requires commitment by administration and medical staffs, the benefits in improved patient outcomes, decreased complication rates and length of stay, and increased patient and provider satisfaction can outweigh the costs. In the case of the hospitals and physicians in Alaska who are already providing trauma care, an inclusive trauma system would likely make trauma care easier and less costly.

The cost of readiness is significant in trauma centers and may be addressed through several means. The recently introduced trauma activation fees using the 68x designation on the UB 92/UB 04 form can relieve a significant portion of these costs. Trauma activation fees can only be submitted if the center is verified/designated. A number of states have provided financial support to their trauma centers through legislation or appropriations. State financial support for trauma care is usually linked to trauma center verification/designation and continued participation in an organized trauma system. Trauma center verification/designation carries important benefits to hospitals in terms of disaster

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preparedness, and this may be especially relevant in Alaska given its unique geography and circumstances.

The issues of poor case mix and disruption of hospital operations are best addressed by considering the impact of verification/designation on hospital functions. For a hospital that is already caring for trauma patients, the introduction of a trauma system will likely mean an overall increase in the efficiency of caring for these patients, secondary to improvements required in the verification process. Decreased ICU and hospital length of stay, lower resource consumption and lower rates of complications will improve hospital bottom lines while increasing patient and provider satisfaction.

Physician concerns should be carefully addressed as a functional trauma system requires broad physician support. This is especially true for the specialties of general surgery (including pediatric surgery), orthopedic surgery, neurosurgery, anesthesia and emergency medicine. The Anchorage area hospitals have ample physician specialization to provide optimal care with the following estimated numbers:

- 30 surgeons, many sub-specialized.
- 40 orthopedists
- 6 neurosurgeons
- 4 cardiac surgeons
- 2 pediatric surgeons

Education can alleviate the concerns that trauma patients are more litigious than average.

The concerns regarding reimbursement and work hours are real and require more focused solutions. Trauma patients do, in fact, have higher rates of uncompensated care than elective patients in almost all regions of the United States. They are also more likely to arrive during evening and night hours.[4] The specific concerns of physicians should be acknowledged and actions should be taken to address them. For hospitals, actions may include one or more of the following options:

- Provide an on-call stipend to cover the perceived burden of trauma call. This would include high volume specialists who are not ordinarily in-house and who agree to participate in the activities of the trauma center, including performance improvement and continued medical education (CME). Most frequently this would include general surgery, orthopedics, and neurosurgery.

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- Recruit one or more trauma/surgical critical care specialists to provide the core trauma care functions. Such individuals would support the private physicians and decrease their burden by providing back-up, assuming the care of patients admitted to the hospital, and taking responsibility for organizing the requisite activities for verification. By providing an actual trauma service with a specialized team led by a trauma/surgical critical care boarded specialist, the community surgeon can transfer patient care the following morning and feel confident the patient will receive state-of-the-art care. This frees the private physician to continue with his/her surgical practice. The specialist-led trauma service would improve care by decreasing variability, complications, length of stay and dissatisfaction.
- Support the private physicians through CME expenses, liability coverage, or a fund to cover a portion of uncompensated care exposure.

While this will require substantial financial support from hospital administration initially, the improvement in outcomes and the increase in patient and provider satisfaction should return at least a portion of the investment. Additional revenue through activation fees and state support would also contribute to deferring any start-up and readiness costs. Providing hospitals and physicians with financial support as part of a proposed inclusive trauma system plan will likely facilitate the adoption of trauma center verification/designation.

In addition, the implementation of an inclusive trauma system in Alaska with broad hospital participation would provide a critical element in disaster preparedness.[5] The vital role of trauma centers in support of disaster management should also be a central part of any funding requests to the legislature.

RECOMMENDATIONS:

- Verify/designate all the medical facilities in Anchorage who wish to provide trauma care at levels commensurate with these resources and commitment
- Develop city-wide trauma triage guidelines for Anchorage with further application to the needs of in-coming transfer patient.
    - Establish a predetermined plan that accounts for subspecialty needs of the patient matched with the hospitals' capabilities.
    - Establish trauma diversion guidelines with back-up plans.

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- Develop evidence-based trauma team activation criteria
    - Use the "status 1" only when there is prehospital physiologic evidence that the patient requires an immediate surgical response.
    - Start tracking surgical response times for "status 1" patients from time of notification. Benchmark to the ACS verification guideline of a surgeon being present on arrival of patient or within 15 minutes of notification. The threshold is to meet this 80% of the time.
    - Study outcomes associated with used of the criteria to further refine them for optimal patient outcomes with minimal physician encumbrance.
- Identify physician leadership – trauma champions
    - Encourage Level II trauma centers (or hospitals that seek to become Level II trauma centers) to consider recruiting a trauma/surgical critical care specialist who can provide a knowledgeable back-up for sub-specialized surgeons who may or may not be comfortable with caring for a multi-system critically injured patient.
- Develop trauma chart forms
    - Establish standardized trauma patient admission orders. Establish automatic orders for glucose monitoring and control, peptic ulcer prophylaxis, deep vein thrombosis prophylaxis and surveillance, head injury protocols, etc.
    - Ensure that trauma history and physical forms have prompts for problem documentation areas such as Glasgow Coma Scale scores, procedures performed, notification and arrival times, critical care times, etc.
- Address finance issues
    - Encourage medical facilities to invest in the trauma service to obtain and maintain verification/designation.
        - Recruit and retain trauma/critical care specialists.
        - Initiate discussions with general surgeons to identify their needs to be able to provide the call coverage and to identify patient care issues.
        - Track costs that can be recouped by improved patient length of stay, decreased cost of care, and the value of improved medical staff satisfaction.
    - Charge trauma activation fees (can only be charged by verified/designated centers).
    - Seek legislation to include assistance for uncompensated care and readiness fees for verified/designated trauma centers.

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2. How can Alaska better coordinate resources, especially air medical, for every day trauma responses, as well as disaster response?

Assessment:
Alaskans depend on aircraft for routine travel and medical transport, especially those who reside in the isolated two-thirds of the state without roads. At any given place or time, local providers are familiar with local resources available, but may not know about back-up resources available in the region. Local providers may then be challenged to make multiple calls when their primary local air medical resource is not available.

Coordinating trauma care resources in the state of Alaska requires current knowledge of the status of those resources, e.g., personnel, equipment, communication, facilities. To date, a comprehensive needs or resource assessment of the trauma system has not been conducted. While some of this information is available, such as for facilities, it is lacking for other aspects of the trauma system, such as air medical resources.

Policy Development:
Once an air medical resource assessment has been completed, information collected about all trauma system resources (including military, National Guard, and Coast Guard) should be organized by region and made available to users in an easily retrieved format. A central coordination center could then be created to track the air medical assets available and in use throughout the state, and this information could potentially be available on-line. Likewise, the EMS regions could develop and maintain a regional resource information database that could be updated regularly.

The next step could be the establishment of a regional "one call does all" service. Such services could assist a referring provider to obtain the aircraft that matches the patient's need and local landing restrictions. The regional service could also help direct community-based air medical resources to available and appropriate facilities and assist in the coordination of ramp transfers. The "one call does all" concept includes the identification of the receiving trauma facility that best matches the patient's needs.

The regional centers would feed information about the aircraft deployed to the central coordination hub. This coordination hub would be useful in a state disaster, and could potentially be maintained by the state's emergency management system. This type of statewide system status coordination hub would need to be operable and accessible at all hours and be updated in near real-time.

Another problem that the state faces is the lack of comprehensive guidelines for the indications of air medical transport. The reality is that urgent or even routine, non-emergent medical care not available in the local community may require air

travel. Development of guidelines will help ensure the optimal use of the air resources in a safe and efficient manner.

Assurance:

This service could optimize resource utilization locally and statewide on a continuous basis. Performance improvement could be conducted using trauma registry data to determine changes in time to transfer, and appropriateness of facility selection.

Recommendations

- Decrease patient transfer times by developing a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (e.g., load capacity, instrument rating, and landing requirements).
    - Monitor the availability and location of air resources.
    - Provide availability status to users.
    - Coordinate air medical resources in a disaster situation.
- Develop regional system status databases of current trauma resources that are utilized to provide a 'one call does all' service for referring providers and support a statewide trauma resources data bank.
- Develop a state registry for disaster volunteers, similar to the Emergency System for Advanced Registration of Volunteer Health Professionals.
- Update and keep current the Trauma Triage, Transport and Transfer Guidelines.
- Use the Guidelines for the Management of Head Injuries in Remote and Rural Alaska as a template to develop other transport guidelines to optimize resources.
- In more populated areas with more than one healthcare facility, develop a tracking system of real time bed capacity for time sensitive diseases (trauma, ST elevated myocardial infarction [STEMI], stroke, etc.) and share that information with EMS dispatch in order to prevent delays or mistakes in patient destination (right patient to right facility).

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Acronyms and Glossary

AAC - Alaska Administrative Code
ACEMS - Alaska Council on Emergency Medical Services
ACS – American College of Surgeons
ACS-COT- American College of Surgeons Committee on Trauma
ALS – advanced life support-+
ATAC - Alaska Trauma Advisory Committee
ATLS – Advanced Trauma Life Support

BIS – Benchmarks, Indicators, and Scoring
BLS – basic life support

CARF - Commission on Accreditation of Rehabilitation Facilities
CDC – Centers for Disease Control
CHAs – Community health aides
CME – continuing medical education

DHSS – Department of Health and Social Services
DOT – US Department of Transportation

EMS – Emergency Medical Services
EMSC – Emergency Medical Services for Children
EMTs – Emergency medical technicians

FTE – full-time equivalent

HRSA - Health Resources and Services Administration

ICU – intensive care unit
IPEMS – Injury Prevention and Emergency Medical Services Section

MICPs – Mobile intensive care paramedics
MPH – Master of Public Health degree

NEMSIS – National EMS Information System
NIOSH - National Institute for Occupational Safety and Health
NSC – National Standard Curriculum for EMTs
NTDB – National Trauma Data Bank
NTDS – National Trauma Data Standard

PHTLS – Prehospital Trauma Life Support

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SCI – spinal cord injury
STEMI - ST-Segment Elevation Myocardial Infarction
STIPDA – State and Territorial Injury Prevention Directors Association

TBI – traumatic brain injury
TNCC – Trauma Nurse Core Curriculum
TSC – Trauma system consultation
TSRC - Trauma System Review Committee

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Alaska Council on Emergency Medical Services (ACEMS)

The mission of the Emergency Medical Services program in Alaska is to reduce both the human suffering and economic loss to society resulting from premature death and disability due to injuries and sudden illness. The Governor's Alaska Council on Emergency Medical Services, also known as "ACEMS," provides the Commissioner of the Department of Health and Social Services and the Governor with recommendations related to all aspects of EMS, including distribution of funding, and policy development. The Council:

- brings together technical resources, experience, and knowledge to assist and advise on the continued development of the EMS and trauma system in Alaska;
- advises the state EMS staff and EMS regional directors regarding public education and generation of broad community support for the goals of the EMS program;
- provides recommendations regarding EMS program policy and priorities; and
- reviews EMS or EMS-related program proposals on request of the Commissioner of the Department of Health and Social Services, the Director of the Division of Public Health, and Section of Injury Prevention and EMS staff.

ACEMS was established by Alaska Statute 18.08 and meets two times a year to take action on issues affecting EMS in Alaska.

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Alaska Council on Emergency Medical Services
As of 9/2008

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VACANT *Emergency Nurse Position* *Term Expires 11/05/09*	
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Ken Zafren, MD 10181 Curvi Street Anchorage, AK 99516 PH# FAX# zafren@alaska.com Appointed: 10/21/01	State EMS Medical Director

REGINALD A BURTON, MD, FACS- TEAM LEADER

Dr. Burton started his Trauma career while in high school when he got his first EMT certification. He worked as an EMT throughout college and medical school to offset his tuition. He and his wife, Dr. Snyder, moved to Ohio after finishing his residency in Surgery in 1992.

Dr. Burton was very active in the establishment of the Trauma System in Ohio. He developed and was the Trauma Director of the first ACS verified level III trauma center in Ohio, while continuing to participate in trauma call at the Level I trauma center in Dayton. He gave numerous lectures throughout the state on trauma center development, trauma center Performance Improvement programs, and EMS/Hospital integration of trauma plans. He became the medical director for the Fire/EMS services in two surrounding cities and sat on the regional EMS Council. He was the Co-Chairman of the Southwest Ohio Regional Trauma System from 1997 until 2002. He was the Chairman of the Region 2 Physician Advisory Board to the Ohio State Trauma Board for 5 years until he moved to Nebraska. He sat on the Data Committee of the Ohio Trauma Board during the statewide trauma registry development, and helped work out many issues enabling it to start functioning 2000.

Dr. Burton took a sabbatical and did a Trauma/Surgical Critical Care Fellowship at the renowned R. Adams Cowley Shock Trauma Center in Baltimore Maryland in 2006-7, and is currently the Director of Trauma and Surgical Critical Care at Bryan LGH Medical Center in Lincoln, Nebraska. He is a Clinical Associate Professor in Surgery at the University of Nebraska. He is the Medical Director of Region 2 in the Nebraska Statewide Trauma System, Chair of the Nebraska Statewide Trauma Data and Performance Improvement Committee, and the author of the Nebraska Trauma Performance Improvement training workshop. His team developed a web-based trauma registry reporting system that has enabled small critical access hospitals in rural Nebraska to report their trauma data to the Nebraska Statewide Trauma Registry, and thus also to the National Trauma Data Bank.

Dr. Burton has been a site visitor for the ACS Verification Committee since 2000. He became the Chairman of the Nebraska ACS Committee on Trauma in 2002, and is the current Regional Chief of Region 7(Nebraska, Kansas, Missouri, and Iowa). Dr. Burton was also involved in the ACS Political Action Taskforce briefing on trauma issues to state senators and congressmen in Washington, D.C. in March, 2005. He was the ACSCOT representative to the National EMS Workforce Stakeholders Meeting and the HHS State Trauma Leadership meeting in 2006. He represented rural trauma physicians in the National Rural Health Association's meeting with federal partners in Washington, D.C. this year. Dr Burton has always been an outspoken advocate for Trauma System Development.

JANE W. BALL, RN, DRPH

Dr. Jane W. Ball served as the Director of the National Resource Center (NRC) at the Children's National Medical Center in Washington, D.C. from 1991 through 2006. The NRC provided support to two Federal Programs in the U. S. Department of Health and Human Services' Health Services and Resources Administration (HRSA): the Emergency Medical Services for Children (EMSC) Program and the Trauma-Emergency Medical Services Systems Program. As director of the NRC, she coordinated the support provided to the Federal Program Directors as well as the provision of technical assistance to state grantees. Support to the Federal Program Directors often included meeting facilitation, preparation of special reports (such as the Model Trauma Systems Evaluation and Planning document), and consultation on Program issues. Technical assistance often included strategic planning, providing guidance in securing funding, developing and implementing grants, developing injury prevention plans and programs, building coalitions, shaping public policy, conducting training, and producing educational resource materials.

Dr. Ball has authored numerous articles and publications as well as several health care textbooks, including Mosby's Guide to Physical Examination (6 editions), Child Health Nursing (first edition), Pediatric Nursing: Caring for Children (4 editions), Maternal and Child Nursing (2 editions), and Pediatric Emergencies: A Manual for Prehospital Care Providers (2 editions). One of these texts, Pediatric Nursing: Caring for Children, received the1999 and 2001 Robert Wood Johnson Foundation Last Acts Coalition Outstanding Specialty Book Award. As an expert in the emergency care of children, Dr. Ball has frequently been invited to join committees and professional groups that address the unique needs of children.

Dr. Ball recently completed her term as the President of the National Academies of Practice, an organization composed of distinguished health care practitioners from 10 disciplines that promote education, research, and public policy related to improving the quality of health care for all through interdisciplinary care. She currently serves as the organization's Immediate Past President.

Dr. Ball graduated from the Johns Hopkins Hospital School of Nursing. She obtained her master's degree and doctorate in Public Health from John Hopkins University School of Hygiene and Public Health. She is a Certified Pediatric Nurse Practitioner.

SAMIR M. FAKHRY, MD, FACS

Dr. Fakhry graduated from the American University of Beirut, School of Medicine in 1981. He completed his residency in general surgery and his fellowship in critical care and trauma at the University of North Carolina at Chapel Hill and North Carolina Memorial Hospital, Chapel Hill, N.C. in 1987.

From 1988 until 1991 he led the trauma program as Director for Trauma Services at George Washington University Medical Center in Washington D.C. In 1991, he accepted a position as Director, Surgical Critical Care Services at UNC Hospitals in Chapel Hill, NC. While at UNC, he rose to the rank of Associate Professor of Surgery with Tenure and was awarded several teaching awards by the medical students and the surgical residents. He remained there until 1997 when he was recruited to the Inova Regional Trauma Center at Inova Fairfax Hospital in Falls Church, Virginia as the Chief of Trauma Services.

Since 1997 he has held the position of Chief, Trauma and Surgical Critical Care Services at the Inova Regional Trauma Center. Additionally, he holds the positions of Associate Chair for Research and Education, Department of Surgery; Medical Director for the Inova Regional Trauma Center Injury Prevention Program; Professor of Surgery, VCU, Inova Campus; Clinical Professor of Surgery at Georgetown University School of Medicine; and is the immediate past Chair of the American College of Surgeons Washington DC Committee on Trauma.

Dr. Fakhry has been heavily involved in trauma and surgical critical care research. He has numerous peer-reviewed publications, abstracts and book chapters to his credit. He is a member of many national societies and serves on several national committees and boards. He is a frequent speaker locally as well as nationally.

Dr. Fakhry maintains a high interest in all aspects of trauma. He has been Principal Investigator (PI) for the Crash Injury Research and Engineering Network (CIREN) Center at Inova Fairfax Hospital since May, 2000. With injury prevention as a goal he has worked closely with The National Highway Traffic Safety Administration (NHTSA), automobile manufacturers and bio-engineers to help produce safe vehicles. In addition to the CIREN project, he has been awarded funding for numerous projects in areas of injury prevention, surgical critical care and trauma. These include medical informatics applications, head trauma, intestinal injury, aggressive driving, teen DUI prevention and surgical education.

DREXDAL PRATT

Chief Drexdal Pratt heads the Office of Emergency Medical Services in the Division of Health Service Regulation of the North Carolina Department of Health and Human Services. His agency manages Emergency Medical Services and Trauma and the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Cooperative Agreement.

Mr. Pratt is a graduate of the Institute of Government at the University of North Carolina at Chapel Hill, the EMS Management Institute at the University of North

Carolina at Charlotte, and Forsyth Technical Community College. He is also a Certified Emergency Manager (CEM) and a Certified Public Manager (CPM).

Mr. Pratt joined the North Carolina Office of Emergency Medical Services in 1987 as a Regional Coordinator. He was promoted through the ranks, first to Regional Supervisor, and then to Chief of the agency in 1999.

Mr. Pratt served two terms as Chair of the Region I EMS Advisory Council. He received the National Association of County Commissioner's Achievement Award for coordinating the development of the Stokes County NC computer-aided dispatch program.

Currently, Chief Pratt serves as a Commissioner on the Governor's State Emergency Response Commission and serves as Chairman of the Commission's Homeland Security Medical Committee. In addition, Mr. Pratt serves as Chairman of the NC Hospital Preparedness Committee.

NELS D. SANDDAL, MS, REMT-B

Mr. Sanddal is currently the president of the Critical Illness and Trauma Foundation (CIT), in Bozeman, Montana. CIT is a non-profit organization dedicated to improving the outcomes of people who are injured in rural America through programs of prevention, training, and research. He recently completed a detachment as the Director of the Rural EMS and Trauma Technical Assistance Center which was funded by the Department of Health and Human Services, Health Resources and Services Administration. Mr. Sanddal worked as the training coordinator for the EMS and Injury Prevention Section of the Montana Department of Public Health and Human Services in the late 1970's. He has served as the Chairperson of the National Council of State EMS Training Coordinators and as the lead staff member for that organization, as well as the National Association of EMT.

Mr. Sanddal has been a co-investigator for six state or regional rural preventable trauma mortality studies and has conducted research in the area of training for prehospital and nursing personnel as well as in rural injury prevention and control. He is a core faculty member for the NHTSA Development of Trauma Systems course and has conducted several statewide EMS assessments for NHTSA. Mr. Sanddal served on the IOM Committee on the Future of Emergency Care in the U.S.

He received his EMT training in Boulder, Montana, in 1973 and has been an active EMT with numerous volunteer ambulance services since that time. He currently responds with the Gallatin River Ranch Volunteer Fire Department where he serves as the Medical Officer and Assistant Chief.

He completed his undergraduate work at Carroll College, received his Master's degree in psychology from Montana State University and is currently completing his doctorate in Health and Human Behavior from Walden University.

JIM UPCHURCH, MD, MA, REMTP

Dr. Upchurch began his medical career in 1971 as a Special Forces Medic courtesy of the US Army. He graduated from the University of Texas Medical Branch at Galveston in 1982 and completed a Family Practice residency from the University of Oklahoma in 1985. Since 1985, he has served as an Indian Health Service (IHS) Physician on the Crow Indian Reservation in Montana. The majority of his clinical practice involves emergency medicine (EM), Emergency Medical Services (EMS), surgery and obstetrics. He maintains current National Registry certification and state licensure as a paramedic. In 2003, he completed a masters degree in educational technology from George Washington University.

Dr. Upchurch is a long-standing member of the National Association of EMS Physicians and the American College of Emergency Physicians. Since 1986, he has functioned as EMS medical director for Big Horn County in Montana and guided their basic care program to the advanced life support level, including critical care interfacility transport. He also provides EMS medical direction for Big Horn Canyon National Park and the Incident Medical Specialist Program, US Forest Service, Region I.

Dr. Upchurch is director of a small non-profit organization, EMS Education & Training. They offer distance and face-to-face educational opportunities to rural and frontier EMS personnel in Montana who desire to advance their level of care. He is an active ACLS, ACLS EP, ATLS and PHTLS instructor. Recently, he authored the Geriatric chapter for the sixth edition of *Nancy Caroline's Emergency Care in the Streets*, released in 2007.

Although Montana has no recognized state EMS medical director, Dr. Upchurch has served in that function for many years and represents Montana on the National Council of State EMS Medical Directors of the National Association of State EMS Officials. He functions at the IHS national level as a consultant on EM and EMS issues. He also sits on the Montana Board of Medical Examiners and on the board for the Critical Illness and Trauma Foundation.

JOLENE R. WHITNEY, MPA

Jolene R. Whitney has worked with the Bureau of Emergency Medical Services, Utah Department of Health for 27 years. She spent the first 6 years of her career as a regional EMS consultant. She became Assistant Training Coordinator in 1986. She has been a program manager for EMS systems and trauma system development since 1991. She is currently a Deputy Director for the Bureau of EMS and Preparedness, which includes Trauma System Development, Chemical

Stockpile Emergency Preparedness, Hospital Disaster Planning, ED, Trauma and Pre-hospital databases, EMS Licensing and Operations, CISM, and EMS for Children.

She spent 250 hours in the Olympic Command Center, serving as an EMS liaison for the 2002 Winter Olympics in Salt Lake City, Utah. She has been involved with all aspects of EMS including ambulance licensure, EMS councils, certification and training, computer testing, and curricula development. She has experience in statute and rule development, grant writing, system plan development, coalition building, and disaster preparedness. She has served on several national committees and teams, including a state EMS system assessment for NHTSA, reviewing rural trauma grant applications, developing the HRSA model trauma system plan and the NASMESO trauma system planning guide, and the NHTSA curriculum for an EMT refresher course.

Jolene has a Masters in Public Administration from Brigham Young University and a B.S. in Health Sciences, with an emphasis in Community Health Education from the University of Utah. She was certified as an EMT-Basic in 1979. She also obtained certification as an EMT instructor and became certified as an EMT III (Intermediate) in 1983. She has attended numerous conferences, courses, and workshops on EMS, trauma and disaster planning and response. She also completed a course for investigator training from CLEAR. Jolene is a co-author of three publications on domestic violence and hospital surge capacity planning.

She is the current Chair for the National Council of State Trauma System Managers/NASEMSO. She is a member of the American Trauma Society, previous member of the National Association of State EMS Training Coordinators.

In 2005, she was nominated by her staff and received a Utah Manager of the Year Nominee Award from the Governor. She also received recognition from the Utah Association of Emergency Medical Technicians in 2006.

Appendix B: List of Participants

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TraumaSystems evaluation & planning committee

American College of Surgeons
Trauma Systems Consultation
November 2nd-5th, 2008

Name	Title	Organization
Abbott, Sally	SOA Preparedness Coordinator	SOA (State of Alaska)
Allard, Faith	RNFP Director	SOA
Andraschko, Andrea	Communication Specialist	ARH (Alaska Regional Hospital)
Barros, Nancy	SOA Program Manager	SOA
Bowman MD, J. Dani	Pediatrician	ANMC (Alaska Native Medical Center)
Brown MD, Ken	Planning Manager	BRH (Bartlett Regional Hospital)
Bryson, George	Staff Writer	Anchorage Daily News
Bundy, Tim	Section Chief, EMS	IPEMS (Injury Prevention & Emergency Medical Services) SOA
Butler MD, Jay	Chief Medical Officer	SOA- DHSS
Carr, Pat	Section Chief	SOA Health Planning and Systems Development
Chennault MD, Regina	Surgeon	ANMC
Coopes MD, B.J.	Director of Pediatric ICU	TCHAP (The Children's Hospital at Providence)
Crum RN, Bev	ER Manager	Ketchikan General Hospital
Davis, Rick	COO	ARH (Alaska Regional Hospital)
Derring RN, Shelly	Director of Clinical Operations	Airlift Northwest
DeGreef RN, Margie	Assistant with Administrative Services	PKIMC (Providence Kodiak Island Medical Center)

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Name	Title	Organization
Fisher, Bryan	Chief of Operations	ADHSEM (Alaska Division of Homeland Security and Emergency Management)
Funk, Beth	State Epidemiologist	DHSS (SOA Department of Health and Social Services)
Gariepy RN, Debbie	TNC- Nurse	ARH
Gilkey, Ed	Chief Physician Executive	ANMC
Godfrey, Gerad	Chair	Violent Crimes Compensation Board
Goodrich, Craig	Fire Chief	Anchorage Fire Department
Greenberg MD, Matt	ED Director	YKHC (Yukon Kuskokwim Health Corporation)
Hecks, Sue	Director	Southern Region EMS
Hilgendorf, Rebecca	Acting Director	DSDS (Division of Senior and Disabilities Services) SOA
Hoebelheinrich MD, S. Roger	MD	CPGH (Central Peninsula General Hospital)
Hull-Jilly, Debra	IPU Unit Manager	IPEMS (Injury Prevention & Emergency Medical Services) SOA
Ives, George	Program Manager	PH- SOA
Jessop, Dan	Administrator	ANMC
Johnson, Mark	Volunteer	Former SOA Section of Community Health and EMS
Lamb, Ed	CEO	ARH
Lamoureux, Bruce	Senior Administrator	PAMC (Providence Alaska Medical Center)
Leemhuis RN, Mary	Trauma Program Manager, Nurse	ANMC
Leighty, Bobbi	Director of SE Region EMS	SEREMS (S.E. Region EMS)
Lerner MD, Deborah	Pediatrician	PAMC
Levy MD, Mike	Emergency Medicine Physician	ARH
Mackin, Jim	Preparedness Director	SOA/DHSS

Name	Title	Organization
Mandsager MD, Richard	TCHAP Director	PAMC
Maskay, Raj	Public Health Specialist	Section of Injury Prevention and EMS, SOA
Molitor RN, Jeanne	Course Director	SOA
Olliff, Terry	EMS Unit Manager	SOA IPEMS
Parks MD, Stephen	MD	PAMC/Lifemed
Poggi, Stephen R.	EMS	AFD (Anchorage Fire Department)
Potashnik, Dave	Emergency Medical Service Officer/Assistant Chief	North Slope Borough Fire Department- Barrow
Potts, Joanne	Program Manager	ARH
Robinette MD, Danny	MD	Northern Alaska Medical Surgical
Sacco MD, Frank	Trauma Systems Review Committee Chair/Surgeon	ANMC
Scandling, Bruce	Program Manager/Legislative Liaison	SOA Division of Public Health
Searles MD, Grant	MD	Anchorage Surgical and Bariatric
Simonsen RN, Barb	State Trauma Analyst/Nurse	IPEMS
Smith MD, Linda	ED Physician	ARH
Somervell, Philip	Epidemiologist	NIOSH (National Institute for Occupational Safety and Health)
Thompson RN, Mary	Trauma Program Managaer	PAMC
Wilder MD, Norman	Chief Medical Officer	ARH
Wooley, Bev	Director PH, DHSS	SOA
Zafren MD, Ken	SOA EMS Medical Director	SOA

8
APPENDIX

Objectives and Methodology

- The Coalition for American Trauma Care commissioned Harris Interactive to conduct a survey of the public's views of and support for trauma systems.
- Telephone interviews were conducted with a nationally representative sample of 1000 adults aged 18 and over, between November 3rd and 14th, 2004.
- Final data were weighted by age, education, gender, income, and region, where necessary, using 2003 Current Population Survey data to adjust for sampling biases, if any.
- With 1,000 respondents, the sampling error is +/- 3%.

Key Topics

- Knowledge about leading causes of death
- Perceived value of and expectations about trauma centers
- Perceived value of and expectations about trauma systems
- Willingness to support funding of trauma centers and systems
- Disaster preparedness and trauma systems

Harris Interactive Ground Rules For Publicly Released Surveys

- Harris Interactive Inc. has very strong ground rules for surveys which may be publicly released. No other survey firm has stronger rules.
- Our **Five Rules** ensure that our surveys are never used to lead or mislead policymakers or the public. We do not do "hired gun surveys."
  1. **The survey must be fair, balanced and comprehensive.**
  2. **If the survey is publicly released, the full survey report must be released.**
  3. We will not include questions for possible publication about our clients' company or their products or brand names, or the names of their competitors. (The one exception: we sometimes do readership surveys or audience measurement surveys which ask about our clients.)
  4. **The survey must not be used to mislead the public, the media, policymakers or anyone else.**
  5. **We need to review the information that is being released prior to its release in order to check for accuracy.**

Overview

- Most Americans are not aware that injury is the leading cause of death for children, youth, and adults under the age of 34.
- After hearing a description of a trauma center, Americans value them highly and appreciate the importance of having one within easy reach.
  - Almost all Americans feel it is extremely or very important to be treated at a trauma center in the event of a life-threatening injury.
  - Nearly nine in ten Americans think it is extremely or very important for an ambulance to take them to a trauma center in the event of a life-threatening injury, even if it is not the closest hospital.
  - Nearly all Americans *believe* that if they had a serious or life-threatening injury, they *would* be taken to the hospital that is best equipped to handle their specific injury in less than 1 hour.
- Majorities of Americans feel that having a trauma center nearby is as important as or more important than having a Fire Department or Police Department.

Overview (cont.)

- After hearing a description of a trauma system, nearly all Americans recognize the importance of having a trauma *system* in place in their state.
- Large majorities feel that having a trauma *system* in place is as important as or more important than having State Police or HAZMAT teams.
- About two in three Americans would be extremely or very concerned if they learned that the trauma system in their state did not meet recognized standards. (*However, a 2002 survey of the status of trauma system development conducted by the Health Resources and Services Administration of the U.S. Department of Health and Human Services shows that only 8 states have fully developed trauma systems, 12 states do not have the authority to designate trauma centers, and the rest are in varying stages of partial development.*)
- Americans are willing to spend their own money to have trauma centers and systems in place in their states.
- Generally, Americans have high expectations of their states' trauma centers and systems when it comes to handling natural disasters or terrorist attacks.

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

October 13, 2008

Regina Chennault, MD
Frank Sacco, MD
4315 Diplomacy Drive
Anchorage, AK 99508

Via fax: 729-2746

RE: Alaska Trauma System

Dear Drs. Chennault and Sacco:

Thank you, Dr. Chennault for presenting at the ASMA House of Delegates Meeting on Saturday, September 27, 2008.

By consensus the ASMA HOD supported the concept of an appropriate trauma system for Alaska. However, the proposal recommended that there be a $500,000 cap on all damages for treatment of trauma patients in a state certified trauma center. The HOD recommended that be dropped from your proposal as any cap on economic damages would likely be found unconstitutional in Alaska. Additionally, the HOD also recommended that the proposal be amended to provide for a mechanism to directly compensate physicians for providing treatment for uninsured trauma patients in a state certified trauma center. (This would be for physicians who are not employees of that certified trauma center).

Several individual HOD members also suggested that you may wish to explore Alaska's "Good Samaritan" laws in lieu of any special economic damages caps which, as previously stated, are constitutionally problematic.

Please let me know if I may be of any future assistance.

Sincerely,

By: James J. Jordan, Executive Director
For: The Alaska State Medical Association

CC: John Raster, MD, Speaker of the House
Tom Vasileff, MD, President
J. Ross Tanner, MD, Immediate Past President

NATIONAL CONFERENCE of STATE LEGISLATURES

IN DEPTH
STATE HEALTH *NOTES*

Volume 27, Issue 461 February 20, 2006

PREPARING FOR THE WORST: STATES ADDRESS TRAUMA CENTERS' TROUBLES

By Christina Kent

Victims of traumatic events are at least 25 percent more likely to live if they're taken to a certified trauma center than if they are taken to a non-trauma center, according to a carefully controlled, nationwide study in the Jan. 26 *New England Journal of Medicine*.

That finding could give a boost to state legislators who are scrambling to find new sources of funds for the centers, which provide care for the most expensive conditions in the nation. In January, the Agency for Healthcare Research and Quality reported that trauma disorders have become, for the first time, the most expensive condition to treat. According to the agency's Medical Expenditure Panel Survey, trauma-related disorders cost the nation $71.5 billion in 2003 – topping the cost of treating heart conditions ($68 billion), cancer ($48 billion), mental disorders ($47 billion), and cardiopulmonary disease and asthma ($46 billion).

Trauma centers differ from general hospital emergency departments in that they provide, on a 24/7 basis, teams of trauma surgeons, plastic surgeons and other specialists who can deal with the most severe injuries within the "golden hour" – the early period of trauma where skilled intervention may mean the difference between life and death or life-long disability. The centers are capable of dealing with the most severe, life-threatening injuries, including blunt force wounds, multiple internal injuries, burns, broken bones and severe shock.

"Trauma is the number one killer of people aged one to 40," said Dr. J. Wayne Meredith, chairman of the American College of Surgeons' trauma committee. "One of the most prominent tools to prevent those deaths is the trauma system."

The nation's approximately 600 regional trauma centers – which also are often public and teaching hospitals – collectively lose $1 billion a year, according to Connie Potter, executive director of the National Foundation for Trauma Care. And they're facing growing pressure from rising health-care costs, increases in the number of un- and underinsured patients, and physicians' growing unwillingness to provide on-call trauma care, which many regard as underpaid and highly risky (because of possible malpractice lawsuits).

A 2004 report by the Foundation says that, without corrective action, the current rate of closures among the nation's trauma centers will increase, and 10 percent to 20 percent will close within three years.

Preventing Closures

States play an enormously important role in providing trauma care. Not only do they pass legislation authorizing state agencies to design trauma systems, but they strive to keep the trauma centers functioning by channeling to them special funding streams.

Since car crashes are the number one cause of trauma (see chart), many states elect to help pay for trauma care by imposing fines on individuals who are convicted of drunken or reckless driving, or who lose their driver's

license. Some states also use revenues from tobacco, alcohol or firearms taxes, while others tax auto insurance or fine persons convicted of illegal drug distribution.

A number of states are currently considering legislation to shore up their trauma centers; some bills would address the crisis in getting physicians to provide on-call trauma care by increasing their reimbursement.

In New Mexico, HB 356 and SB 356, introduced at the behest of Gov. Bill Richardson, would provide $6 million to create a trauma system fund. Of that amount, $4 million would go to support trauma services at the University of New Mexico hospital and $2 million would go to strengthen the trauma system throughout the state.

In Hawaii, the Legislature is considering HB 3142, which states that Hawaii's "extreme isolation and limited physician re-supply capability renders Hawaii uniquely vulnerable to natural disasters that may occur in a mid-Pacific environment." The bill would create a fund to reimburse the state's only trauma center for documented un- or under-compensated care (including supplemental funding for treatment given to Medicaid beneficiaries). The fund would draw money from state surcharges, the state's environmental response revolving fund, as well as any funds that are separately appropriated by the Legislature or granted by Congress (as long as they don't place an obligation upon the Legislature to continue the purpose for which the federal funds are made available).

In Florida, HB 1697 and HB 497 were signed into law in 2005 after first being vetoed by the governor, who reportedly had concerns about the way the funds were to be distributed. The first bill is expected to raise as much as $4.7 million annually for the state's trauma centers by increasing the penalties for motorists who cause serious injuries (they now will be charged $500) or fatalities ($1,000) in traffic accidents.

The second bill will provide new funding for in-state trauma care by increasing the fine for running a red light from $60 to $125. Florida's 20 trauma centers incur an annual net loss of $96 million, said Amy Maguire, director of the Alliance to Save Florida's Trauma Care. The funds will be distributed to the hospitals based on their state of "readiness" (e.g., how many physicians are on call), and the severity and volume of injuries treated.

Pennsylvania, which has one of the oldest trauma systems in the nation, is considering a bill (HB 502) that would seek to retain trauma providers by increasing their reimbursement. The bill notes that many high-risk health-care providers and institutions in the state are being paid less than Medicare rates by private insurers. "[H]igh-risk health-care providers and institutions may leave this Commonwealth or close down if the low reimbursements continue," the bill states. It would require insurers to pay 25 percent more than the Medicare fee to high-risk providers (defined as those who pay malpractice premiums in one of the four highest classes) for providing covered treatment to trauma patients at a state-accredited Level 1 or 2 trauma center – or the provider's "usual and customary charge," whichever is less.

If states play the primary role in creating trauma centers, the federal government historically also has contributed. For years, the Health Research and Services Administration's (HRSA) Trauma/Emergency Medical Services program provided grants to states to help them plan trauma systems. But the federal FY 2006 budget zeroed out funds for that program. It had been funded at about $3.4 million a year since 2001, Potter said, and grants to individual states had averaged about $40,000 per state.

Both Potter and Meredith were highly critical of the fact that the program was eliminated. "Having a federal agency that supports trauma care is critical," Meredith said. "It's the catalyst, the grist of the mill." Trauma costs the nation billions of dollars a year, he noted. "Spending $3 to $4 million to keep that on track seems like a pretty good investment to me." Repeated calls to HRSA for comment were not returned.

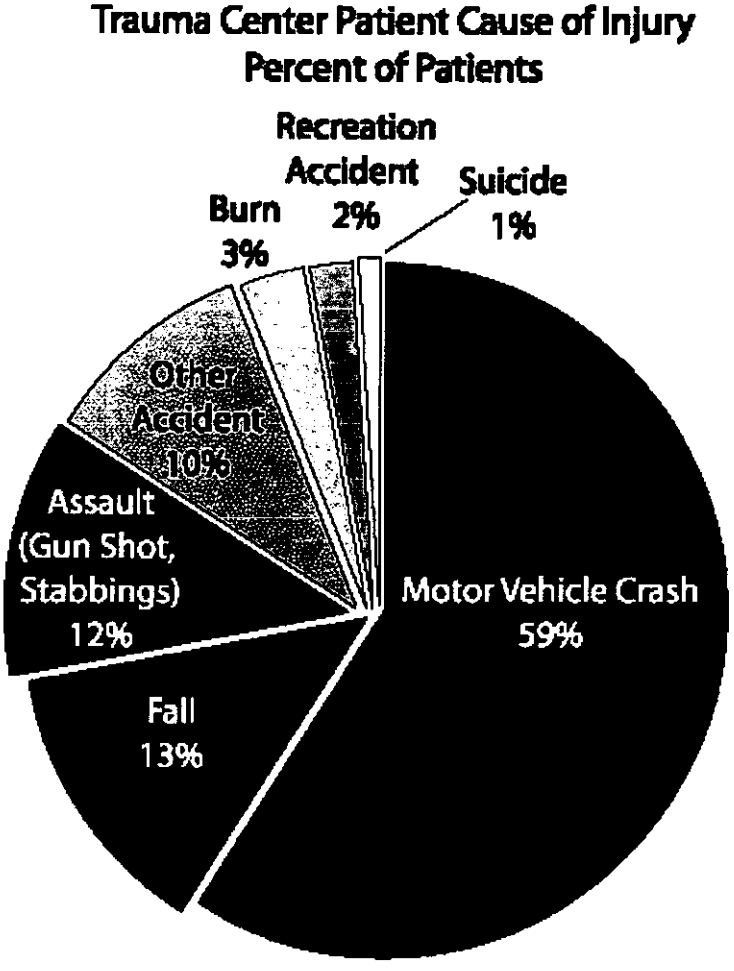
How Many?

September 11th and Hurricanes Katrina and Rita have raised the profile of trauma centers. But it's not clear how many centers the nation needs. A September 2005 issue brief by Charles Branas at the University of Pennsylvania notes that the geographic distribution of trauma centers varies widely across states and regions. Branas and colleagues calculated that 84.1 percent of the U.S. population has access to a Level 1 or 2 trauma center within one hour. (Level 1 and 2 trauma centers provide the most sophisticated care; Level 3 centers transport the most severely wounded patients to a Level 1 or 2 center.)

The Northeast has the greatest access, followed by the West, the Midwest, and the South. About 36.7 million people – most of whom live in rural areas – do not have access within one hour, Branas found.

A significant proportion of people could reach a trauma center within the "golden hour" by crossing state lines, Branas pointed out. As of 2005, 47 states had protocols to enhance interstate cooperation during mass casualty incidents, but just 31 states had standardized protocols for border crossing of day-to-day trauma patients.

Policymakers who are trying to evaluate their trauma systems can measure how long it takes their state's residents to reach a trauma center, in comparison to national norms, Branas suggested. This would enable policymakers to "more realistically allocate scare resources," he wrote.



Tara Lubin contributed reporting to this story.

(printer-friendly version)

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DRAFT

Summary of Trauma Systems and Funding Mechanisms by State

DRAFT

State	ACS Trauma System Consulation	ACS BIS Facilitation	Legislated Trauma System?	Is that System Funded?	Fines/Fees on Moving Violations	Fines/Fees on Other Criminal Penalities	Motor Vehicle Registration/License Plates or Driver's License Renewal Surcharge	Cigarette Excise Tax	Gambling	General Revenue Funds	Surcharge on 911 calls	Other	
Alaska	2008	575	Yes	No									
Alabama			No	No									
Arkansas	In Discussion		Yes	Yes				X					
Arizona	2007		Yes	Yes				X	X*				*Money to Level I only
California	2002*		No	Yes	X								*Marin County (San Rafel, CA)
Colorado	In Discussion		Yes	Yes			X						
Connecticut	2006		Yes	No									
Delaware			Yes	Yes				X					
District of Columbia	In Discussion		No	No									
Florida			Yes	Yes	X								
Georgia	2009		No	No						X*			* Not a permanent funding source.
Hawaii	2005		Yes	Yes				X					
Iowa			Yes	No									
Idaho			No	No									
Illinois	2006		Yes	Yes	X	X							
Indiana	2008		Yes	No									
Kansas		2008	Yes	Yes	X								
Kentucky			Yes	No									*No Permanent Funding Source
Louisiana		Possible 2009	Yes	No									
Massachusetts			Yes	No									
Maryland			Yes	Yes			X						
Maine			Yes	No									
Michigan			No*	No									*Development of System in Progress
Minnesota	2007		Yes	Yes						X*			*$ from General fund, but generated from a hospital license fee of all Hospitals & money from Dept of Health
Missouri			Yes	Yes			X					Weapons License, ATV registration, Boat registration	
Mississippi			Yes	Yes	X		X	X					
Montana	1999		Yes	No									
North Carolina	2004		Yes	No									
North Dakota	2008		Yes	No									
Nebraska			Yes	Yes			X						
New Hampshire			Yes	No									
New Jersey	2008		No	No									
New Mexico			Yes	Yes						X*			*Yearly Legislative Appropriation. The surcharges to to Pre-hospital/EMS.
Nevada	2004*		Yes	No									*Clark County (Las Vegas, NV)
New York			Yes	No									
Ohio	2002*		Yes	Yes		X							*Tri-State Trauma Coalition (Cincinnati, OH)
Oklahoma			Yes	Yes	X		X	X					
Oregon			Yes	Yes						X			
Pennsylvania	2007		Yes	Yes	X	X							
Rhode Island	2004		No	Yes	X								
South Carolina			Yes	No									
South Dakota			No	No									
Tennessee	2008		Yes	Yes				X					
Texas		2005*	Yes	Yes	X						X		*Southwest Region

Please Contact Mindy Baker, 312-202-5363 (mbaker@facs.org) State Affairs Associate with corrections/additions etc.

DRAFT

Summary of Trauma Systems and Funding Mechanisms by State

DRAFT

State	ACS Trauma System Consulation	ACS BIS Facilitation	Legislated Trauma System?	Is that System Funded?	Fines/Fees on Moving Violations	Fines/Fees on Other Criminal Penalities	Motor Vehicle Registration/License Plates or Driver's License Renewal Surcharge	Cigarette Excise Tax	Gambling	General Revenue Funds	Surcharge on 911 calls	Other
Utah		2005	Yes	Yes	X	X						
Virginia		2005	Yes	Yes	X		X					
Vermont			No	No								
Washington			Yes	Yes	X		X					Surcharge on sale or lease of a new vehicle
Wisconsin			Yes	Minimal						X*		
West Virginia	poss 2009		Yes	No								
Wyoming	2004		Yes	No								

*Partial funding for Trauma Coordinator position and $50, 000 for RTAC development and infrastructure

Please Contact Mindy Baker, 312-202-5363 (mbaker@facs.org) State Affairs Associate with corrections/additions etc.

Uncompensated Trauma Care by State

Arkansas	Tobacco Tax 56 cents Per Pack
Iowa	Tobacco Tax
Oklahoma	Medicaid Enhanced Rates State Trauma Fund $24 million Vehicle License Fees
Wisconsin	$1 Increase in Vehicle Registration Fees
Hawaii	$5 Registration Fee for EMS
Minnesota	General Fund $10 Failure to Wear Seatbelt Hospital License Fee (Base Fee Plus Per Bed Fee)
South Carolina	Trauma Fund-no Dedicated Funding Considering Surcharge for Seatbelt Violations, Drunk Driving, Alcohol Tax, Gun Tax
Texas	Surcharges on Drunk Driving and Reckless Driving to Trauma Fund
New Mexico	General Fund-Proposed 1% Fee on Home, Rental, Auto Insurance Policies
North Carolina	General Fund-HRSA Bioterrorism and Preparedness Money

Kentucky	Proposed 5% Tax on Guns and Ammunition
Kansas	Fees on Moving Violations Line Item
Florida	$5 Motor Vehicle Violation Fee Vehicle License Fees $25 Drunk Driving Charge
Rhode Island	$1 Surcharge on all Violations
Arizona	2.3 Million from DUI and Moving Violations
Massachusetts	Vehicle License Fees
Maine	Vehicle License Fees

TRAUMA LEGISLATION STICKS FROM OTHER STATES

State Mandated Designation
Hospital Licensure Dependent on Designation
Medicaid Reimbursement Rates Lower if Not Designated
Medicaid Reimbursement Rates Higher if Designated
Medicaid Eligibility Dependent on Designation

SB 172

4826

Comparison of Health Commission Authorizing Language

	Administrative Order #246	SB 172 Olson	HB 25 Hawker	HB 75 Cissna
Name	Alaska Health Care Commission	Alaska Health Care Commission	Alaska Health Reform Policy Commission	Alaska Health Commission
Purpose	"...to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state."	"...to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state."	"...to consider the entire spectrum of health care related issues in the state and formulate targeted and specific policy recommendations to be considered by the legislature and by the executive branch."	"(1) to consider the entire spectrum of health care related issues in the state and formulate targeted and specific policy recommendations to be presented to the legislature and the executive branch; (2) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and affordability of health care for all citizens of the state; and (3) to provide an annual report to the legislature that includes a comprehensive list of policy options considered by the commission."
Organizational Location	Department of Health & Social Services	Department of Health & Social Services	Department of Health & Social Services	Department of Health & Social Services
Authorizing Date & Sunset	• Took effect 12/4/08 • Technically in effect for one year unless extended; members appointed through April 2010	• Takes effect immediately on signature of the Governor • Commission expires 06/30/14	• Takes effect immediately on signature of the Governor • Authorizing legislation repealed 7/1/15	• Takes effect 7/1/09 • No sunset

4827

	Anna Oshie 2/4	SB172 - Olson	HB35 - Hawker	HB78 - Gruenn
Membership	• 10 Members (7 voting; 3 non-voting) • Appointed by the Governor : All voting Members and non-voting executive branch representative Voting Members • Chief Medical Officer DHSS (CHAIR) • Health care provider who is actively practicing profession and licensed in Alaska, and not affiliated with ASHNHA • Health care consumer Representatives of the: • Tribal health community • Alaska State Chamber of Commerce • Alaska State Hospital & Nursing Home Association (ASHNHA) • Health insurance industry Non-Voting Members Representatives of the: • executive branch • Alaska House of Representatives (appointed by Speaker of the House) • Alaska Senate (appointed by President of the Senate)	• 10 Members (7 voting; 3 non-voting) • Appointed by the Governor : All voting Members and non-voting executive branch representative • Staggered 3-year terms Voting Members • DHSS medical director (CHAIR) • Health care provider who is actively practicing profession and licensed in Alaska, and not affiliated with ASHNHA • Health care consumer (must be Alaska resident and may not be employed by or have a business in the health care industry) Representatives of the: • Tribal health community • Alaska State Chamber of Commerce • Alaska State Hospital & Nursing Home Association (ASHNHA) • Health insurance industry Non-Voting Members Representatives of the: • Office of the Governor • Alaska House of Representatives (appointed by Speaker of the House) • Alaska Senate (appointed by President of the Senate)	• 16 Members (11 voting; 5 non-voting) • Appointed by the Governor: All voting members and executive branch rep • 5-year terms Voting Members • DHSS Commissioner or Designee (CHAIR), plus • 10 members who have specialized training or experience and are recognized leaders in the members' field: o 3 members representing private health care interests o 3 members representing organizations that provide health care coverage, including ▪ An employer that provides employer-sponsored health insurance plan, ▪ A union that has a union health care trust, ▪ A 3rd party insurance provider o 2 members representing health care consumers o 1 member representing non-Native federal health care services o 1 member representing tribal health care services Non-Voting Members • 2 members from the Senate (appointed by President) • 2 members from the House (appointed by the Speaker) • 1 member appointed by the Governor	• 15 Members (all voting) • 3 members appointed by the Governor –health insurance industry rep, and two health care consumer/advocates. • Remaining members appointed by group they represent • Staggered 3-year terms • Chair annually elected by members Voting Members Representatives of: • AK Mental Health Trust Authority • UA health education and training programs • AK Native Tribal Health Consortium • AK Primary Care Association • AK State Hospital & Nursing Home Association • Health insurance industry • Alaska Nurses Association Plus • Health care consumer/advocate • Health care consumer/advocate who is a small business owner • 6 members of the legislature (2 majority and 1 minority caucus member from each body; at least 1 from each body must be HSS Committee member)

Duties	1. Serve as the state health planning and coordinating body; 2. Consistent with state and federal laws, provide recommendations for and foster the development of a: A. comprehensive statewide health care policy; B. strategy for improving the health of Alaskans that includes: i. encouraging personal responsibility in prevention and healthy living for all residents of the state; ii. a reduction in health care costs for all residents of the state to be below the national average; iii. access in communities of the state to safe water and wastewater systems; iv. the development of a sustainable health care workforce in the state; v. quality health care being accessible for all residents of the state; vi. increasing the number of residents of the state who are covered by health care insurance; and 3. Submit a report to the Governor and the Legislature on or before January 15, 2010 regarding the commission's recommendations and activities.	1. Serve as the state health planning and coordinating body; 2. Consistent with state and federal laws, provide recommendations for and foster the development of a statewide health plan containing the following: A. comprehensive statewide health care policy; B. strategy for improving the health of Alaskans that includes: i. encouraging personal responsibility for prevention, healthy living, and acquisition of health insurance; ii. reduces health care costs through • Enhanced market forces • Fraud reduction • Health information technology • Management efficiency • Preventative medicine • Successful innovations id'd by others • Other cost-saving measures iii. eliminates known health risks, including unsafe water and wastewater systems; iv. develops a sustainable health care workforce; v. improves access to quality health care; vi. increases the number of insurance options for health care services; and 3. Submit an annual report to the Governor and the Legislature by January 15 of each year regarding the commission's recommendations and activities.	1. Provide a public forum for the consideration and discussion of health policy alternatives; 2. develop, coordinate, and recommend to the legislature and to the governor health policy reform initiatives; 3. coordinate policy development with state, federal, and private sector interests that finance, provide, or regulate the delivery of health care; 4. coordinate health policy development among relevant state agencies; 5. develop policy recommendations to: (A) improve individual access to health insurance and health care services; (B) promote healthful life choices made by individuals; (C) contain health care costs; (D) enhance diversity of health care options; (E) improve quality of health care; (F) inform consumers; (G) meet current and future workforce needs in the health care industry; and 6. Develop viable financing proposals to support the commission's recommendations.	• Serve as the state health planning and coordinating body. • Provide recommendations for and foster the development of a statewide health plan containing the following: 1. a comprehensive statewide health care policy; 2. a strategy for (A) encouraging personal responsibility in prevention and healthy living for all residents of the state; (B) reducing health care costs for all residents of the state to below the national average; (C) ensuring access in communities to safe water and wastewater systems; (D) developing a sustainable health care workforce in the state; (E) ensuring access to quality health care being accessible for all residents of the state; and (F) increasing the number of residents of the state who are covered by insurance for health care services.

Reports	Submit a report to the Governor and the Legislature on or before January 15, 2010 regarding the commission's recommendations and activities.	Submit an annual report to the Governor and the Legislature by January 15 of each year regarding the commission's recommendations and activities.	Submit an annual report to the legislature and governor by January 15 of each year summarizing the significant work, findings, and recommendations of the commission. The first report must include a 5-year strategic plan with prioritized, targeted, and defined objectives as well as an evaluation of the strengths, weaknesses, and relative performance of health care services and conditions in the state. Subsequent reports must include revisions to the plan (if any) and report on progress in meeting the objectives.	Submit an annual report to the legislature and governor by February 1 of each year and present key findings in person to the legislature. Report must summarize significant work, findings, and recommendations of the commission. The first report must include a 5-year strategic plan with prioritized, targeted, and defined objectives as well as an evaluation of the strengths, weaknesses, and relative performance of health care services and conditions in the state. Subsequent reports must include revisions to the plan (if any) and report on progress in meeting the objectives.
Administrative & General Provisions	• Employ 1 Executive Director • DHSS may assign employees to serve as staff to the commission • Shall adopt bylaws governing proceedings and activities • Members do not receive compensation • Members entitled to per diem and travel expenses • May use teleconferencing and other electronic means to the extent practicable • Meeting conducted in accord with Open Meetings Act (AS 44) • Records subject to inspection and copying as public records under AS 40	• Employ 1 Executive Director • DHSS may assign employees to serve as staff to the commission • Shall adopt bylaws governing proceedings and activities • Members do not receive salary • Members entitled to per diem and travel expenses	• Employ 1 Executive Director • Meet regularly in person or by teleconference • Quorum = majority of voting members • Votes of members to be recorded • Action requires affirmative vote of majority of voting members present • Member may not be recused from voting solely based on conflict of interest • Members not entitled to salary • Members entitled to per diem, reimbursement for travel, other expenses authorized under AS 39.20.180	• Employ 1 Executive Director • DHSS may assign employees to serve as staff to the commission • Maintain web site with info on commission and annual reports • Shall adopt bylaws governing proceedings and activities • Members not entitled to salary • Members entitled to per diem, reimbursement for travel, other expenses authorized under AS 39.20.180 • Departments of Administration; Commerce, Community & Economic Development; Labor & Workforce; and Law shall cooperate

Additional Provisions	None	• Transition: The department may adopt regulations necessary to implement changes made by the act • Transition: The members appointed to the Alaska Health Care Commission established under Admin Order #246 shall serve as the members of the commission under AS 18.09.010 (as amended by this bill) for one-year to three-year staggered terms as determined by the governor.	None	• Requires mandatory reporting to DHSS by health care facilities on price, services offered, and other information • Requires DHSS to contract for a comprehensive study of the effects of the certificate of need program.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/27/09

FURTHER: Finance

Date of 5-Day Notice: March 11, 2010
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: March 18, 2010

Health and Social Services Committee considered SENATE BILL NO. 172

SB 172 ALASKA HEALTH CARE COMMISSION

"An Act establishing the Alaska Health Care Commission in the Department of Health and Social Services; and providing for an effective date."

and recommends:

[X] be **replaced** with [ ] **SCS** or [X] **CS** SB172 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[X] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
H+SS	2/1/2010	✓			

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	✓			
	PARNELL	X			
	DYSON			X	
CHAIR:	DAVIS	X			

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
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Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 17, 2010

SUBJECT: Legislative Confirmation of Commission Members (CSSB 172(HSS), (Work Order No. 26-LS0790\P))

TO: Senator Bettye Davis
Chair of the Senate Health and Social Service Committee
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

Tom Obermeyer has asked for a memo that describes the limits of the legislature's role of confirmation in the review of the appointment of persons for positions in the executive branch.

*

Constitutionally, the underpinnings of the legislature's role in the confirmation of certain executive branch appointees to hold the office are to be found in two sections of article III of the Alaska Constitution, sections 25 and 26:

> **Department Heads.** The head of each principal department shall be a single executive unless otherwise provided by law. He shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session, and shall serve at the pleasure of the governor, except as otherwise provided in this article with respect to the secretary of state. The heads of all principal departments shall be citizens of the United States.
>
> **Boards and Commissions.** When a board or commission ***is at the head of a principal department or a regulatory or quasi-judicial agency***, its members shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session, and may be removed as provided by law. They shall be citizens of the United States. The board or commission may appoint a principal executive officer when authorized by law, but the appointment shall be subject to the approval of the governor.

(Emphasis added.)

In *Bradner v. Hammond*, 553 P.2d 1 (Alaska 1976), the Alaska Supreme Court reached the conclusion that

> . . . ***the appointment of executive officers is an executive function***; for without such a power, the responsibility for executing executive duties would be diffused and the goal of separation of branches of government, avoiding too great a concentration of power in one branch, would be defeated.

and, further that

> . . . under Alaska's constitution confirmation is a specific attribute of the appointive power of the executive. Other courts which have been called upon to resolve this issue have been unanimous in their holdings that ***confirmation is not a distinct legislative power, but rather a part of the executive power of appointment which has in turn been delegated in some specific instances by constitution to the legislative branch of government.***

Bradner, at 6 - 7 (emphasis added; notes omitted).

*

Procedurally, the legislature's role in confirmation is spelled out almost entirely in AS 39.05.080.

The Alaska Health Care Commission established in CSSB 172(HSS) is an advisory board that does not sit at the head of a principal department, a regulatory agency, or a quasi-judicial agency. Therefore, the appointees to the commission are not subject to legislative confirmation by operation of the constitution. The legislative role is limited to establishing such commissions and to providing guidance to the legislature on the qualifications of commission members. The appointment itself is otherwise an executive function in which the legislature plays no role.

If I may be of further assistance, please advise.

JMM:lmb
10-009.lmb

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB172
() Publish Date:

Identifier (file name): SB172-DHSS-PHA-02-01-10
Dept. Affected: Health & Social Services

Title: Alaska Health Care Commission
RDU: Public Health
Component: Public Health Administration

Sponsor: Olson

Requester: Senate HSS
Component Number: 292

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITU	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	134.5		134.5	134.5	134.5	134.5	134.5
Travel	35.0		35.0	35.0	35.0	35.0	35.0
Contractual	300.0		320.5	320.5	320.5	320.5	320.5
Supplies	20.5		10.0	10.0	10.0	10.0	10.0
Equipment	10.0		0.0	0.0	0.0	0.0	0.0
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**500.0**	**0.0**	**500.0**	**500.0**	**500.0**	**500.0**	**500.0**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	500.0		500.0	500.0	500.0	500.0	500.0
1005 GF/Program Receip							
1037 GF/Mental Health							
Other Interagency Receip							
TOTAL	**500.0**	**0.0**	**500.0**	**500.0**	**500.0**	**500.0**	**500.0**

Estimate of any current year (FY2010) c 500.0

POSITIONS

Full-time	**1.0**		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece*

SB 172 establishes the Alaska Health Care Commission in DHSS to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. The commission would be composed of 10 members. SB 172 closely parallels Administrative Order #246 of December 2008 establishing a health care commission to address Alaska's health care challenges.

The current Alaska Health Care Commission recently adopted a formal policy recommendation to establish a permanent health care commission in statute to address the need for health care reform in Alaska. The

(continued on page 2)

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Officer/Director
Division: Public Health
Phone: 269-8126
Date/Time: 12/28/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 2/1/2010

STATE OF ALASKA BILL NO. SB172

2010 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

(Continued from Page 1)
The commission based this recommendation on the finding that the need for a plan to address health care cost, access and quality issues is greater than ever before. Health care expenditures in Alaska more than tripled between 1991 and 2005 from $1.6 billion to $5.3 billion. Costs are expected to double again, to over $10 billion, by 2013. The Alaska economy cannot sustain this inflationary growth, and government (all levels - local, state, and fed) carries 64% of this cost burden between the cost for government health care programs and provision of health care insurance for government employees. *(Data cited from "Alaska's $5 Billion Health Care Bill - Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.)*

The two most recent groups to work on the issue of health care reform in Alaska, the Alaska Health Care Roundtable (2005) and the Alaska Health Care Strategies Planning Council (2007), both recommended that a permanent body be established to address the problem of health care reform. The problem is too great in scope and too complex to be able to plan and follow-through in just one or two years time through an ad-hoc body.

$500.0 in state general funds is required for operations of the health care commission, as follows:

71000 Personal Services: The bill states that an Executive Director would staff the Commission; administrative support would be provided by existing DHSS staff. Personal services costs of $134.5 is Range 23, Step F.

72000 Travel Travel and per diem for Commission staff and for 8 Commission members to conduct quarterly face-to-face public meetings. The two other members are legislators and would have per diem and travel covered.

73000 Contractual Professional services contracts will be needed to supplement staff research, and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies
In addition to day-to-day office supplies, FY11 includes start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment
FY11 includes purchase of a server; in subsequent fiscal years provide technology upgrades and maintenance will be covered through the contractual line.

The bill becomes effective immediately upon the Governor's signature. This means there may be some limited costs in FY10 that will have to be absorbed by the Department of Health & Social Services.

26-LS0790\P
Mischel
3/15/10

CS FOR SENATE BILL NO. 172(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR OLSON

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission in the Department of Health and Social Services; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

New Text Underlined [DELETED TEXT BRACKETED]

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(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 2.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care.

Article 1. Alaska Health Care Commission.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purpose of the commission is to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state.

Sec. 18.09.020. Composition; chair. The commission consists of 12 members as follows:

(1) nine voting members appointed by the governor as follows:

(A) the state officer assigned the duties of medical director for the department, who shall serve as chair;

(B) one member who represents the tribal health community in the state;

(C) one member who represents a statewide chamber of commerce who is not financially associated with the health care industry;

(D) one member who represents the Alaska State Hospital and Nursing Home Association;

(E) one member who is a health care provider and

(i) engaged in the active practice of the health care provider's profession in the state;

(ii) licensed to practice in the state;

(iii) not affiliated with the Alaska State Hospital and Nursing Home Association;

(F) one member who represents the health care industry in the state;

(G) one member who is a

(i) health care consumer;

(ii) resident of the state; and

(iii) not employed by and does not have a business interest in the health care industry;

(H) one member who is a licensed primary care physician in the state and who is in the active practice of family medicine, primary care

internal medicine, or pediatric medicine;

(I) one member who represents the Alaska Mental Health Trust Authority; and

(2) three nonvoting members appointed as follows:

(A) one ex officio member from the house of representatives, appointed by the speaker of the house of representatives;

(B) one ex officio member from the senate, appointed by the president of the senate;

(C) an ex officio member representing the Office of the Governor.

Sec. 18.09.030. Public members' terms of office. (a) Public members of the commission serve for staggered terms of three years or until a successor is appointed.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) A public member may serve not more than two consecutive terms.

(d) In this section, "public member" means those members appointed under AS 18.09.020(1)(B) - (I).

Sec. 18.09.040. Executive director. The commission shall employ an executive director, who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning

(1) a quorum to transact commission business and other aspects of procedure;

(2) frequency and location of meetings;

(3) establishment, functions, and membership of committees; and

(4) conflicts of interest that require

(A) a member to declare a substantial financial interest in an official action and to request to be excused from voting in that instance;

(B) a ruling by the chair on a request by a member to be excused from voting;

(C) an opportunity to override a ruling by the chair on a majority vote;

(D) filing of a written disclosure form with the department that lists all potential conflicts of interest of a member valued at more than $5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for improving the health of all residents of the state that

(A) encourages personal responsibility for disease prevention, healthy living, and acquisition of health insurance;

(B) reduces health care costs by using savings from

(i) enhanced market forces;

(ii) fraud reduction;

(iii) health information technology;

(iv) management efficiency;

(v) preventative medicine;

(vi) successful innovations identified by other states; and

(vii) other cost-saving measures;

(C) eliminates known health risks, including unsafe water and wastewater systems;

(D) develops a sustainable health care workforce;

(E) improves access to quality health care; and

(F) increases the number of insurance options for health care services.

(b) The commission may hold public hearings to gather information and opinions from health care consumers on matters before the commission. Hearings shall be conducted under AS 44.62.210, except that the commission shall provide public notice of hearings not less than 15 days before the conduct of the hearing and include not fewer than three notices published in the statewide news media.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities. The report shall include voting records, copies of financial disclosures, and conflicts of interest statements.

Sec. 18.09.080. Compensation, per diem, and expenses. A member appointed to the commission under AS 18.09.020(1) is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "department" means the Department of Health and Social Services.

*** Sec. 3.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

*** Sec. 4.** AS 44.66.010(a) is amended to read:

(a) Boards and commissions listed in this subsection expire on the date set out after each:

(1) Alcoholic Beverage Control Board (AS 04.06.010) - June 30, 2010;

(2) Board of Parole (AS 33.16.020) - June 30, 2016;

(3) Regulatory Commission of Alaska (AS 42.04.010) - June 30, 2011;

(4) Alaska Commission on Aging (AS 47.45.200) - June 30, 2016;

(5) Council on Domestic Violence and Sexual Assault (AS 18.66.010) - June 30, 2014;

(6) special education service agency (AS 14.30.600) - June 30, 2013;

(7) [REPEALED

(8)] Statewide Suicide Prevention Council (AS 44.29.300) - June 30, 2013;

(8) [(9)] Alaska Seismic Hazards Safety Commission (AS 44.37.065) - June 30, 2012**;**

(9) Alaska Health Care Commission (AS 18.09.010) - June 30, 2014.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: ALASKA HEALTH CARE COMMISSION. The members appointed to the Alaska Health Care Commission, established by Administrative Order No. 246 dated December 4, 2008, shall serve as the voting members of the Alaska Health Care Commission under AS 18.09.010, enacted by sec. 2 of this Act, for one-year to three-year staggered terms as determined by the governor according to AS 39.05.055.

*** Sec. 7.** This Act takes effect immediately under AS 01.10.070(c).

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 10, 2010

SUBJECT: Sectional Summary (CSSB 172(HSS), Draft Version "S")

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill. You also asked for a comparison of the "A" version and the "S" version. The only substantive difference in the two versions is the membership of the commission.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds a cross reference to the health plan and commission established in AS 18.09, added by section 2 of the bill, to the Department of Health and Social Services authority related to public health.

Section 2. Establishes the Alaska Health Care Commission in the Department of Health and Social Services for the purpose of providing recommendations for and fostering the development of a statewide plan to address health care issues in the state. Requires the commission to perform specified duties, to hold public hearings, and to submit an annual report to the legislature and to the governor.

Section 3. Adds the executive officer of the commission established in sec. 2 of the bill to the list of employees in the partially exempt state service classification under the state personnel act.

Section 4. Adds the commission established in sec. 2 of the bill to the list of boards and commissions for purposes of establishing an expiration date of June 20, 2014.

Section 5. Authorizes the Department of Health and Social Services to proceed to adopt regulations needed to implement the bill.

Section 6. Provides a temporary transition of commission members to include staggered terms of members currently serving on the commission established by executive order.

JMM:ljw
10-147.ljw

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Mischel
3/9/10

CS FOR SENATE BILL NO. 172(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR OLSON

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission in the Department of Health and Social Services; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 2.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care.

Article 1. Alaska Health Care Commission.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purpose of the commission is to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state.

Sec. 18.09.020. Composition; chair. The commission consists of 12 members as follows:

(1) nine voting members appointed by the governor, including the state officer assigned the duties of medical director for the department, who shall serve as chair; and

(2) three nonvoting members appointed as follows:

(A) one ex officio member from the house of representatives, appointed by the speaker of the house of representatives;

(B) one ex officio member from the senate, appointed by the president of the senate;

(C) an ex officio member representing the Office of the Governor.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(1) serve for staggered terms of three years or until a successor is appointed.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) A member may serve not more than two consecutive terms.

Sec. 18.09.040. Executive director. The commission shall employ an executive director, who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning

(1) a quorum to transact commission business and other aspects of procedure;

(2) frequency and location of meetings;

(3) establishment, functions, and membership of committees; and

(4) conflicts of interest that require

(A) a member to declare a substantial financial interest in an official action and to request to be excused from voting in that instance;

(B) a ruling by the chair on a request by a member to be excused from voting;

(C) an opportunity to override a ruling by the chair on a majority vote;

(D) filing of a written disclosure form with the department that lists all potential conflicts of interest of a member valued at more than $5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for improving the health of all residents of the state that

(A) encourages personal responsibility for disease prevention, healthy living, and acquisition of health insurance;

(B) reduces health care costs by using savings from

(i) enhanced market forces;

(ii) fraud reduction;

(iii) health information technology;

(iv) management efficiency;

(v) preventative medicine;

(vi) successful innovations identified by other states; and

(vii) other cost-saving measures;

(C) eliminates known health risks, including unsafe water and wastewater systems;

(D) develops a sustainable health care workforce;

(E) improves access to quality health care; and

(F) increases the number of insurance options for health care services.

(b) The commission may hold public hearings to gather information and opinions from health care consumers on matters before the commission. Hearings shall be conducted under AS 44.62.210, except that the commission shall provide public notice of hearings not less than 15 days before the conduct of the hearing and include not fewer than three notices published in the statewide news media.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities. The report shall include voting records, copies of financial disclosures, and conflicts of interest statements.

Sec. 18.09.080. Compensation, per diem, and expenses. A member appointed to the commission under AS 18.09.020(1) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "department" means the Department of Health and Social Services.

*** Sec. 3.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

*** Sec. 4.** AS 44.66.010(a) is amended to read:

(a) Boards and commissions listed in this subsection expire on the date set out after each:

(1) Alcoholic Beverage Control Board (AS 04.06.010) - June 30, 2010;

(2) Board of Parole (AS 33.16.020) - June 30, 2016;

(3) Regulatory Commission of Alaska (AS 42.04.010) - June 30, 2011;

(4) Alaska Commission on Aging (AS 47.45.200) - June 30, 2016;

(5) Council on Domestic Violence and Sexual Assault (AS 18.66.010) - June 30, 2014;

(6) special education service agency (AS 14.30.600) - June 30, 2013;

(7) [REPEALED

(8)] Statewide Suicide Prevention Council (AS 44.29.300) - June 30,

2013;

(8) [(9)] Alaska Seismic Hazards Safety Commission (AS 44.37.065) - June 30, 2012;

(9) Alaska Health Care Commission (AS 18.09.010) - June 30, 2014.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: ALASKA HEALTH CARE COMMISSION. The members appointed to the Alaska Health Care Commission, established by Administrative Order No. 246 dated December 4, 2008, shall serve as the voting members of the Alaska Health Care Commission under AS 18.09.010, enacted by sec. 2 of this Act, for one-year to three-year staggered terms as determined by the governor according to AS 39.05.055.

*** Sec. 7.** This Act takes effect immediately under AS 01.10.070(c).

26-LS0790\E
Mischel
3/1/10

CS FOR SENATE BILL NO. 172(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR OLSON

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission in the Department of Health and Social Services; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 2.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care.

Article 1. Alaska Health Care Commission.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purpose of the commission is to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state.

Sec. 18.09.020. Composition; chair. The commission consists of 12 members as follows:

(1) nine voting members appointed by the governor; and

(2) three nonvoting members appointed as follows:

(A) one ex officio member from the house of representatives, appointed by the speaker of the house of representatives;

(B) one ex officio member from the senate, appointed by the president of the senate;

(C) an ex officio member representing the Office of the Governor.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(1) serve for staggered terms of three years or until a successor is appointed.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) A member may serve not more than two consecutive terms.

Sec. 18.09.040. Executive director. The commission shall employ an executive director, who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing

proceedings and other activities, including provisions concerning

(1) a quorum to transact commission business and other aspects of procedure;

(2) frequency and location of meetings;

(3) establishment, functions, and membership of committees; and

(4) conflicts of interest that require

(A) a member to declare a substantial financial interest in an official action and to request to be excused from voting in that instance;

(B) a ruling by the chair on a request by a member to be excused from voting;

(C) an opportunity to override a ruling by the chair on a majority vote;

(D) filing of a written disclosure form with the department that lists all potential conflicts of interest of a member valued at more than $5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for improving the health of all residents of the state that

(A) encourages personal responsibility for disease prevention, healthy living, and acquisition of health insurance;

(B) reduces health care costs by using savings from

(i) enhanced market forces;

(ii) fraud reduction;

(iii) health information technology;

(iv) management efficiency;

(v) preventative medicine;

(vi) successful innovations identified by other states;

and

(vii) other cost-saving measures;

(C) eliminates known health risks, including unsafe water and wastewater systems;

(D) develops a sustainable health care workforce;

(E) improves access to quality health care; and

(F) increases the number of insurance options for health care services.

(b) The commission may hold public hearings to gather information and opinions from health care consumers on matters before the commission. Hearings shall be conducted under AS 44.62.210, except that the commission shall provide public notice of hearings not less than 15 days before the conduct of the hearing and include not fewer than three notices published in the statewide news media.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities. The report shall include voting records, copies of financial disclosures, and conflicts of interest statements.

Sec. 18.09.080. Compensation, per diem, and expenses. A member appointed to the commission under AS 18.09.020(1) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "department" means the Department of Health and Social Services.

*** Sec. 3.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

* **Sec. 4.** AS 44.66.010(a) is amended to read:

(a) Boards and commissions listed in this subsection expire on the date set out after each:

(1) Alcoholic Beverage Control Board (AS 04.06.010) - June 30, 2010;

(2) Board of Parole (AS 33.16.020) - June 30, 2016;

(3) Regulatory Commission of Alaska (AS 42.04.010) - June 30, 2011;

(4) Alaska Commission on Aging (AS 47.45.200) - June 30, 2016;

(5) Council on Domestic Violence and Sexual Assault (AS 18.66.010) - June 30, 2014;

(6) special education service agency (AS 14.30.600) - June 30, 2013;

(7) [REPEALED

(8)] Statewide Suicide Prevention Council (AS 44.29.300) - June 30, 2013;

(8) [(9)] Alaska Seismic Hazards Safety Commission (AS 44.37.065) -

June 30, 2012;

(9) Alaska Health Care Commission (AS 18.09.010) - June 30, 2014.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: ALASKA HEALTH CARE COMMISSION. The members appointed to the Alaska Health Care Commission, established by Administrative Order No. 246 dated December 4, 2008, shall serve as the voting members of the Alaska Health Care Commission under AS 18.09.010, enacted by sec. 2 of this Act, for one-year to three-year staggered terms as determined by the governor according to AS 39.05.055.

*** Sec. 7.** This Act takes effect immediately under AS 01.10.070(c).

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON

CAPITOL BUILDING
ROOM 514
JUNEAU, AK 99801-1182
PHONE: (907) 465-3707
FAX: (907) 465-4821

Senate Bill 172 Alaska Health Care Commission

26-LS0790\A

SPONSOR STATEMENT

Alaska is currently facing serious healthcare cost, access and quality issues. Between 1991 and 2005, health care expenditures in our state more than tripled from $1.6 billion to $5.3 billion. Costs are expected to double again by 2013 to over $10 billion. All levels of government – state, local, and federal – are affected, and Alaska's economy cannot sustain this inflationary growth. The purpose of SB 172 is to establish in statute the Alaska Health Care Commission to address the need for health care reform in our state. This issue is complex and broad in scope, and cannot be dealt with adequately unless we have a permanent body to plan and follow through for long range comprehensive health care reform.

The two most recent groups to work on the issue of health care reform in Alaska, the Alaska Health Care Roundtable (2005) and the Alaska Health Care Strategies Planning Council (2007), both recommended that a permanent body be established to address the problem of health care reform. The Roundtable (which met for 2 years) and the Planning Council (which met for 6 months) recognized that the problem is too great to be effectively addressed through a short-term, ad-hoc body.

The Alaska Health Care Commission would be established in the Department of Health And Social Services, and would consist of a ten member body including public officials and private citizens. Representatives from both the executive and legislative branches of state government are included, as well as citizens representing the private business sector, the health care community, and consumers. Three members are to be ex officio appointees from the legislature and the governor's office.

The composition and small size would enable efficient and effective teamwork and decision-making, while bring a balance of viewpoints and perspectives.

The commission would provide its recommendations and support the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the State. A plan for reform will be based on education, sustainability, management efficiency, health care effectiveness, private-public partnerships, research, personal responsibility and individual choice.

Alaska's need for healthcare reform is pressing and must be dealt with thoroughly and efficiently, with a long range view towards meaningful and lasting change. The Alaska Health Care Commission would play an important role in this process, and it is essential that we make it a permanent component of the Department of Health and Social Services, so that present as well as future issues with Alaska's healthcare systems can be better anticipated, understood and addressed.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB172
() Publish Date:

Identifier (file name): SB172-DHSS-PHA-02-01-10
Dept. Affected: Health & Social Services

Title: Alaska Health Care Commission
RDU: Public Health
Component: Public Health Administration

Sponsor: Olson

Requester: Senate HSS
Component Number: 292

Expenditures/Revenu (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITU	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	134.5		134.5	134.5	134.5	134.5	134.5
Travel	35.0		35.0	35.0	35.0	35.0	35.0
Contractual	300.0		320.5	320.5	320.5	320.5	320.5
Supplies	20.5		10.0	10.0	10.0	10.0	10.0
Equipment	10.0		0.0	0.0	0.0	0.0	0.0
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**500.0**	**0.0**	**500.0**	**500.0**	**500.0**	**500.0**	**500.0**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	500.0		500.0	500.0	500.0	500.0	500.0
1005 GF/Program Receip							
1037 GF/Mental Health							
Other Interagency Receip							
TOTAL	**500.0**	**0.0**	**500.0**	**500.0**	**500.0**	**500.0**	**500.0**

Estimate of any current year (FY2010) c 500.0

POSITIONS

Full-time	1.0		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece:*

SB 172 establishes the Alaska Health Care Commission in DHSS to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. The commission would be composed of 10 members. SB 172 closely parallels Administrative Order #246 of December 2008 establishing a health care commission to address Alaska's health care challenges.

The current Alaska Health Care Commission recently adopted a formal policy recommendation to establish a permanent health care commission in statute to address the need for health care reform in Alaska. The

(continued on page 2)

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Officer/Director
Phone 269-8126
Division: Public Health
Date/Time 12/28/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/1/2010
DHSS Finance & Management Services

STATE OF ALASKA BILL NO. SB172

2010 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

(Continued from Page 1)
The commission based this recommendation on the finding that the need for a plan to address health care cost, access and quality issues is greater than ever before. Health care expenditures in Alaska more than tripled between 1991 and 2005 from $1.6 billion to $5.3 billion. Costs are expected to double again, to over $10 billion, by 2013. The Alaska economy cannot sustain this inflationary growth, and government (all levels - local, state, and fed) carries 64% of this cost burden between the cost for government health care programs and provision of health care insurance for government employees. *(Data cited from "Alaska's $5 Billion Health Care Bill - Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.)*

The two most recent groups to work on the issue of health care reform in Alaska, the Alaska Health Care Roundtable (2005) and the Alaska Health Care Strategies Planning Council (2007), both recommended that a permanent body be established to address the problem of health care reform. The problem is too great in scope and too complex to be able to plan and follow-through in just one or two years time through an ad-hoc body.

$500.0 in state general funds is required for operations of the health care commission, as follows:

71000 Personal Services: The bill states that an Executive Director would staff the Commission; administrative support would be provided by existing DHSS staff. Personal services costs of $134.5 is Range 23, Step F.

72000 Travel Travel and per diem for Commission staff and for 8 Commission members to conduct quarterly face-to-face public meetings. The two other members are legislators and would have per diem and travel covered.

73000 Contractual Professional services contracts will be needed to supplement staff research, and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies
In addition to day-to-day office supplies, FY11 includes start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment
FY11 includes purchase of a server; in subsequent fiscal years provide technology upgrades and maintenance will be covered through the contractual line.

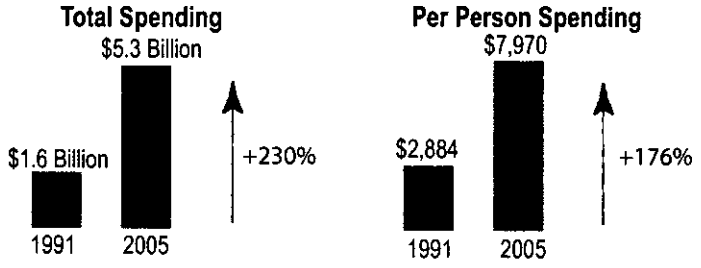
The bill becomes effective immediately upon the Governor's signature. This means there may be some limited costs in FY10 that will have to be absorbed by the Department of Health & Social Services.

Alaska's $5 Billion Health Care Bill—Who's Paying?

By Mark Foster and Scott Goldsmith

March 2006
UA Research Summary No. 6
Institute of Social and Economic Research • University of Alaska Anchorage

Figure 1. Growth in Alaska Health-Care Spending, 1991-2005



Source: Authors' estimates

Spending for health care in Alaska topped $5 billion in 2005. Just how big is $5 billion? It is, for perspective, one-third the value of North Slope oil exports in 2005—a year of high oil prices. It's nearly one-sixth the value of everything Alaska's economy produced last year.

In 1991, health-care spending in Alaska was about $1.6 billion. Even after we take population growth into account, spending for health care increased 176% per Alaskan in 15 years. These soaring costs are taking a growing share of family and government budgets, increasing labor costs, and putting businesses at a competitive disadvantage.

The $5.3 billion in spending in 2005 was all for the 665,000 people who live in Alaska, but individuals didn't pay all the bills. They paid nearly 20% out of their pockets and through payroll deductions. Businesses (including non-profits) and governments paid about 80%. Of course, individual Alaskans and other Americans indirectly pay all these costs, because they buy goods and services, own businesses, and pay taxes.

What does health-care spending buy? Stays in the hospital, visits to doctors and dentists, prescription drugs, and more, as well as program administration and public health programs. Our estimates don't include capital expenditures.[1]

Who pays the bills, and how has that burden shifted as spending increased?

• *Private and government employers spent about $2 billion for employee health-care coverage in 2005.* For comparison, they paid $11.8 billion in wages in 2005. With rising costs, businesses and governments have become increasingly likely to pay health-care bills themselves—"self-insure"—rather than pay through insurance premiums.

• *Alaska households spent just over $1 billion for health care in 2005, up from $361 million in 1991.* That includes everything individual Alaskans spent—not only their out-of-pocket costs, but also what was deducted from their paychecks to help pay for health coverage through their employers.

• *Governments spent $2.2 billion for health care programs in 2005, up from $736 million in 1991.* Medicaid spending was almost $1 billion.

Health-care spending could double again by 2013, if current trends continue. Why are costs of medical care so high, and why are they increasing faster than everything else? Why have health-care costs in Alaska stayed higher than U.S. averages, even as other costs moved closer to national levels? Are we getting better care now? Who can't afford care?

We're starting to assemble data to help answer those questions. Alaskans face some hard choices about how to control costs but still have a health-care system that provides good care and is accessible to everyone. We hope to provide some useful insights.

This publication is the first step in ISER's research on the health-care industry. It starts with our new estimates of spending and of changes since 1991, when we last looked at health-care spending.[2] But cost alone is only one part of the complicated health-care story, and here we also begin looking at:

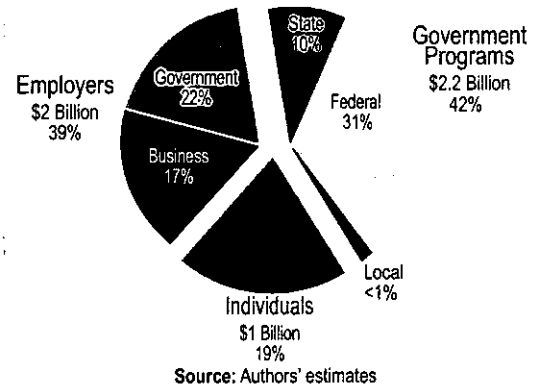
• Who are the most expensive patients? Our analysis of national data shows that the average "high-cost" patients aren't as expensive as you might think.

• Who is more likely to have health insurance provided through their jobs at a reasonable cost? Single people working for big companies.

• How does use of the health care system in the U.S. compare with use in other countries? Canadians and Australians seem to use their systems about as much.

• What is driving costs? Despite what many people think, there are no simple explanations: it's a puzzle with many pieces.

Figure 2. Who Pays The Bills?
(Total 2005 Spending: $5.3 Billion)



Source: Authors' estimates

Understanding Alaska (UA) is a special series of ISER research studies examining Alaska economic development issues . The studies are paid for by the University of Alaska Foundation. UA reports are available from ISER's offices and at: **www.alaskaneconomy.uaa.alaska.edu**

Organization of Summary

We first describe what health-care dollars buy—what shares go to doctors, hospitals, drugs, and other expenses. Then we look in more detail at our estimates of health-care spending in 2005 and the changes since 1991. We think our estimates are a good effort to update our previous work. But the health-care industry is complex, and tracking all the spending is difficult.

After we talk about spending, we give readers a glimpse of related health-care issues. In some cases we have no Alaska data and rely on national figures, which are still useful in illustrating important issues.

Pages 4, 5, and 6 discuss access to, use of, and benefits from the health-care system: who is uninsured; who has health-care coverage and how that coverage is provided; which patients get the costliest care; how Americans' use of medical care compares with use by people in other industrialized countries; and whether we've gotten healthier in exchange for more spending.

Page 7 summarizes what we know about how medical costs in Alaska differ from the U.S. average, and page 8 concludes with a discussion about the many things that may be driving health-care costs.

Keep in mind that population growth and general inflation account for part of the increase in health-care spending since 1991. Alaska's population increased from about 570,000 in 1991 to 665,000 by 2005. Also, prices for everything Americans buy also went up, by about 43% nationwide and 39% in Anchorage. But prices of medical care nearly doubled (Figure 3).

What Are We Buying?

Figure 4 shows that as of 2000, more than 70% of Alaska's health-care spending was for hospital care and visits to doctors. Prescription drugs accounted for about 9% and dental care 7%. The "other" category includes medical products, health care provided on the job and in schools, and Medicaid payments for in-home care.

Nursing home and home health care made up only 2% of health-care spending in 2000, far short of the U.S. average of 11%—and that share actually dropped between 1990 and 2000, despite fast growth in the number of Alaskans over 65. There has been a shift in how long-term care is provided in Alaska. A change in Medicaid allowed payment for in-home and assisted-living care for people who would otherwise have been cared for in nursing homes.

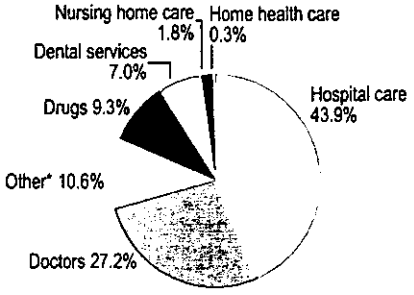
All types of health-care spending grew rapidly since 1990, but the fastest growth was in prescription drugs and the "other" category (described in the footnote to Figure 4).

How Has Spending Changed?

Table 1 details who paid for health-care in 2005. Figures 5 and 6 show changes in levels and shares of spending from 1991 to 2005.

• Growth in government spending wasn't uniform. The federal government's share of spending increased (Figure 5). Costs for Medicare and Medicaid more than quadrupled and costs for the Indian Health Service doubled.

Figure 4. What Are We Buying?
(Alaska Health Care Spending, 2000)



*Includes, among other things, durable and non-durable medical products, direct services employers provide employees, government expenditures in schools, and Medicaid payments that allow people to be cared for at home instead of in institutions.
Source: Center for Medicare and Medicaid Services

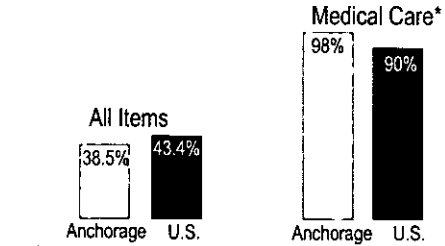
• State government's share dropped, partly because the federal government paid a bigger share of Medicaid costs in 2005 than in 1991.[3]

• Local government is the smallest government spender, but the local share of spending increased, mostly because of growing costs for employee health coverage.

• Employers saw the fastest growth. Combined spending by private and government employers increased about 290% (Figure 6).

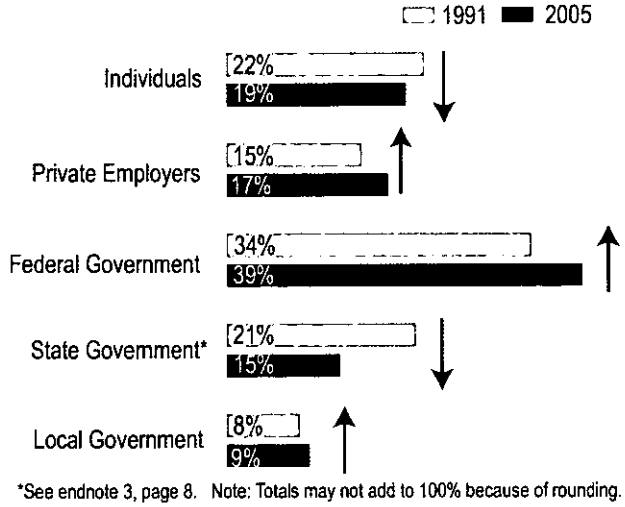
• Spending by individual Alaskans didn't go up as much—184%—but the $1 billion they spent in 2005 was still more than the $922 million businesses spent.

Figure 3. Increase in Consumer Price Index Anchorage and U.S., 1991-2005



*Measures price increases in a specific "market basket" that includes hospital care, visits to doctors and dentists, nursing home care, and medical supplies; also indirectly measures increases in health insurance premiums.
Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers, Anchorage and U.S. City Average

Figure 5. How Did Shares of Spending Change From 1991 to 2005, Among Those Who Buy Health Care?



*See endnote 3, page 8. Note: Totals may not add to 100% because of rounding.
Source: Authors' estimates

4864

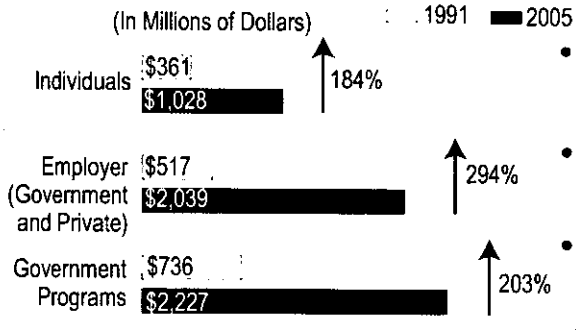
Table 1. Health-Care Spending in Alaska, Fiscal Year 2005
(Total Spending: $5.3 Billion)

Who Provides the Coverage?	Who Buys the Care? (In Million of Dollars)					
	Individuals	Businesses	Local Government	State Government	Federal Government	Total
Individuals	**$1,028**					**$1,028**
Out-of-pocket costs	$431					
Individual policies	$276					
Payments for employer-based insurance	$320					
Employers (Including retiree coverage)		**$922**	**$454**	**$252**	**$411**	**$2,039**
Insurance Premiums		$303	$103	$72	$75	
Self-Insured Costs[a]		$485	$352	$180	$115	
Military Medical Costs					$221	
Worker's Compensation (medical benefits)		$134				
Government Health Programs			**$38**	**$535**	**$1,654**	**$2,227**
Medicare					$419	
Medicaid				$303	$667	
Other Public Programs						
Federal						
Indian Health Service Contracts					$401	
Veterans' Affairs					$105	
Community Health Centers					$29	
State						
Grant to local governments, private groups				$116		
API, Pioneers' Homes				$55		
Other State-Administered				$31		
Elementary and Secondary Schools			$3	$8	$33	
WAMI Medical Education				$2		
Department of Corrections				$21		
Local						
Health and hospital spending			$35			
Total Spending	**$1,028**	**$922**	**$492**	**$787**	**$1,950**	**$5,294**

[a]Many organizations that self-insure—that is, they pay some of their bills themselves—also still carry some insurance to help cover extraordinary risks.

Source: Authors' estimates Note: Totals may not sum because of rounding.

Figure 6. How Did Spending Change From 1991 to 2005, Among Those Who Provide Coverage?



Source: Authors' estimates

Biggest Kinds of Changes

- Individual Alaskans have seen big increases not only in costs they notice most—how much they have to pay out of their own pockets—but also in less obvious costs: deductions from their paychecks to pay their share of employer-based insurance.
- Both private and government employers became much more likely to self-insure. Self-insurance costs made up about two-thirds of combined employer spending for insurance premiums and self-insurance in 2005, up from about one-third in 1991.
- Spending for Medicaid more than quadrupled (from $215 million to $970 million), so that in 2005 it alone made up nearly $1 in every $5 of health-care spending. Analysts attribute the fast growth of Medicaid nationwide to growing numbers of eligible Americans, including low-paid workers whose employers don't provide coverage and low-income seniors; to program expansion; to increasing prices of medical care; and to treatment of medical conditions at lower thresholds.

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Health-Care Coverage

Most Alaskans—an estimated 87%—have some form of health-care coverage, either through private insurance or government programs.[4] Some people have more than one kind of coverage, so the percentages in Figure 7 add to more than 100%.

Around 64% of Alaskans are covered by private insurance, 38% by government programs, and nearly 13% have no coverage. Nationwide, 68% of people are covered by private insurance, 30% by government programs, and close to 16% have no coverage.

Alaskans are more likely to have coverage through the military (reflecting the state's large number of active-duty and retired military); the Indian Health Service (because Alaska Natives make up 20% of the population); and Medicaid (the joint federal-state program mainly for low-income and disabled people). Fewer Alaskans are covered by Medicare, because fewer are over 65.

We don't know characteristics of the 13% of Alaskans with no health-care coverage, but we know that nationwide the uninsured are most likely to be young adults and to have annual incomes below $25,000 (Figure 8).

Children in Alaska are more likely to have coverage than both adults in Alaska and children nationwide. Figure 9 shows that about 8% of children in Alaska had no coverage in 2003, compared with the U.S. average of nearly 12%.[5] The smaller share of uninsured children in Alaska is probably due to the fact that Alaska Native children are eligible for care through the Indian Health Service, and also to the Denali KidCare program, an extension of Medicaid that provides coverage for low-income children without other coverage.

It's outside the scope of this summary to describe all the ways that families, communities, and governments are affected because millions of Americans lack health insurance. But a recent report by the National Academy of Sciences broadly summarized those effects. It found that the uninsured are in worse health; that uninsured children are more likely to have development delays; that the direct costs of caring for uninsured Americans fall heavily on local communities; and that governments pay hospitals large public subsidies to offset their costs for uncompensated care.[6]

The 64% of Alaskans with private insurance either pay for that coverage themselves (through individual policies) or are covered through their jobs and share the costs with their employers. Figures 10, 11, and 12 show how the rising costs of medical care have affected health-insurance coverage for Alaskans working for private industry.

Figure 7. Health-Care Coverage, Alaska and U.S., 2004

	Private Insurance	Medicaid	Medicare	Military	IHS only*	None
Alaska	63.5%	15.3%	7.3%	11.6%	4.2%	12.8%
U.S.	68.1%	12.9%	13.7%	3.7%	N/A	15.7%

*Authors' adjustment. See endnote 4, page 8.

Note: Totals are more than 100% because some people have more than one coverage.
Source: U.S. Census Bureau, Current Population Survey, 2004

Figure 8. Who Is Most Likely To Be Uninsured in U.S.?

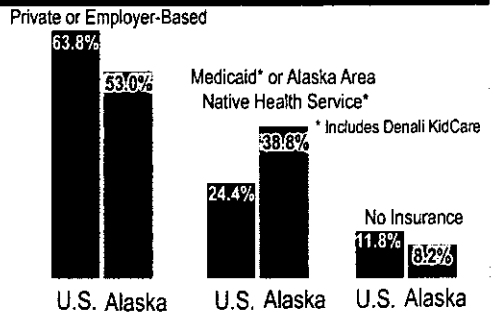
By Age	Percent Uninsured
18-24	31%
65+	1%
By Annual Income	
Less than $25,000	24%
$75,000+	8.4%

Source: U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the U.S.*, 2004

• Health insurance in Alaska was already more expensive in the 1990s and still is. In 2003, insurance premiums for family coverage at private firms were about $10,500 in Alaska and $9,200 nationwide. By 2005, those premiums had jumped to an average of $11,268 nationally (Figure 10).

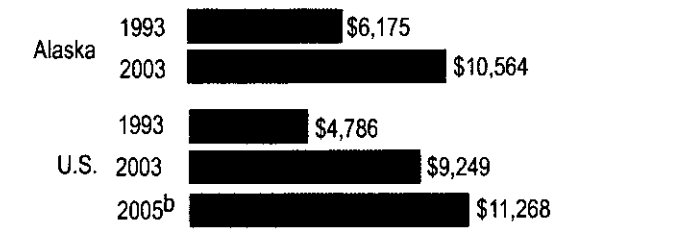
• Premiums are higher in Alaska, but workers here pay a smaller share, as Figure 11 shows. As of 2003, employees at private firms in Alaska paid 11% of the premiums for single-person coverage and 17% for family coverage, compared with 17% for single-person coverage and 25% for family coverage nationwide. But employers, especially at small firms, have been shifting more insurance costs to workers. The 2005 UBA-Ingenix Health Plan Survey found that employees of businesses nationwide paid 43% of the premiums for family coverage.

Figure 9. Health-Care Coverage for Children (18 and Under), Average 2001-2003



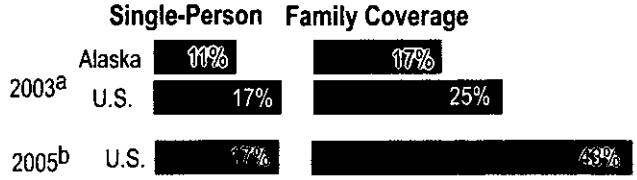
Source: American Academy of Pediatrics, adjusted U.S. Census data; see endnote 5, page 8.

Figure 10. Health Insurance Premiums For Family Coverage[a], Private Firms



[a]Total costs shared by employer and employee. [b] Alaska figures for 2005 not available.
Sources: Medical Expenditure Panel Survey, U.S. Agency For Health Care Research and Quality, 2003; 2005 UBA/Ingenix *Health Plan Survey*

Figure 11. Share of Health Insurance Premiums Employees Pay
(At Private Firms Offering Health Insurance)



[a]Reported in Medical Expenditure Panel Survey, 2003
[b]Alaska 2005 figures not available; national figures from 2005 UBA/Ingenix *Health Plan Survey*

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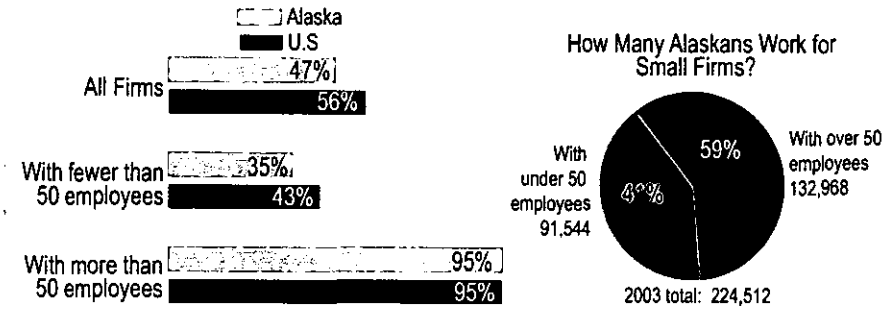
Figure 12. Private Firms Offering Health Insurance,* Alaska and U.S., 2003



* Not all workers at firms that offer insurance carry that insurance. **Source:** Medical Expenditure Panel Survey, 2003

• Small Alaska businesses are less likely to offer insurance coverage. Only about a third of those with fewer than 50 employees offer coverage, compared with 43% nationwide (Figure 12).

A lot of Alaskans work for small businesses. In 2003, about 91,500 of the state's 224,500 private-industry employees worked for businesses with fewer than 50 employees. That's more than 40% of all those with jobs in private industry.

Who Costs the Most and the Least?

We've talked about the costs of health care and of health-care coverage. Now we turn to the other side of the equation: who's getting the benefits of the spending?

Health-care spending in Alaska was close to $8,000 per person in 2005. But not everyone is average. The cost of care for a few is significantly higher than average, but for many it's only a few hundred dollars a year.

As a first step toward understanding who gets the benefits of health-care spending, ISER analyzed national data on the characteristics of high- and low-cost patients. That data is from a federal panel survey—that is, a survey that follows households over time.

As Figure 13 shows, just 5% of patients nationwide account for almost half of all health-care spending in any given year, while at the other extreme 50% of patients account for just 3% of spending in a year.

A lot of Americans tend to think that the most expensive patients are probably very old, or suffering from some catastrophic illness or injury, and are possibly uninsured.

The high-cost patients are older; health-care costs do go up as people age.[7] But their average age is 57, and fewer than 40% are over 65. The average bill for high-cost patients in 2002, under $20,000, doesn't reflect major illnesses or end-of-life care. Rather, it's for a few days in the hospital for surgery, several visits to doctors, and significant spending for prescription drugs. Few of the high-cost patients—2%—are uninsured.

The low-cost patients are mostly young, averaging 28 years old. They may see a doctor or a dentist once a year, and they pay almost half their modest medicals bills out of their pockets.

Many of the low-cost group—nearly 20%—are uninsured. The share of uninsured patients in this group tracks with what the National Academy of Sciences has reported: that the uninsured often don't have any medical costs at all in a year, and among those who do, their expenses are less than half the average for people under 65.[8]

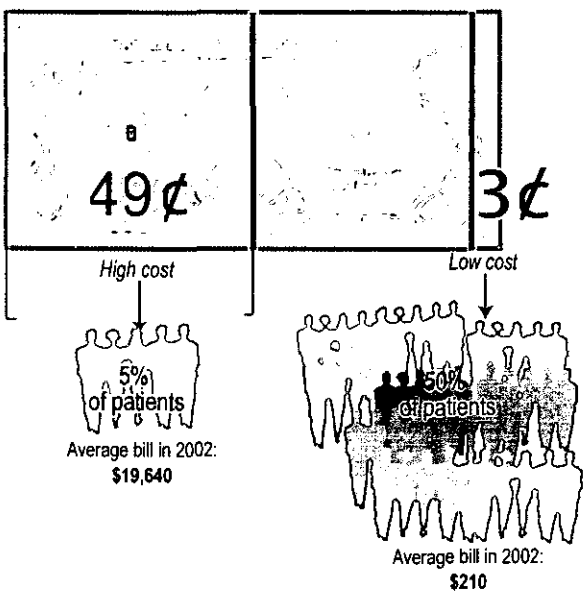
Keep in mind that it's easy to go from being a low-cost patient in one year to a much costlier one the next—a car accident, the sudden onset of an illness, or a hundred other unpredictable events can push anyone into the ranks of the high-cost patients.

Figure 13. Who Are the High-Cost and the Low-Cost Patients in the U.S.?

Distribution of Health-Care Spending on Patients, 2002

Who Are the High-Cost Patients?

- Mostly middle-aged people (average age 57), who are hospitalized for a few days, see doctors several times a year, and spend considerable money (average $3,000) on prescription drugs.
- About 40% are over 65
- They are from all income levels. A third have high incomes (family income over $80,000), and about a fifth are poor (family income under $18,000).
- Only 2% are uninsured. More than two-thirds have private insurance, and nearly a third are covered by government health programs, the most common being Medicare.
- They pay about 12% (average $2,400) of their bills out-of-pocket.



Who Are the Low-Cost Patients?

- Mostly young (average age 28), healthy people, who are likely to see a doctor and a dentist once a year and spend little (average $44) for prescription drugs.
- About 3% are over 65
- They are from all income levels, with almost the same breakdown as among high spenders: nearly a third have high incomes and about a fifth are poor.
- Nearly 20% are uninsured. About 17% are covered by government programs, most commonly Medicaid. The majority have private insurance.
- They pay about 40% (average $84) of their bills out-of-pocket.

Sources: *MEPS Statistical Brief No. 81, May 2005 and analysis of MEPS data by Stephanie Martin of ISER*

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Do We Use More Medical Care?

Americans spend more on health care than anybody else. Do Americans increase health-care costs by getting more medical care than people in other developed countries? Or conversely, do countries with national health-care systems hold down costs by rationing care?

Figure 14 compares Americans with the British, Canadians, New Zealanders, and Australians on use of, access to, and satisfaction with their health-care systems. The comparison countries all have some form of national health-care system.

Overall, the comparisons show that residents of all four countries are almost equally likely to see doctors and have diagnostic tests, and that Americans are slightly more likely to take prescription drugs.

Americans are, however, more likely to skip medical tests because of cost and less likely to get appointments the same day they call. They also seem to be somewhat less satisfied with care they get from their doctors and in the emergency room.

Figure 14. Use of Medical Care, U.S. and Selected Countries, 2004
(Percent of Survey Respondents)

	U.S.	Great Britain	New Zealand	Canada	Australia
Saw at least one doctor in previous 2 years	**97%**	95%	97%	95%	98%
Regularly take prescription drugs	**46%**	44%	39%	43%	39%
Had blood tests, x-rays, or other diagnostic tests in past 2 years	**84%**	71%	82%	84%	83%
Able to get doctor's appointment same day when sick	**33%**	41%	60%	27%	54%
Skipped medical tests, treatment or follow-up because of cost	**27%**	2%	20%	8%	18%
Rate regular doctor's care excellent or very good	**61%**	64%	74%	68%	71%
Among those who used emergency room, share who rate emergency services fair or poor	**34%**	23%	27%	27%	23%

Source: Commonwealth Fund International Health Policy Survey, 2004

Are We Healthier?

Another important aspect of the health-care story is what we're getting in return for the high spending. Are Alaskans healthier than in 1990?

The answer seems mixed. In 2005 the United Health Foundation ranked Alaska as among the most improved states in health outcomes since 1990. Despite that improvement, the foundation still ranks Alaska somewhere in the mid-range of states on health measures—because 15 years ago Alaska was ranked toward the bottom.[9] Figure 15 illustrates some of the improvements Alaska has made since 1990.

Rates of infectious disease (which include hepatitis, tuberculosis, and many more) went from far above the U.S. average in 1990 to significantly below by 2005. Infant mortality dropped in Alaska and throughout the country.

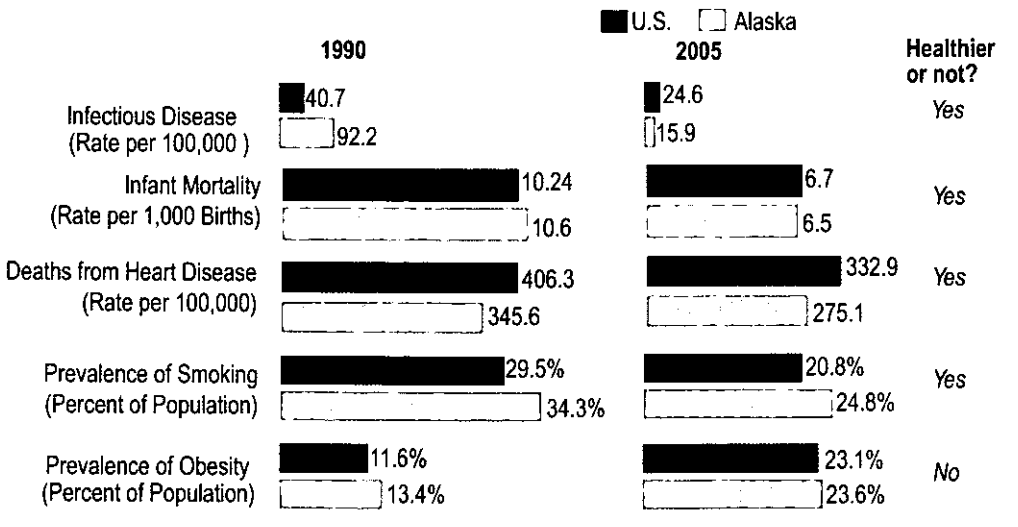
Declines in infectious disease and infant deaths in Alaska can be traced partly to public-health spending for immunizations, as well as for safe water and sewer systems, new housing, and better access to medical care in remote villages.[10] In Alaska and nationwide, advances in treatment and technology have also reduced infant deaths.

With improved treatments for heart disease, the rate of death from heart disease declined by 20% in Alaska since 1990, dropping slightly faster than the national rate.

Rates of smoking among Alaskans fell also, but Alaskans are still more likely to smoke than other Americans. Again, public-health campaigns to fight smoking likely contributed to the decline.

On the down side, Alaskans and other Americans are far more likely to be obese now than in 1990—and obese people are more likely to require treatment for diabetes and high blood pressure.

Figure 15. Are Alaskans Healthier Now Than in 1990?



Source: United Health Foundation, *America's Health Rankings 2005*

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Alaska and U.S. Costs

Years ago, everything cost more in Alaska, and costs still remain high in remote areas. But in Anchorage and other urban places, the historically high costs of many things have moved closer to U.S. averages in recent times, as the population grew, local markets got bigger, and infrastructure and transportation improved.

But costs of medical care haven't declined relative to U.S. averages. Overall medical costs are probably somewhere in the range of 25% higher in Alaska, but that cost difference varies quite a bit among services and procedures, and prices don't always reflect cost.

Alaska has fewer practicing doctors per capita than the nation as a whole, but somewhat more dentists—so how the supply of medical professionals may affect costs is not clear (Figure 16).

Figures 17 through 20 show some examples of cost differences, but it isn't a comprehensive picture.

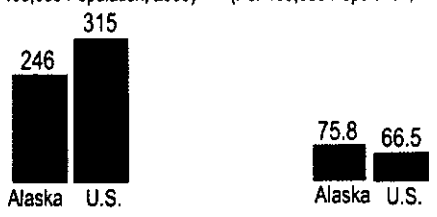
- Overall costs of medical and surgical procedures in Alaska were about 18% above the U.S. average in 2001 and dental procedures 37% more (Figure 17).

- Average costs of a visit to a doctor's office were 30% higher in Alaska in 2001. But the average is a mix of private insurance and government payments. A private insurer in Anchorage and Fairbanks paid nearly twice as much as Medicare for an office visit in 2001, as Figure 18 shows.

- Alaskans don't use as many prescription drugs as other Americans—mostly because there are fewer Alaskans over 65—but we pay more. In 2003, the average price of retail prescriptions was 25% higher in Alaska.

- Costs of hospital care went up faster in Alaska than nationwide from 2000 to 2003—so in 2003 average expenses for a day in an Alaska hospital were 42% above the U.S. average, compared with 30% in 2000.

Figure 16. How Do Numbers of Alaska Doctors and Dentists Compare with U.S. Averages?



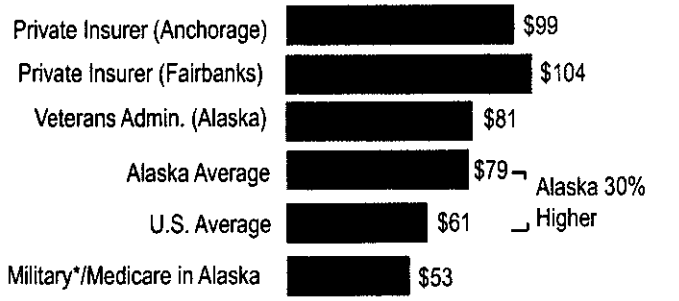
Note: Figures updated and corrected March 2007; see endnote 11.
Sources: American Medical Association; American Dental Association; U.S. Census Bureau

Figure 17. How Much Higher are Medical Costs in Alaska?
(Costs Paid by Private Insurer, 2000)

	Percent Above U.S. Average
Medical/Surgical Procedures	18.1%
Dental Procedures	37.7%

Source: Ingenix data base; cited in Alaska Division of Medical Assistance, HealthCare Cost Analysis, 2001

Figure 18. Costs of An Office Visit, Alaska and U.S., 2001
(Established Patient, 15 minutes)



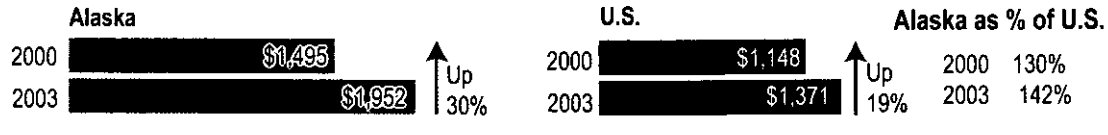
*Insurance coverage for active-duty and retired military personnel for medical care not available from military facilities.
Source: GAO Report GAO-01-620, May 2001

Figure 19. Prescription Use and Cost, Alaska and U.S., 2003

	Prescriptions Per Capita	Average Price of Retail Prescriptions	Average Cost Per Capita
United States	10.7	$52.97	$566.78
Alaska	6.3	$66.89	$421.41

Source: Kaiser Family Foundation, based on data from Verispan, LL.C.: Special Data Request, 2004; and U.S. Census Bureau, State Population Datasets for six Race Groups

Figure 20. Hospital Costs, Alaska and U.S. , 2000 and 2003
(Expenses per In-Patient Day)



Source: 2003 American Hospital Association, Annual Survey

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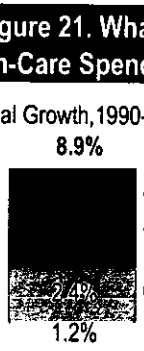
Figure 21. What's Driving Health-Care Spending In Alaska?



What's Driving Costs? It's a Puzzle

Spending for health care in Alaska increased an average of nearly 9% a year from 1990 to 2005—and that figure doesn't reflect the big capital costs for building hospitals and clinics in the state since 1990.

More people and general inflation together account for only about 40% of that growth. So what's driving the rest?

Just about everybody has an opinion about what's pushing up medical costs, here and nationwide. Alaska has some special conditions—mostly small markets and high costs in rural areas—but other possible contributors to high costs are common to Alaska and the rest of the country.

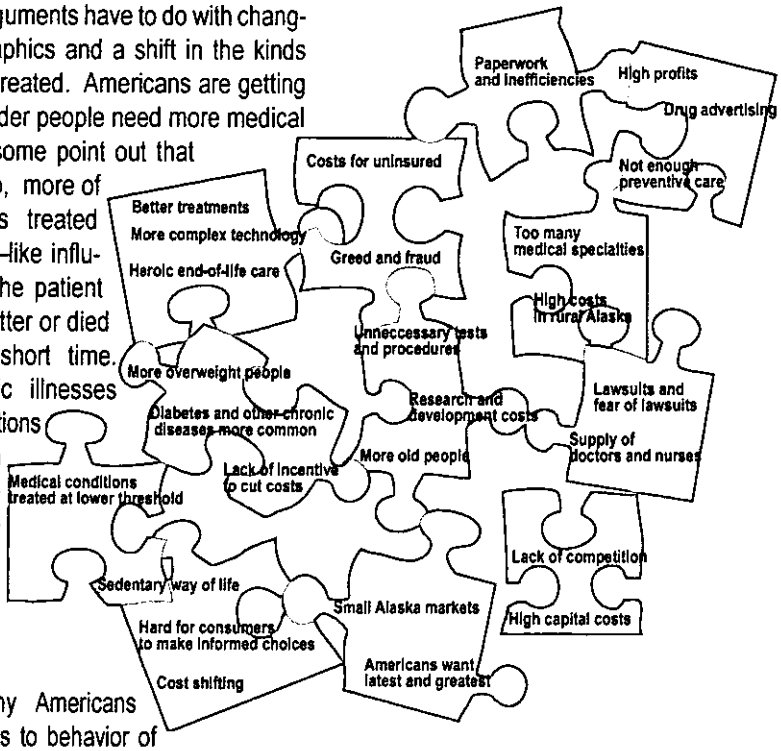
Some people think the big factors have to do with our system of delivering health care. Those include market forces—like lack of competition, for instance, and lack of incentives in many parts of the system to control costs—as well as inefficiencies created by the complexity of the U.S. system.

Other arguments related to the delivery system are that Americans get more medical care than they need, because most of the bills are still paid by health insurance. Others believe, by contrast, that costs of caring for uninsured people are responsible.

Others blame environmental factors, especially Americans eating too much and not exercising—leading to the spread of diabetes and other conditions requiring more care.

Still others say the growth has to do with changes in treatments and technology—treating conditions at lower thresholds (like the recent drop in the cholesterol level at which doctors recommend treatment); more effective but costlier treatments and prescription drugs; and more complex technology.

Other arguments have to do with changing demographics and a shift in the kinds of illnesses treated. Americans are getting older, and older people need more medical care. Also, some point out that decades ago, more of the illnesses treated were acute—like influenza—and the patient either got better or died in a fairly short time. Now, chronic illnesses and conditions—like high blood pressure—are common and require long-term treatment.



And many Americans link high costs to behavior of drug companies, the insurance industry, the medical and legal professions, and individual Americans. Such behavior would include, for instance, insurance and drug companies making high profits; doctors overbilling government programs; and patients filing lawsuits—causing doctors to practice "defensive medicine."

Probably there are other opinions we haven't discussed here. We're not endorsing any of them, but merely pointing out that many things could be contributing to rising costs—and it's a puzzle how all the pieces fit together. We will learn more as we study Alaska's health-care system. But for now, we want to emphasize that the answer to what is driving health-care costs is not simple, and finding solutions won't be simple either.

Endnotes

1. Our estimates are based on the Center for Medicare and Medicaid Services' definitions of personal health care spending. See http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage. We have also included insurance costs, to capture the expenses paid by employers and employees.

2. ISER *Research Summary* No. 53, "The Cost of Health Care in Alaska," December 1992.

3. The decline in state share is expected to ameliorate somewhat beginning in FY 2006, due to a decision by the 9th District Appellate Court to disallow the Fair Share program that enabled tribal hospitals to receive a higher reimbursement than non-tribal hospitals for uncompensated care.

4. U.S. Census Bureau figures from the Current Population Survey classify Alaskans with coverage only through the Indian Health Service as "uninsured." We have adjusted those figures, separating those with IHS-only coverage from the uninsured. The adjustment is based on methods of the University of Minnesota's School of Medicine, State Health Access Data Center.

5. American Academy of Pediatrics figures for uninsured Alaska children are adjusted U.S. Census figures, separating children with IHS-coverage only from the "uninsured" category.

6. National Academy of Sciences, *Hidden Costs, Value Lost: Uninsurance in America.* Available at: http://www.nap.edu/catalog/10719.html Public subsidies for uncompensated care are illustrated in the State of Alaska's FY 2007 budget request, which includes $27 million to help Alaska hospitals pay for uncompensated care.

7. In 1999, for example, health-care spending for Americans 75 to 84 was seven times higher than for those 18 and under.

8. See note 6.

9. United Health Foundation, *America's Health Rankings*, 2005 edition.

10. See Chapter 3 in ISER report, *Status of Alaska Natives 2004*, May 2005.

11. Our original figure for number of dentists per 100,000 in Alaska was incorrect. We thank researchers at Health Planning and Systems Development in the Alaska Department of Social Services for helping us identify that error. A separate addendum, *Dentists in Alaska*, prepared in March 2007, provides more information about the source of the error and the correction. See: http://www.iser.uaa.alaska.edu/Publications/researchsumm/UA_RS6_addendum03_07.pdf

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COMMONWEALTH NORTH

Alaska Primary Health Care: *OPPORTUNITIES & CHALLENGES*

Approved by the Board of Directors on June 7, 2005
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EXECUTIVE SUMMARY

Why Alaska health care issues must be addressed and solved

Health care is not a goal or end in itself. The ultimate goal of health care and of this study is health and wellness for Alaskans. Alaskans must identify and improve the aspects of health care that are under our control. Many health care issues are national, that Alaskans cannot affect. Therefore, it is even more important to address and solve issues we can do something about. Furthermore, the demographics of an aging population will put foreseeable pressure on all fronts.

ACCESS

- Approximately 110,000 Alaskans have no health insurance coverage.
- Many others have minimal or inadequate coverage.
- Thousands are turning to hospital emergency rooms as a source of primary health care, often without ability to pay.
- Adequate health care in remote areas is a significant logistical, financial and educational challenge.

QUALITY

- Based on the 2004 National Healthcare Quality Report, Alaska has low rankings in several key measures of cancer, heart disease, maternal and child health, respiratory diseases, and nursing and home health care.
- Many Alaskans are in high-risk health categories, many are not receiving adequate care.

COST

- Alaska health care costs are approximately 40% higher than Seattle (per Premera, corroborated by Providence and Alaska Regional)
- Medicaid costs to the State of Alaska are rising dramatically, to over $1 billion in 2005. It is placing a strain on the state budget.
- Health care insurance premiums are also rising dramatically, creating a significant burden on employers and employees.
- Alaska hospitals are losing tens of millions of dollars from uncollectable accounts arising from excessive emergency room use and they are unable to reduce the amount of emergency room care provided due to Federal law.

What can we do?

There are four major interrelated factors driving primary healthcare in Alaska today:

1. Health and wellness of the population
2. Availability of care and insurance
3. Affordability of care and insurance
4. Financial health of the stakeholders, such as employers, providers and individuals

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These drivers are currently interacting in a "cost spiral" that is creating a very serious situation nationally and in Alaska. The rate of increase in the cost of health care is unsustainable—if unchecked health care increases will price employers out of the market. Already industries such as automobiles are threatened. We need to avoid similar impacts in Alaska.

We believe that with focus and coordination Alaskans can impact this "cost spiral" positively through specific actions in the four areas mentioned above:

1. Lifestyle and prevention: Raise public awareness and increase personal responsibility for wellness
2. Access: Make services and insurance more widely available
3. Quality: Continue improving quality of care that is delivered
4. Costs: Reduce costs of service delivery and insurance to make them more affordable

There are many health care initiatives already underway in these areas by various governmental and non-governmental entities. Some have proven to be effective and cost-efficient. Others show significant promise. Health care reform is complex and controversial, with multiple players and competing interests. Inconsistent tracking and trending create significant factual disputes about healthcare systems. Any major reform has potential to create both winners and losers.

Given this environment, the Study Group came to three overarching conclusions:

1. The Study Group process itself has been enlightening, educational and productive.
2. Every aspect of health care is complex. Understanding the system and improving it is beyond the capacity of any one element within the system.
3. The Study Group recommends that an ongoing body be established to continue and deepen this Group's work.

The time to act is now. Involvement of Alaskans in the health care debate is vital. Reform of some sort is inevitable, and Alaskans should control it as much as possible to our own benefit. Since there is no single forum today where the disparate players can come together to agree on facts, share solutions and craft a win-win for our unique Alaskan conditions, this Study Group recommend formation of—

The Alaska Health Care Roundtable ("Roundtable")

The goals of the Roundtable are to continue communication and foster action among parties that have a long-term vested interest in health care reform. It must set a standard of credibility and create timely actionable ideas that can gather bipartisan support, get quick approval and become part of a long-term fiscal plan for Alaska. It would be a sounding board and facilitator for ideas and recommendations, with a focus on lifestyle and prevention, access, quality and cost.

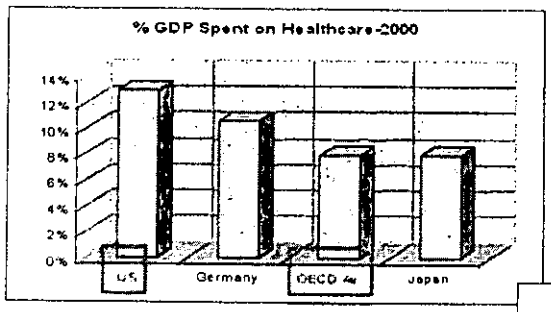
The core membership in the Roundtable would be self-selecting, comprised of members with a long-term compelling interest in improving the Alaska health care system. Examples of core members would be major employers at risk, health care providers and local foundations. A wide variety of other potential members, resources and ad hoc participants could be included as needed. Funding would be by voluntary contributions by the participants and the community.

INTRODUCTION

The big picture: National background issues and the state of health in the U.S.

While the focus of this study is factors controllable in Alaska, it is important to understand the national context in which we operate. The United States spends more on health care than any other country, measured either as a percentage of gross domestic product, or in terms of money spent per person. The OECD, or Organization for Economic Cooperation and Development, is a group of industrialized nations that are an appropriate benchmark for U.S. expenditures and performance.

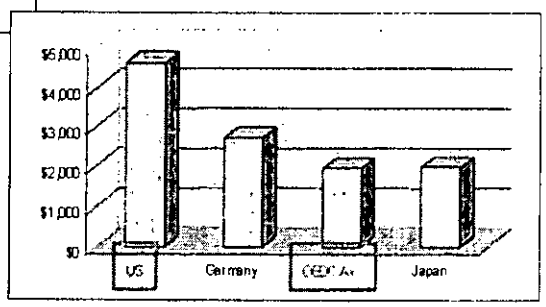
The National Situation - Spending



OECD—Organization for Economic Cooperation and Development

Source: Commonwealth Fund

Per capita health care expenditures by country



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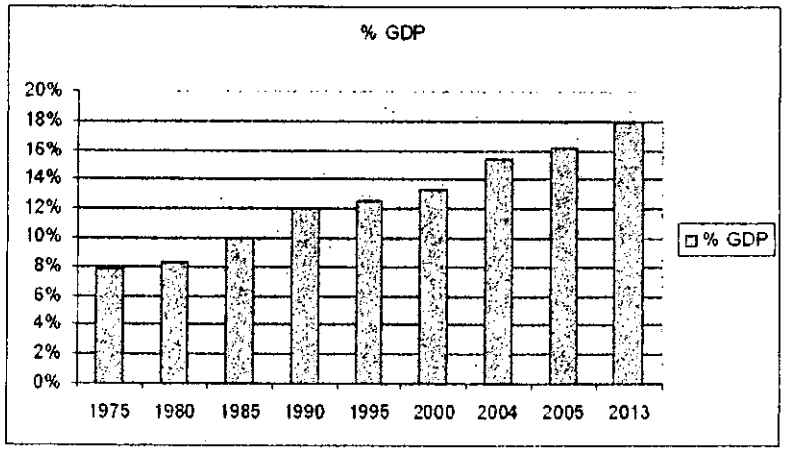
Health care spending has risen dramatically in recent years, increasing from about 8 % of the gross domestic product in 1975 to over 16% today. The Commonwealth Fund, a private nonpartisan foundation that supports independent research on health and social issues, projects that by 2013 the U.S. will be spending 18% of GDP on health care.

Many factors contribute to these increases. Often cited are huge costs caring for the last three months of life, advertising driven consumerism, high cost of technology, defensive medicine practiced to avoid malpractice suits, malpractice insurance, a fractionated payment system and massive cost shifting to those able to pay caused by inadequate or no health insurance for many Americans (and Alaskans). The crushing cost of health care threatens whole industries and affects our worldwide ability to compete economically.

The National Spending Situation:
Trend in Healthcare Costs as a % of GDP



Source: Commonwealth Fund

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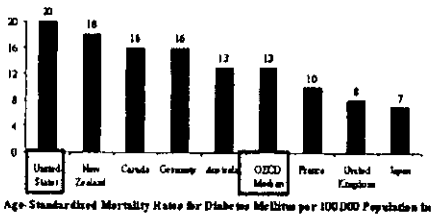
The **Commonwealth Fund** is a foundation specializing in health care issues.

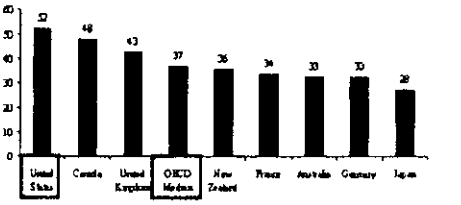
In terms of outcomes, the United States has obtained poor results from the massive amounts invested. By many measures, the U.S. trails other industrialized nations, as represented by Organization of Economic Cooperation and Development averages. We also have a higher percentage of uninsured than most advanced countries, which tend to have centralized health care systems.

The National Situation: Outcomes



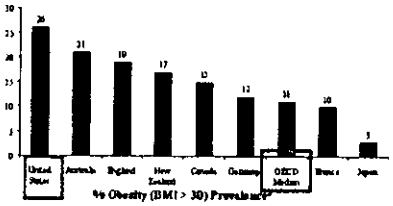
Age-Standardized Mortality Rates for Diabetes Mellitus per 100,000 Population in 1999[34]

DIABETES



Age-Standardized Mortality Rates for Lung Cancer per 100,000 Population in 1999

LUNG CANCER



% Obesity (BMI > 30) Prevalence[35]

OBESITY

And, the U.S. ranks only

- #28 overall in infant mortality
- #24 in life expectancy

Sources: OECD Health Data 2002,
March of Dimes Data Center 2002
World Health Organization 2000

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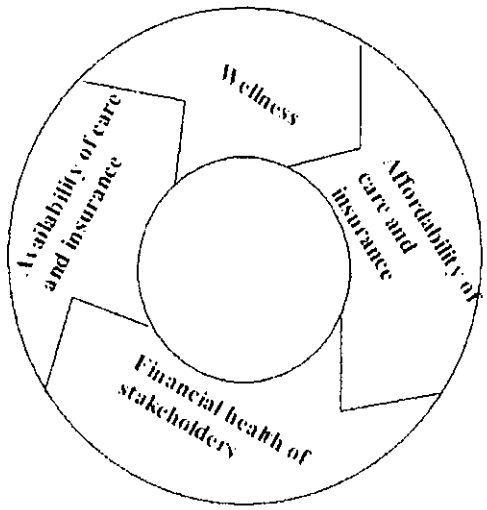
A conceptual framework of four primary healthcare factors can help us understand how all the different factors are interrelated.

Four Primary Healthcare Factors and how they are interrelated



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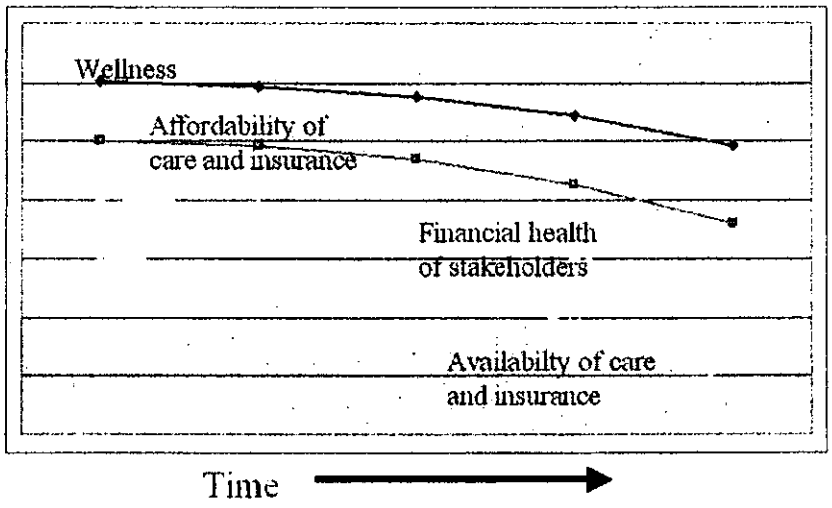
- Wellness of the population
- Affordability, coordination and quality of care and insurance
- Availability of care and insurance
- Financial health of stakeholders including:
  - Health care providers (physicians, clinics, hospitals)
  - Companies, institutions and government

These factors are all part of a complete cycle. Each factor affects the other. Therefore they are portrayed in a circle.

As time goes on, each of these factors influences the others, with the ultimate result of either undermining or improving the health and wellness of our people.

The conceptual crux of the problem



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A significant problem is a de facto dynamic in our current U.S. health care policy.

The motto of a popular Alaska establishment embodies this unintended and unwanted de facto policy, to wit—

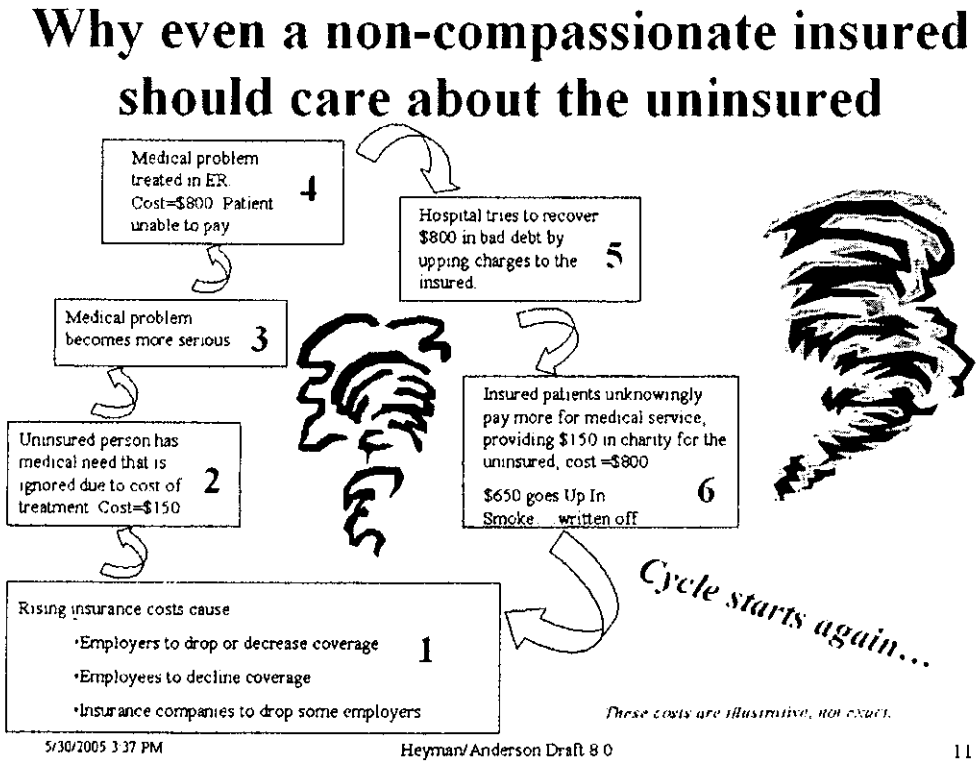
"We cheat the other guy and pass the savings on to you!"

This phenomenon has impacts both nationally and in Alaska, and Alaskans are not always the beneficiary, creating serious cost shifting and economic dislocations.

A SIGNIFICANT ISSUE FOR HEALTH CARE IN ALASKA

The focus of this study is what can be done in Alaska. It does not address national issues such as a single payer system, rationing of health care or national structural issues. However, the following conceptual illustration is both a national and Alaska problem.

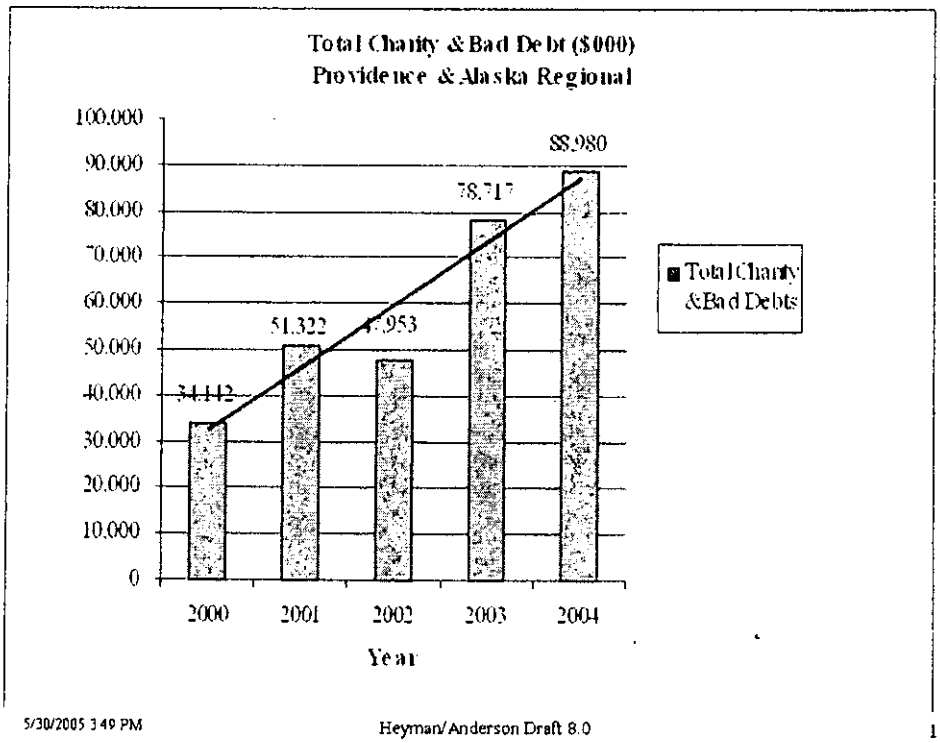
It shows how the high cost of health care causes people to postpone needed care, which increases ultimate costs of treatment, frequently and reluctantly performed by practitioners at unneeded and inappropriate levels. Often the emergency room of a hospital becomes a highly expensive primary care facility. If treated earlier, medical conditions could have better outcomes at a lower cost.



A federal law, the Emergency Medical Treatment and Active Labor Act ("EMTALA") requires that hospital emergency rooms treat and not turn away any patients who show up, regardless of ability to pay.

4881

Emergency rooms are becoming primary care treatment centers for those without access to, or awareness of, alternatives. Current waits can be up to two hours, especially during high traffic times like early evenings or weekends. This creates inefficient use of specially trained staff and is enormously expensive. Many ER patients have no insurance coverage or other means to pay their bill. The financial burden then falls on the hospital to write off uncollectible accounts.



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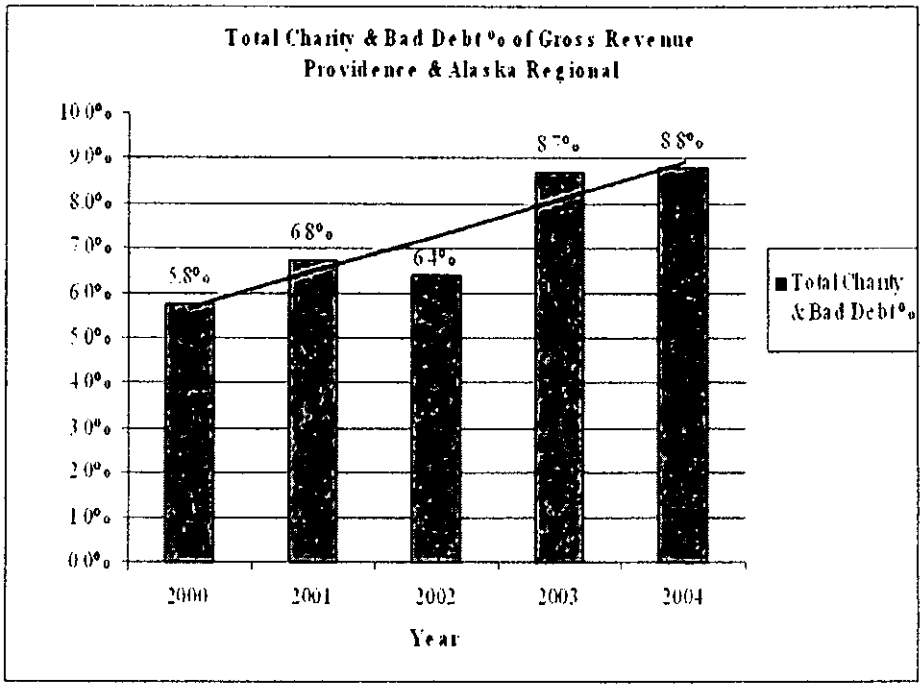
Note: the numbers above are in thousands of dollars. E.g. 88,980 = $88,980,000

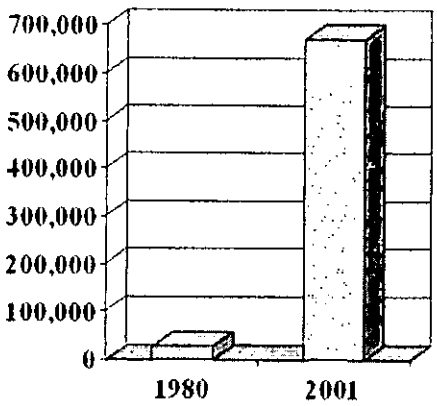
4882



The financial impact on hospitals is even more acute than the slide above suggests. While the percentage of charity and bad debt compared to gross revenue has increased dramatically in recent years, the bottom line impact is significantly greater because actual hospital cash collections are much less than the gross revenue billings used in the chart above.

Hospitals are not the only ones affected. Individuals unable to pay medical expenses are filing for bankruptcy at staggering rates. Although Alaska data are not available, national data are noted below.

Personal Bankruptcies due to Health Care Costs-U.S.



- Between 1980 and 2001 medically driven bankruptcies increased 23 times
- 60% skipped doctors visits
- 47% skipped prescription medicines

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Source: American Medical Association 2/05 and a Harvard Law School/Medical School 2/05 studies.

70% of these debtors had some form of health insurance at the start.

Main factors cited for declaring bankruptcy were:

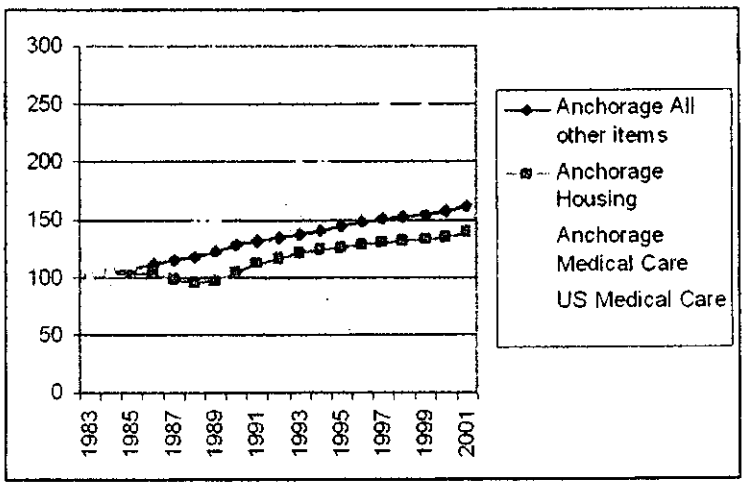
Hospital costs	42%
Prescription drug costs	21%
Doctor bills	20%

Cost: What do Alaskans pay? Why?

The impact of **bad debt** on the health care system has been clearly illustrated in the preceding charts.

Increasing Cost of Medical Care in Alaska

Anchorage CPI-U for selected components 1982-2001



Source Alaska Economic Trends June 2004

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Premera, Alaska's largest health care insurer, reports that their **Alaska costs are about 40% higher than Seattle**. General observations by resource people have referenced a 40% differential overall, more in some specialties, less in others. Local hospitals have corroborated this differential. Other information points to even larger discrepancies on reimbursement rates for physicians. The Alaska Division of Medical Assistance Health Care Cost Analysis Report placed Alaska in the top five states in terms of the cost of medical and surgical procedures.

Small practices and increasing personnel costs contribute to the high cost of medicine in Alaska. Also there is general, but not substantiated, belief that the **Alaska population is too small to support HMOs**. Any discussion of managed care has been resisted by medical providers.

Dependence on "Fair Share" and other sources of federal dollars place about $800 million potentially at risk, an important share of current health care funding to Alaska. Alaska also faces **competition from other states** for willing providers. Furthermore, **reimbursement**

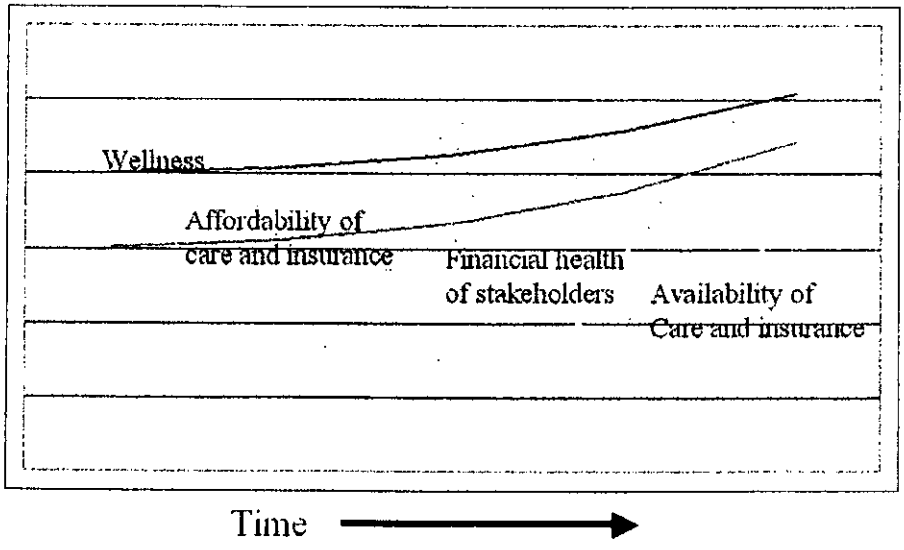
formulas are going down. The state is now paying over one billion dollars annually to pay Medicaid expenses.

Cost of health insurance—there is no public oversight of health care insurance rates by the Division of Insurance as there is in some other states. They are a result of negotiations between insurance companies and large groups.

The **Certificate of Need** situation needs to be objectively analyzed and considered as a component in a comprehensive statewide health care plan. Critics of the Certificate of Need claim the process stifles competition and innovation. Supporters claim it prevents unnecessary duplication of facilities and allows more rational allocation of assets.

The impact of tort issues on health care. The cost of malpractice insurance and defensive medicine is hard to quantify, but is deemed to be substantial. OB/GYN liability insurance is $60-65k/year. SB 67 puts a 250k cap on non-economic suffering. The California experience with a similar cap since 1975 has been positive. Alaska has only two traditional liability carriers. However, compared to U.S. averages, malpractice insurance costs in Alaska are middle of the pack.

Is a trend reversal possible in Alaska?



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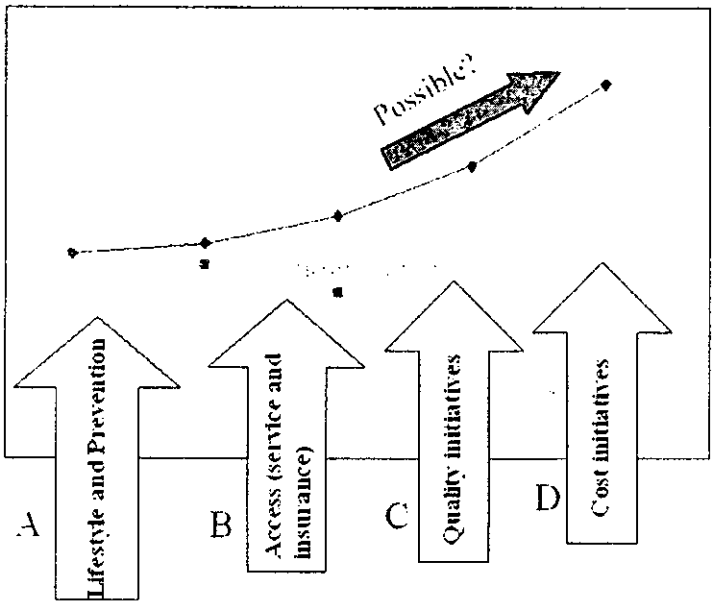
Perhaps, with coordinated and focused effort



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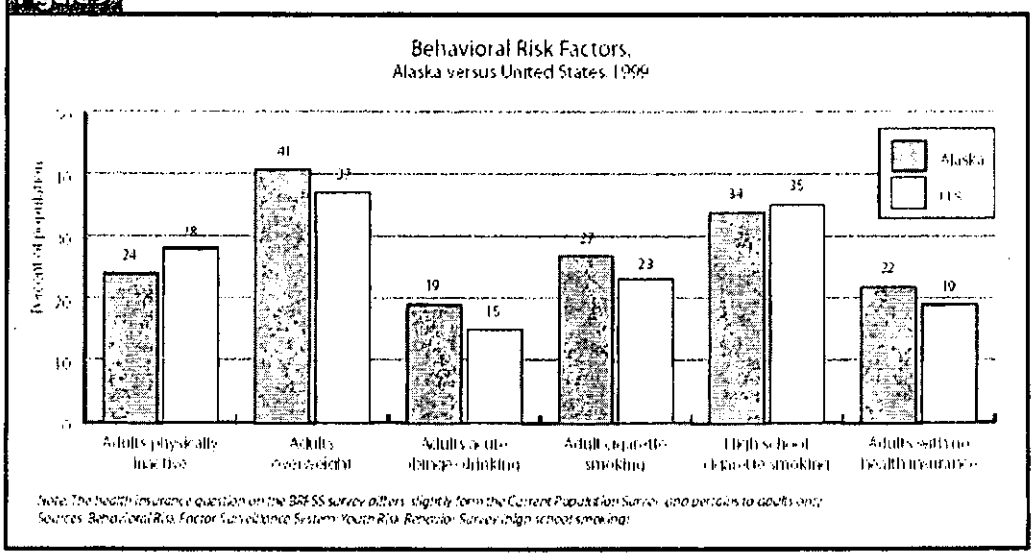
Quality of Alaska's health: Based on the 2004 National Health Care Quality Report of 100 measures of health care quality, Alaska is about average for the U.S. However, as the charts on page 7 indicate, the U.S. trails many other industrialized nations.

Unfortunately, Alaska mirrors poor National behavioral risk factors

Figure 9



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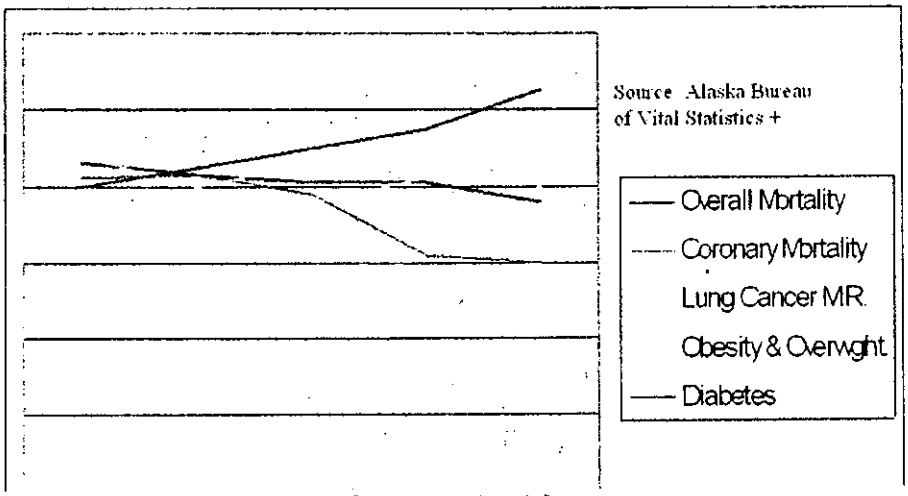
Alaska Trends in major disease



Trends only—not incidence rates

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(Vertical axis is rates of disease, horizontal axis is time)

While progress has been made in heart and lung disease, obesity and diabetes have negative trends.

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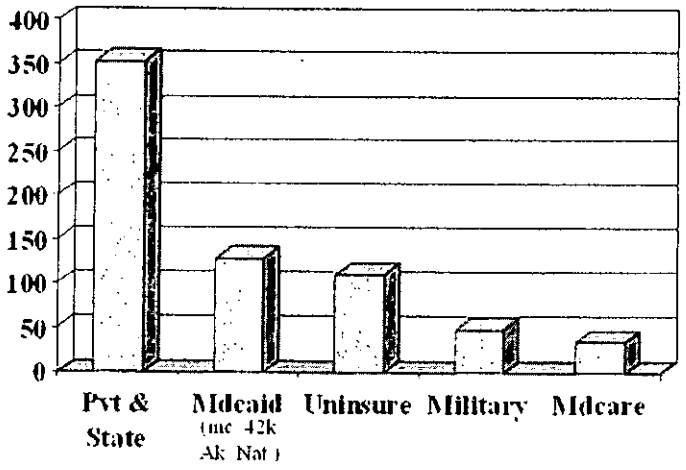
How is Alaska's health care being paid? What about those without coverage?

Currently about 110,000 Alaskans do not have health care insurance. Approximately 82% of Alaskans have some type of insurance coverage, as illustrated by the chart below. The column for private and state coverage includes state employees. Medicaid covers over 40,000 Alaska Natives, the remainder of which are covered under federal programs. Military and Medicare coverage rounds out the picture. However, an unquantified, but suspected to be substantial, number of people have inadequate insurance coverage.

Alaska's Insurance Coverage



Source Navigant Consulting, AK Journal of Commerce

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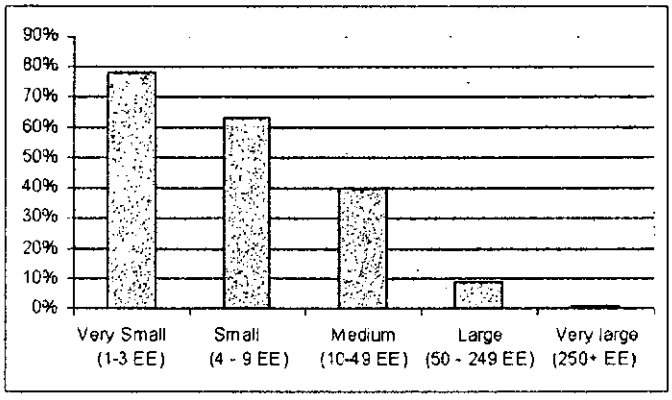
The majority of Alaskans without insurance work for smaller businesses.

Alaskan firms NOT offering health insurance



And only [illegible]% of Alaskans were employed in firms with over 50 employees

Source: Alaska Dept of Labor and Workforce Development, 2002

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Safety net providers

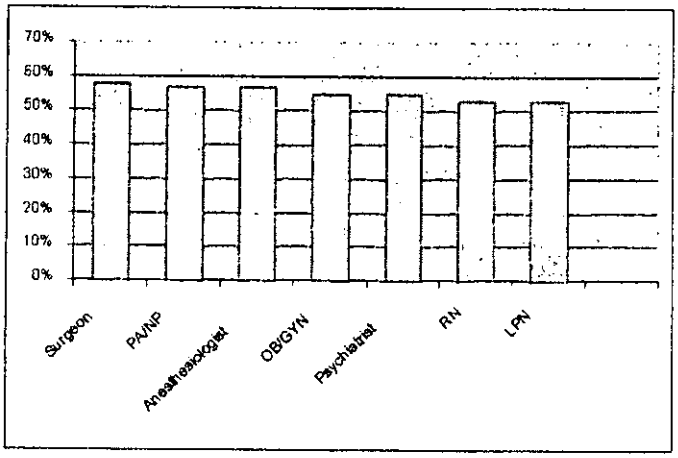
There are 34 federally sponsored Community Health Centers (CHCs) in Alaska. They see all patients and charge a sliding fee schedule based upon income. Although there are the Neighborhood Health Center in Anchorage and the Interior Community Health Center in Fairbanks (both federally sponsored CHSs), a large number of uninsured patients receive their care in the city's emergency rooms.

Under federal law, patients who visit the emergency rooms must be seen regardless of their ability to pay. This results in the uncompensated care that was referenced previously.

Although not safety net providers, the Alaska Native Health system provides care to an estimated 125,000 Alaska Natives through an extensive network of community health aid clinics, regional hospitals and a major referral center.

Healthcare Provider Shortages are Projected for Alaska

PERCENT OF PROVIDERS CURRENTLY MORE THAN 45 YEARS OF AGE



Sources: AK Department of Labor

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Shortage of doctors: ½ doctors in Alaska are over 50. Fewer doctors are practicing than are licensed. Compared to the rest of the U.S., Alaska has 17-30% fewer doctors per capita, partly because we have a relatively younger population. However Alaskans are aging, and the need will increase. Today Alaska needs 472 more doctors than it has. The shortage will increase in the future. Statewide Alaska has a 25-30% shortage of physicians. Physicians are practicing fewer hours and retiring younger than in past decades. As a result it may require more than one new physician to replace a retiring one. 70% of doctors in the lower 48 practice near where they did their residency. The rate of return on a medical education is diminishing compared to other professions. Medical students average $100,000 of debt; specialties can be $250,000 with an average of 8 years post-graduate education. Similarly, graduating dentists average nearly $200,000 in debt. In contrast, graduating attorneys and MBA's begin earning money faster and with less debt.

Nurse Practitioners and Physician Assistants provide care to Alaskans in a wide variety of settings, including rural and urban primary care clinics, urban specialty practices, and remote critical access hospitals that were historically difficult to staff with other providers. There are over 200 physician assistants and 420 nurse practitioners working in Alaska. This gives Alaska one of the highest ratios of nurse practitioners per capita in the nation.

As in 25 other states nurse practitioners are licensed to practice autonomously. A recent Columbia University study (JAMA, 2000) and another from Yale University (1992), compared physician and nurse practitioner practice. They found that patients expressed a high degree of satisfaction with the care they received, that accuracy of diagnosis and health outcomes were equivalent, and that Nurse Practitioners provide quality, cost-effective care to their patients.

The role and extent of coverage of complementary and alternative medicine (chiropractic, acupuncture, etc.) in Alaska is undefined, but substantial. As of May 25, 2005, the Alaska Division of Occupational licensing listed the following numbers of active licenses for the following types of doctors:

Allopathic doctors (M.D.)	2,377
Chiropractic doctors (D.C.)	227
Osteopathic doctors (D.O.)	183
Podiatrist (D.P.M.)	20

SPECIFIC ALASKAN RECOMMENDATIONS FOR IMPROVEMENT

This Study Group has identified a continuum of challenges, many of which are interrelated to each other. While they may all be part of a whole, the Study Group identified discrete categories to more readily focus on how each recommendation may be best implemented. A chart below summarizes the recommendations and identifies which parties are affected by, or responsible for, each recommendation.

However, in the process of assessing health care in Alaska, and looking for improvements, the Study Group developed consensus on three overarching conclusions:

1. **The Study Group process itself, which includes representatives of all key components of the health care system in Alaska, has been enlightening, educational and productive. For the first time in recent years, key players have been able to share experiences and ideas in a supportive and cooperative environment.**

2. **Every aspect of health care is complex. Education, technology, funding, social and demographic factors, economics, federal and state laws and regulations all have many interrelated facets. Understanding the health care system, and improving it, are beyond the capacity of any one element within the system.**

3. **Therefore, a fundamental recommendation of the Study Group is that an ongoing body be established to achieve multiple goals:**

    a. **Continue the communication process started by this Study Group among the key elements in the Alaska health care system and the broader Alaska community.**

    b. **Create a body that will have a long-term vested interest in understanding and improving the system. Some solutions are immediate, others will take generations. But without consistent advocacy, the system is unlikely to make needed fundamental changes.**

    c. **Through the quality of its participants, and the comprehensiveness and depth of its vision, the body will set a standard of credibility that will sustain its ongoing operations and facilitate implementation of its recommendations.**

In that spirit, this Study Group offers the "Yarmon Plan" as a starting point for structuring such a body.

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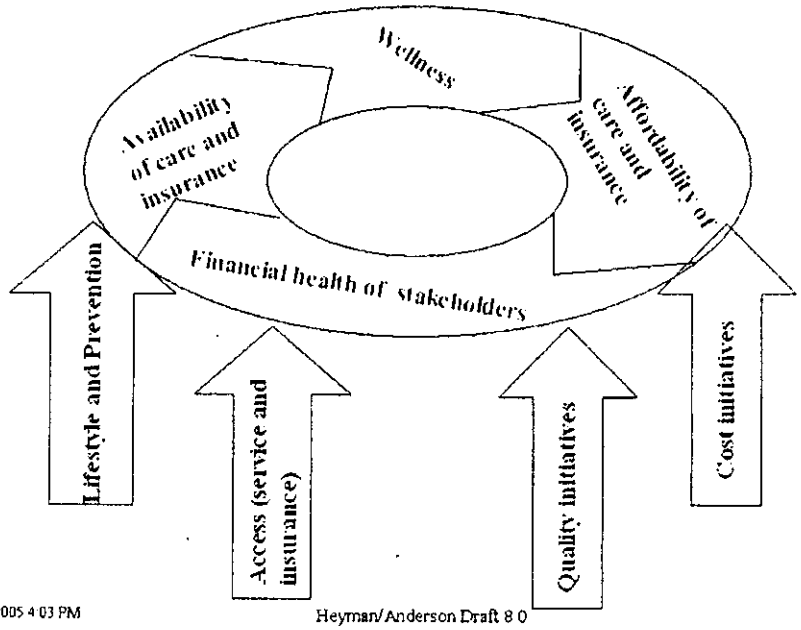
The **Roundtable** Proposal (The Yarmon Plan)



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The Alaska Health Care Roundtable

Goals: a, b, c on the previous page. Create a timely, actionable package that will gather bipartisan political support, get quick approval, and become a significant part of a long-term fiscal plan for Alaska.

Focus: Access, quality and cost. Function as both a sounding board and facilitator for ideas and recommendations.

Structure: Create the **"Alaska Health Care Roundtable"**

Membership in the Roundtable: Self-selecting. Must have a core of members who have a long-term compelling interest in improving access, quality and cost of health care in Alaska. Examples of potential members would be:

a. Major employers
b. Providers
c. Foundations
d. Other participants as invited by the Roundtable

Funding: Voluntary contributions by the participants.

Strategic relationships: Form a research relationship with the **University of Alaska/Institute of Social and Economic Research (ISER)**. The Roundtable itself could focus on strategic policy and political analysis. UA would provide in-depth research as needed on a contract basis.

Tactics: Secure the support of major employers and secure their interest in funding such a Roundtable. There is no point in CWN issuing a major recommendation that will fall flat on its face. Get seven or more CEOs of major employers to make a financial commitment to the project and be present at its unveiling.

Create a package of recommendations that will be dynamic, compelling and politically impossible not to accept. Create a "win-win" atmosphere so all participants can claim victory.

Local or regional Roundtables can address "nuts and bolts" issues of cooperation, implementation, sharing and efficiency.

Potential resources, ad hoc participants or additional members: Business leaders of large businesses, business leaders of small businesses, Alaska Natives, labor, non-profit (Foraker Group), education, military, insurance industry, state government (legislature, administration), health care providers, Medicare, Medicaid

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Summary table of recommendations with affected and responsible parties
The following chart summarizes various recommendations that were suggested in the course of our study. They are a starting point of menu items for the Roundtable to analyze and prioritize.

A = Parties affected by or benefiting from the listed Recommendation

R = Parties responsible for implementing the listed recommendation

Recommendation	Individuals	Legislature	Governor	Local Governments	Private Sector	Health Care Professionals & Institutions	Universities (or schools)	Insurance Companies
Lifestyle & Prevention								
1. Walkable community	AR			AR	AR	AR	AR	AR
2. Public Health role	A	R	R	AR	A	A	AR	A
3. School phys ed	A	R	R	AR	A	AR	R	A
4. Schools nix bad foods	AR	R	R	AR	A	AR	AR	A
5. Incentivize behaviors	AR	AR	AR	AR	AR	A	AR	AR
7. Rural dentistry	A	A	A	AR	A	AR	AR	AR
8. Drug/psych facilities	A	AR	AR	AR	A	AR	A	AR
9. U.S. preventive health recommendations	AR	AR	AR	AR	AR	AR	AR	AR
10. Circumpolar health studies	A	AR	AR	AR	A	A	A	A

4897

Access	Indiv.	Legis.	Gov.	Loc Gv	Private	HC	Univ/Sc	Ins. Cos
1a. Expand WWAMI	A	R	R	A	A	AR	AR	AR
1b. Market AK To MDs	A	R	R	AR	AR	AR	A	AR
2. Cut liability ins. Cost factors	A	R	R	A	A	AR		AR
3. Cover uninsured	AR	AR	AR	AR	AR	AR	AR	AR
4. Pool small cos.	A	R	R	AR	AR	A		AR
5. Promote lower cost centers	A	AR	AR	AR	AR	AR	A	A
6. Same day non ER alternatives	A	R	R	AR	A	AR	A	AR
7. Examine other state models e.g. UT, ME	A	R	R	A		R	R	AR
8. More GME $ for family practice	A	R	R	A	A	AR	AR	A
9. Improve MD reimbursements	A	R	R	A	A	AR		AR
10. Medicare licensing requirement	A	R	R	A	A	A	A	A
11. Public insurance hearings	A	R	R	A	A	A	A	AR
Quality								
1. Evidence based prevention, Intervention	AR	AR	AR	AR	AR	AR	AR	AR
2. Use bench-marks	A	R	R	AR	AR	AR	AR	AR
3. Measure, disclose quality info	AR	AR	AR	AR	AR	AR	AR	AR
Costs								
1. Prevention education, intervention	AR	AR	AR	AR	AR	AR	AR	AR
2. Electronic medical records	A	AR	AR	AR	AR	AR	AR	AR
3. Drug formularies	AR	AR	AR	AR	AR	AR	A	AR
4. Health care <> State fiscal plan	A	AR	AR	AR	AR	AR	AR	AR
5. Disclose fees clearly	A	R	R	A	A	AR	A	AR
6. Community duplication dialogue	A			AR	AR	AR		AR
7. Joint purchasing	A			AR	AR	AR		A
8. Allocation & rationing	A	AR	AR	AR	A	AR	AR	AR
9. Fee transparency legislation	A	R	R	AR	A	AR	AR	AR
10. Legislative ins., reimbursement, tort solutions	A	R	R	AR	AR	AR	AR	AR

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The impact of lifestyle and prevention

First and foremost, this is an issue of individual responsibility. This means that each of us is ultimately responsible for our own health, how we eat, exercise and live. Nevertheless, many collective societal educational and social efforts can help further acceptance of this individual responsibility through application of sound health maintenance principles.

Our society is not used to facing the facts of collective issues. They are not part of the national or state non-Native psyche. Currently, the health care industry plugs holes in the dike that are the result of unhealthy lifestyles. We need to go way upstream and focus on prevention.

Fortunately, we can learn from the positive example of reduction of smoking in America. Much remains to be done. Today's limited but meaningful success is the result of a long-term effort that lasted over a generation. Extensive public education, warning labels, laws banning smoking in public places and a consistent message from the health care community ultimately resulted in societal changes that now appear to have gained a self-reinforcing life of their own.

1. **Plan a "walkable community."**
    a. Land use designed to facilitate walking and biking can encourage cardiovascular health. Maintaining safe municipal trail systems, seasonal bike paths, and cleared wintertime walkways permit citizens to practice healthful life habits year around.
    b. Enlightened city planning and architecture can promote a more active lifestyle.
    c. As public demand for exercise opportunities grow, their inclusion in real estate development and city planning can improve property values.

2. **The role of public health as community educator and provider.** Municipal health departments need to serve many more people than those who seek care at the clinic. Promoting wellness and healthful living habits to the entire community is an essential part of the public health mission. This portion of the mission needs to be funded adequately in the budget.

3. **The importance of physical education in the schools— (not a "frill")** It is important to teach children about the relationship between health, diet and exercise. Not every child will want to join a sports team, but learning to be responsible for their own health by incorporating physical activity into their daily lives is an important health lesson that cannot be ignored.

4. **Eliminate internal inconsistencies and conflicts between programs and objectives.** For example, eliminate financial incentives in schools to promote unhealthy foods. Provide a financial alternative to schools that have come to rely upon income from selling junk foods in the schools.

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5. **Incentivize healthy behaviors through workplace activities.** Convince the Top 49 Alaska businesses to educate their employees on healthy lifestyles and offer healthful workplace activities. The Top 49 businesses would represent a large percentage of the Alaska population not already covered by Federal or Alaska Native health care systems. Encourage a **Top 49 Health Summit** to facilitate understanding and participation of these large Alaska businesses.

6. Develop intervention programs for **promoting the traditional rural diet.**

7. **Reconsider rural access to dentistry as part of the study.** Many rural communities lack a sufficient population to support construction of a simple dental facility to house a full time dental practice. The investment required to maintain a facility for use by an itinerant dentist would likely need to be made by the community, possibly partnering with the state. Lack of roads prevents the use of mobile dental clinics that are used in other remote locations worldwide.

8. **Reduce the critical shortage of facilities for alcohol and drug detox, and psychiatric facilities. The lack of services these facilities provide can increase costs in the long run.** Persons affected by alcohol and drug use, and the accidents they cause, account for a significant portion of the population needing care in hospital emergency rooms and psychiatric facilities. Yet Alaska has too few beds to treat those in need of drug and alcohol recovery. As a result we are forced to tolerate that burden of higher healthcare costs. Detox beds make good economic and health policy sense.

9. Find ways to incorporate **U.S Task Force on Preventive Health** recommendations into medical practices, schools, work environments and homes.

10. **Continue the Institute of Circumpolar Health Studies** to analyze common problems and look for solutions that will work for all circumpolar peoples. Similar environments and cultures may result in shared knowledge that can benefit those in northern latitudes. Many health issues in Alaska relate to weather, the environment, subsistence food quantity and quality, potable water and sanitation issues. These are issues shared by other circumpolar peoples. Alliances with other circumpolar countries, and organizations like the Institute for Circumpolar Health Studies may provide new insights in resolving some of these issues.

Access improvement recommendations

1. **Workforce development issues**
   a. **Expand the WWAMI program.** Improve the supply of primary care providers (family practice physicians, internists, nurse practitioners, physician's assistants), especially outside of Anchorage. Current or potential shortages can be identified in specific specialties.
   b. **Market the Alaska lifestyle to Outside doctors.** JV with tourism, the State Medical Board, ASMA. Create a dog and pony show.

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2. **Investigate and modify the factors that influence the cost of professional liability insurance**

3. **Reduce the number of uninsured Alaskans**— A non-government designed system is probably preferable to a government-operated system.

4. **Investigate pooling smaller companies a la the Foraker Group in an effort to reduce premium costs.**

5. **Promote lower cost models such as neighborhood health centers where appropriate**

6. Educate the public and promote same day access to **alternatives other than hospital emergency rooms**. This involves creation of more readily available and timely access to primary care. Alternatives could include increasing the number of primary care providers and clinics, establishing a variety of disincentives for visits for minor complaints, and establishing a system for care for the uninsured. Emergency rooms themselves may need to be reorganized and redesigned to separate life-threatening emergencies from routine medical needs.

7. **Examine uninsured models elsewhere; e.g. Utah, Maine and Florida.**

8. **Adjust the Medicare (GME) reimbursement formula for Family Practice Residency programs.**

9. **Ensure adequate government reimbursement to doctors, hospitals, community health centers, mid-level practitioners and community health aides without unreasonable bureaucratic burdens.**

10. **Consider making accepting Medicare patients a condition of licensure in Alaska. This has been done in Massachusetts.** Weigh the advantages of increased access for Medicare patients against the negative effect of attracting practitioners to Alaska.

11. Consider **public hearings for health care insurance and professional liability insurance rates** to facilitate price transparency. Currently insurance rates are largely negotiated between large institutional users and insurance carriers. As private contracts, the resulting rates are not disclosed. Individuals have little or no negotiating power and either have to accept or reject rates offered to them. The thought is that greater transparency could result in more favorable, or at least understandable, rates for individual consumers.

Quality improvement recommendations

1. **Promote and encourage primary prevention, early intervention, and evidence based practices by providers and payers of health care.**

2. **Use meaningful benchmarks; e.g. the Alaska 20/20 example.**

3. **Measure quality of service and make the information publicly available.**

Cost reduction recommendations

1. **Prevention through Public health education, and early intervention** Preventing illness will save more lives, more lost work time and more healthcare dollars than any other option available to us as a community. Consider the adage "the cheapest health insurance is healthcare you don't need." Measures include flu shots when they are recommended and vaccinations against common diseases. Encourage the following behaviors: weight control, regular exercise, avoiding cigarettes and excessive alcohol, fat, salt, and sugar, adequate water consumption, and controlling blood pressure.

2. Encourage and promote the establishment of an **Electronic Medical Record** with a common interface as a means to improved safety and efficiency of health care.

3. **Drug formularies**—utilize where appropriate and effective.

4. **Promote the strong interrelationship between cost of health care and a state fiscal plan** as a means of putting health and budget decisions in perspective.

5. **Fee and billing transparency.** Mandatory disclosure of fees in advance of treatment and "understandability" standards for medical billing.

6. Encourage **local cooperation and sharing of services and facilities**. Promote community by community dialogue on the cost of duplication

7. Analyze the possibility of saving money by **joint purchasing** by appropriate parties.

8. **Allocation and rationing** might be considered if other measures fail to stabilize health care costs.

9. **Suggest legislation to mandate fee transparency**

10. **Consider legislative solutions to tort and liability issues.** Quantify professional liability insurance, patient reimbursement and tort issues—are there legislative solutions? Look at tort reform experiences Outside, such as MICRA, for ideas that might apply to Alaska.

SUCCESS STORIES AND PROMISING PROGRAMS

Alaska has a number of programs that have proven to be successful:

Lifestyle and prevention

- The South Central Foundation Primary Care Clinics place great emphasis on prevention. This results in some of the best state data for immunization rates, colorectal screening, mammograms and other standard preventive health interventions.

Access

- Anchorage Neighborhood Health Center
- Other community health centers
- Health aides in rural Alaska
- South Central Foundation has programs that have established same day access. Utilization rates for emergency room use and specialty services have fallen dramatically. Utilization rates of primary care services have also had a modest decrease.

Quality

- Hospital quality control programs have been established in all the major hospitals in Alaska with excellent results. For example, Providence Hospital received national recognition for reducing surgical site infections after joining a national collaborative focus on this issue. Alaska Regional Hospital was recognized for reducing pneumonias after intubations. The Alaska Native Medical Center has developed a national reputation for quality improvement activities working in close association with the Institute for Health Care Improvement. All of our major hospitals have joined the national initiative known as the "100,000 Lives Campaign" to save this many lives in U.S. hospitals by June 2006.

Costs

- The Alaska Federal Health Care Partnership, consisting of the DOD, VA, Coast Guard and the Alaska Native Health System, have been able to reduce costs by bulk purchasing and the sharing of clinical resources.

Other programs show promise:

- The State of Alaska has developed benchmarks for population health improvement targets in a document called "Healthy Alaskans 2010."

Lifestyle and prevention

- The Anchorage Daily News and a growing number of businesses are discussing wellness incentives in an effort to reduce health care costs. Generally all of these approaches are similar. Employees who agree to join this effort receive personal health care improvement plans and personalized coaching on a regular basis. Some companies offer health care premium discounts as an incentive to participate.

Access

- Anchorage Project Access is a developing physician initiative in Anchorage (adopting a national model) to provide free care to uninsured individuals who meet certain low-income criteria. Almost all physicians and hospitals currently provide uncompensated care. By organizing this effort, other communities with this program have been able to efficiently provide more care to the uninsured.

Quality

- A new initiative in the U.S., public reporting of quality indicators in hospitals and nursing homes, is being required by the Center for Medicaid/Medicare Services (CMS). Hospital quality reports are now available on the Web under the title of "Hospital Compare." Both the federal government and insurance companies are instituting "pay for performance" programs to improve service quality by hospitals and doctors. Countries like Great Britain have already introduced these programs.

APPENDIX

Key ideas in the 1994 CWN study "Health Care: Finding an Alaskan Solution"

1. The health care reform debate is complex and controversial, with multiple players with competing interests.

2. There are significant factual disputes about the health care system.

3. Health care reform creates winners and losers.

4. The most important conclusion for Alaskans: Involvement of Alaskans in the health care debate is vital. Some type of reform is inevitable and Alaskans must work to ensure that reform is responsive to our unique Alaskan conditions.

Study Group Participants

Co-chairs: Thomas Nighswander, M.D and Marvin Swink
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Eric Wohlforth	Attorney, Wohlforth, Vassar, Johnson and Brecht
James Yarmon	CEO, Yarmon Investments, Inc.
Duane Heyman	Executive Director, Commonwealth North

The Charge

Alaska Primary Health Care – Opportunities & Challenges

Approved by the Commonwealth North Board on July 20, 2004

1. Questions to be addressed:

a) How is primary health care currently being delivered to Alaskans?
b) Are Alaskans receiving quality health care under the current scenario?
c) What does the future hold for health care in Alaska?
d) Are there ways to do a better job, such as by bridging the current multiple systems?

2. Scope of study:

The intention of this study is to focus on primary care – the need for Alaskans to receive basic health care. Recognizing there are a number of health care areas which merit similar attention such as long-term care, behavioral health, dental care, etc., the focus of this particular study is to address the past, present and future of primary health care in Alaska. The study will include an update/compilation of previous reports to provide a context.

- The study will briefly explore the historical delivery of health care and how that history impacts the present challenges Alaska faces. In providing this background, the study will also look at the health status of Alaskans – is it above/below that of other states or are we keeping pace?
- The study will explore the "drivers" behind the cost of health care in Alaska and will assess its impact, if any, upon economic development in the State. Access and quality of care/services are a critical determinant of cost within the various health systems in Alaska.
- This study will identify principal health care entities and look at the current multiple health systems – what are the benefits and challenges? Are they sustainable? What impact, if any, do these multiple systems have on the cost and quality of health care?
- There are a number of challenges facing health care providers and recipients. This study will identify those challenges and where possible, potential solutions.
- There are a number of examples where health care entities are collaborating. The study will highlight the best practices and identify additional areas of collaboration. The study will also take into account lessons learned from other states.

3. Nature of report to be issued (Technical, Analytical, or Opinion):

This report will analyze issues, identify a process for addressing them and suggest guiding principles. The report will provide background, current status and recommendations for change or further study. While the report will largely express opinions, it will address technical issues that are necessary aspects of the larger picture.

4. Conflict of interest standards:

The intent of the study is to represent a balance between the geographic, demographic, ethnic and economic interests in Alaska. It is expected that persons with interests in the outcome of the study will be members of the study group and will participate in its deliberations. Study group leaders should request that study group members identify their interests relative to specific points they advocate.

5. Measure of success:

This study will succeed by generating a greater understanding of and insight into health care issues in Alaska and areas in which health providers can work together for the mutual benefit of all Alaskans.

Resource People Interviewed

9.23.04 Ed Lamb, Al Parrish—Hospital perspectives

9.30.04 Barbara Russell—Premera

10.07.04 Alex Spector—VA, Lt. Col. Vic Rosenbaum—Elmendorf Hospital, Maj. Ward Hinger--TRICARE

10.14.04 Commissioner Joel Gilbertson

10.21.04 Paul Sherry—Alaska Native Tribal Health Consortium

10.28.04 Tessa Rinner—Denali Commission

10.28.04 The Maine Plan (Sergei Bogojavlensky, MD)

11.11.04 Norman Wilder MD, MBA (Regional), Roy Davis MD (Providence)—Quality and cost control initiatives

11.18.04 Rod Betit—State Hospital & Nursing Home Association

12.02.04 Catherine Schumacher MD—Access to health care in Anchorage

12.09.04 Cathy Giessel, MS, FNP-CS—The role of nurse practitioners

12.09.04 Harold Johnston, MD—Program Director, Alaska family Practice Residency

1.06.05 Joan Fisher – Executive Director, Anchorage Neighborhood Health Center and Medical Director, Dr. Tom Hunt and Beverly Wooley, Director, Anchorage Municipal Health Department

1.27.05 Janet Trautwein – VP Government Affairs, National Assn of Health Underwriters

1.28.05 (Forum) panel discussion with Commissioner Joel Gilbertson, Al Parrish, Randall Burns—Alaska Small Hospital Performance Improvement Network, Dr. David Snyder—Alaska Native Medical Center

2.03.05 James Jordan, Executive Director, Alaska State Medical Association

3.10.05 Ann Conway, Maine Center for Public Health

3.25.05 Joseph Ditre, Executive Director, Consumers for Affordable Health Care Foundation (Maine)

Sectional analysis: Alaska Health Care Commission Bill

Section 1

AS 18.05.010(b)- Establishes the Alaska Health Care Commission in the Department of Health and Social Services that will work toward recommendations for a statewide health plan under AS 18.09.

Statewide Health Care
Section 2

Sec 18.09.010-This section is the basic language to establish the Commission and outline the commission's primary objectives.

Sec 18.09.020-Creates a 10 member Commission made up of Health Professionals and the public including three ex officio appointees from the legislature and the governors office.

Sec. 18.09.030- Members will serve three year staggered terms. Should an opening occur prior to the completion of the term the governor shall appoint a replacement.

Sec. 18.09.040- Creates the position of executive director as a partially exempt position appointed by the commission.

Sec. 18.09.050- Permits the Department to assign employees to work with the Commission as support staff.

Sec. 18.09.060- The commission shall submit internally by-laws for consideration by the full Commission. By laws will establish quorum requirements, time and locations for meetings, etc. The section also defines conflicts of interests when voting and annual reporting requirements

Sec. 18.09.070- This section defines the duties of the Commission, to include goals and language for input from the public through the public hearing process.

Sec. 18.09.080- Standard language that allows members to receive per diem and travel but no salary for serving on the commission.

Sec. 18.09.900- Authorizes the Department to promulgate the necessary regulations to maintain the commission

Sec 18.09.990- Defines the use of the words commission and department.

Section 3

AS 39.25.120 (c)(7)- adds the commissions executive director position to the list of existing executive directors serving other boards and commissions.

Section 4

AS 44.66.010 (a)- Sunset- the commission expires unless renewed by the legislature on June 30, 2014

Section 5

Uncodified language- Permits the department to begin the regulatory process which can not take effect until this bill is singed into law.

Section 6

Uncodified language- The members already serving on the commission shall continue in their positions based on the staggering of their terms.

Section 7

Effective date- Immediate effective date clause.

Principles, Elements and Specific Steps

Draft 8 August 29, 2007

Proposal by the Alaska Health Care Roundtable to help the Council achieve the goals it identified at its first meeting:

Health Care Strategies Planning Council Mission Statement (Approved at the June 11, 2007 meeting)

Develop strategies, including performance measures, to provide health care access for all Alaskans by 2014 with the goal of making Alaskans the healthiest population in the nation.

The definition of "access" includes: coverage, affordability, timely service, quality of care, prevention, managing chronic conditions, workforce issues and cost.

Roundtable recommendations are as follows:

Principles of reform — Guidelines for creating effective specific action steps

- Creating healthier people who consume less medical services is the only major sustainable strategy to slow growth of health care costs.

- Plans, programs and policies must encourage and support the principle of individual responsibility to maintain and protect each person's health.

- Dramatically improve value for every health care dollar.
    - Health services that effectively educate and motivate individuals underpin an effective, efficient health care system. Prevention and timely appropriate levels of care earn strong return on investment (ROI) for both employer and public programs. Examples are immunization programs, hypertension or HIV screening, promoting prenatal care, etc.
    - Organizational wellness programs, government or private, are starting to prove that improving employee health is a win/win for both employees and employers.

- Financially support carefully planned experimentation with different types of health delivery models and payment models. Alaska is a highly diverse state. The wide variety of community sizes, many in remote areas, with differing access to care and different prevailing payment systems argues towards creating a variety of solutions from which to choose. Employers are particularly concerned about quality.

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- All Alaskans need quality, affordable health care that provides:
  - Physical access
  - Financial access
  - Information access

- Facilitate universal participation in the most appropriate fashion for each individual. Forms of coverage or care include:
  - Employer-based
  - Individual-based
  - Federal programs
  - Military programs
  - Alaska Native programs

- Rely on and develop the private insurance market in sectors where it is currently working and other sectors where it can be logically employed. Avoid creating costly state bureaucracies that duplicate private sector capabilities.

- "Grow our own" health care practitioners at all levels as much as possible.
  - In-state education and clinical training increases the likelihood of keeping graduates in Alaska.
  - In-state education stems the flow of education dollars Outside and helps generate a sustainable economy.
  - Create specialized programs to meet the needs of rural Alaska.

- Collaboration and cooperation is essential. The problem is larger than any one part of the system can solve. Areas to address are financing and insurance, workforce development, facilities and citizen education. Private, state, federal and Native resources will need to be coordinated so all can contribute to the solution.

- Generate sufficient information and research, both in Alaska and from best practices Outside, to support sound fact-based decision making.

- Provide sufficient and appropriate facilities where necessary around the state. Emphasize regional planning, coordination, cooperation and efficiency.

- Develop a statewide electronic health record network that is secure and interoperable with existing systems to improve quality of care and reduce waste by providing necessary medical information to providers.

Elements of reform — Building blocks for a better system

- The problem is huge and complex. Businesses, individuals and governments all must contribute to managing and financing a new Alaskan health care system for it to be sustainable.

- We must stem erosion of employer-sponsored insurance. Keep what works and reshape or fill in as necessary. Reform plans should build on and improve existing parts of the system that work without harming those who are already well served.

- Information to evaluate costs and alternatives before and after treatment is an essential building block of individual financial responsibility. Information access and transparency seems like a basic need, but is elusive. Technology and disclosure requirements will help.

- Encourage adequate federal Medicare reimbursement of provider's costs, but cobble together work-arounds until that happens. This can include creative use of Medicare and Medicaid waivers. Keep track of the changing federal health care environment to uncover opportunities and influence needed change.

- Electronic health records are the cornerstone to modernizing Alaska's health care. Build on existing private and state-level initiatives.

- Develop navigation aids and fail-safe systems to help people gain access to and deal with complexities of the system. Navigation aids must take into account the human, as well as the technological networks, which build healthy lives.

- Alaska has information gaps that need to be filled to chart an optimum path to progress. Fundamental research will enable policy-makers to make sound decisions based on facts: 1. Quantify and identify the source of Alaska cost differentials vs. Outside. 2. Understand who is not covered or insufficiently covered. 3. Continue to define work force development challenges across the full job spectrum.

- Build on the many Alaskan programs that have proven effective or show promise in the areas of quality, access and cost control.

- Monitor and learn from other state's experience in coverage and cost control.

- Alaska will need an ongoing official state-wide group to monitor the ever-changing health care scene and find appropriate synergies.

Specific immediate steps to consider

- Establish an ongoing Alaska health care council/commission/board to coordinate public policy.
- Support and coordinate Alaska research and monitor national research and developments.
- Develop a variety of Alaska health care reform plans based on research to be able to compare and contrast their benefits, costs and impacts.
- Support the next step in development of Alaska electronic health records.
- Develop and monitor quantifiable health care goals for Alaska.
- Support workforce development capable of filling current and anticipated needs.
- Encourage primary care capability based on the "Medical Home" model which provides an ongoing health care point of contact. Examples are family physicians or community health centers.
- Monitor and improve liability and tort laws to help reduce malpractice insurance costs, encourage quality improvements and make Alaska a more attractive place to practice medicine.
- Encourage schools at all levels to foster healthy life styles and offer sports and exercise programs that build life long healthy habits.
- Work with the federal delegation and authorities to maximize federal support of Alaska projects and programs and to support national health care reform efforts that will benefit Alaskans.
    - E.g. Develop stand-alone Medicare clinics in major Alaska hubs via an open RFP process
- Identify pseudo-reform "myths"—things to avoid.

Pseudo-reform "myths" — Things to avoid

- Continued employer transfer of health care costs to employees.
- Assuming that "market forces" alone will make health care better and more efficient. Health Savings Accounts (HSAs) may be part of a total solution, but not the only solution. Even enlightened health care consumers do not have access to information they need to "shop around" for best value.
- Freezing or reducing state funding. The State of Alaska will need to make additional financial and programmatic investments as a full partner in a comprehensive solution.
- Reliance on the federal government to solve the problem. National solutions are necessary and hopefully will be forthcoming. However, in the interim, Alaska needs to do what it can to help itself.

- Assuming, hoping or praying that the problem will solve itself and go away. Effective, creative coordination of every tool available within Alaska is the only chance for success. An ongoing, adequately resourced council, commission or board will need to continue the work of the Alaska Health Care Strategies Planning Council.

Why we need to act now

- As a small state with significant resources, Alaska has the elements it needs to improve the health of its citizens in the long-term.
- Guiding principles will focus the creativity and coordination needed to achieve this lofty, but basic human goal.
- Unchecked, current health trends will create the first generation in 100 years that can expect a shorter life span than their parents.
- Insufficient federal reimbursements are transferring a huge financial burden to the private sector which in turn is passing costs on to employees.
- A mandatory rational system based on the strongest elements already in place can provide basic care for all Alaskans enabling a shift of emphasis towards prevention.
- Investing in prevention and individual responsibility offer high "bang for the buck." Healthy people feel better and place less financial demands on the system.
- The aging population will increase per capita costs of health. These increases can be mitigated by effective primary prevention and health promotion.
- Everyone and all parts of society need to be part of the solution—businesses, individuals and all levels of government.
- The health care system is not a goal in and of itself. The real goal is healthy Alaskans who know they will be properly cared for if they do get sick.

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Background — An unsustainable deteriorating situation

- Many thanks to the Alaska Health Care Strategies Planning Council and key legislators for beginning a formal state dialogue.
- Businesses face annual double-digit increases in health care costs. This necessitates:
  - Cutting back coverage
  - Increasing employee financial contributions
  - Educating and empowering employees to develop healthier lifestyles
- The situation is bad and getting worse.
  - According to a July 2007 Commonwealth Fund report comparing states, Alaska ranks 26th overall, 36th for access and 49th in quality.
  - Medicare and Medicaid do not reimburse providers for their cost of doing business. This "pinch" is being passed on to businesses and insurers, creating an ever-escalating financial burden on them. Health care costs for businesses are a financial ball and chain not shared by international competitors.
  - Many Alaskans are without any health care coverage, or have inadequate coverage.
    - Over 90,000 Alaskans have no health care coverage—if living together, they would be the second largest city in Alaska.
    - Many more are under-insured.
  - Everyone has nominal access to some form of health care at the emergency room, but it is after-the-fact and expensive.
  - Many people in need do not know where to turn because of:
    - Lack of knowledge
    - Lack of money
    - Linguistic and cultural barriers
    - Crushing work and family schedules
  - Alaska is short 300 doctors today, with more needed to replace an aging work force. Similar shortages exist for nurses and other health practitioners.
  - Potential gas pipeline construction will further strain an already challenged Alaska health care system.

- The unhappy net result:
  - Alaska has the highest per capita state expenditures on health care in America ($8,000 per person).
  - America has the highest per capital health care expenditures in the world ($7,000 per person).
  - Alaska and America have poor health compared to other industrialized nations despite having greater expenditures on health care.
  - Alaskan and American businesses are becoming less competitive compared to international businesses in countries with public health care systems.

- A caring, humane and financially efficient society cannot continue this downward spiral. Serious national conversations and major state-level reform efforts are under way. Fortunately, Alaska has potential building blocks for a better system and guidelines to help use them.

Alaska Health Care Strategies Planning Council

Final Report: Summary and Recommendations

Making Alaskans the healthiest people in the nation...

December 23, 2007

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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

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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

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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.*

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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.*

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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.*

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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.*

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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.

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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

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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
• Create an ongoing and quasi-independent "Alaska Health Care Commission."			
• Promote incentives for clinic use, rather than the use of emergency rooms for routine/primary care.			
• Promote the use and expansion of Community Health Centers throughout the state.			
• More effectively target recruitment of health care professionals by marketing Alaska to rest of nation/world as a great place to live, work, raise a family, enjoy nature, etc.			
• Conduct a comprehensive, statewide health care workforce assessment.			
• Continue to support Alaska Native Tribal Health Consortium's ongoing efforts to develop sustainable, community-specific water and wastewater capacity in all villages.			
• Increase quality of and access to Telemedicine, Community Health Aides/Practitioners, Community Mental Health Aides and Community Dental Health Aides.			
• Implement a prevention-focused "Fit for Life" social marketing program that is multigenerational and culturally aware.			
• Emphasize the role of the public health nurses in prevention and wellness – from well-baby checks on up to flu shots for elders.			
• Support programs to encourage employers to offer employees "time off" for making healthy lifestyle choices and maintaining wellness.			
• Institute "Silver Sneakers Programs" – for elders – to keep elders healthy.			
• Ensure public health immunization funding.			
• Fund free and/or low-cost clinics, keeping in mind uninsured Alaskans.			
• Incorporate a "Wellness Certificate" into the PFD program, and give a five percent boost in the dividend for maintaining a healthy lifestyle.			
• Foster a state culture through policy that rewards schools for wellness.			
• Provide financial incentives for "healthy schools."			
• Support the ongoing efforts to establish comprehensive health care insurance options to employees of Alaska's nonprofit sector.			

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• 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.			

• Expand State role in direct funding of and improving access to Community Health Centers. • Foster a consumer-directed health care approach to long-term care. • Encourage the implementation of a consumer-directed health care system. • Integrate "consumerism," encouraging people to shop around for the best quality and appropriate cost and consider personal responsibility. • Encourage formation of Tobacco Free communities, businesses and workplaces through Statewide Clean Indoor Air Act. • Institute/Increase Alcohol taxes. • Increase fluoride in drinking water. • Reduce barriers to establishing and running CHCs: (state and federal red tape). • Where establishing a CHC is difficult, encourage creation of public-private partnership in creating primary/urgent care clinics.			

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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

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- 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

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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.

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Sarah Palin
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

December 04, 2008

ADMINISTRATIVE ORDER NO. 246

I, Sarah Palin, Governor of the State of Alaska, under the authority of art. III, secs. 1 and 24, of the Alaska Constitution, and in accordance with AS 44.19.145(c), establish the Alaska Health Care Commission (commission) in the Department of Health and Social Services.

PURPOSE

The purpose of the commission is to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state.

DUTIES OF THE COMMISSION

The commission's duties are to:

1. serve as the state health planning and coordinating body;

2. consistent with state and federal laws, provide recommendations for and foster the development of a:

   A. comprehensive statewide health care policy;

   B. strategy for improving the health of Alaskans that includes

      i. encouraging personal responsibility in prevention and healthy living for all residents of the state;

      ii. a reduction in health care costs for all residents of the state to be below the national average;

      iii. access in communities of the state to safe water and wastewater systems;

      iv. the development of a sustainable health care workforce in the state;

      v. quality health care being accessible for all residents of the state; and

      vi. increasing the number of residents of the state who are covered by health

care insurance; and

3. submit a report to the Governor and the Legislature on or before January 15, 2010 regarding the commission's recommendations and activities.

MEMBERSHIP

The commission consists of seven voting members appointed by the Governor, and the voting members serve at the pleasure of the Governor.

Voting members are:

1. the chief medical officer of the Department of Health and Social Services, who shall serve as the chair of the commission;
2. a representative from the tribal health community in this state;
3. a representative from the Alaska State Chamber of Commerce;
4. a representative from the Alaska State Hospital and Nursing Home Association;
5. a health care provider, who is
   A. actively practicing the provider's profession in this state;
   B. licensed in this state; and
   C. not affiliated with the Alaska State Hospital and Nursing Home Association;
6. a representative of the health insurance industry in this state; and
7. a health care consumer who is a resident of this state.

Non-voting members are:

1. an ex officio, non-voting member from the executive branch, appointed by the Governor;
2. an ex officio, non-voting member from the Alaska House of Representatives, appointed by the speaker of the house; and
3. an ex officio, non-voting member from the Alaska Senate, appointed by the president of the senate.

ADMINISTRATIVE SUPPORT

The commission shall employ an executive director, who may not be a member of the

commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director.

The Department of Health and Social Services may assign employees of the Department of Health and Social Services to serve as staff to the commission. The commission shall prescribe the duties of the staff.

The commission shall, upon approval of a majority of its members and consistent with state law, adopt and amend, as necessary, bylaws governing its proceedings and all other activities.

GENERAL PROVISIONS

Commission members do not receive compensation as members of the commission. Members of the commission who are not state or federal employees are entitled to per diem and travel expenses in the same manner permitted for members of state boards and commissions. Per diem and travel expenses for members of the commission who are representatives of a state or federal agency are the responsibility of that agency.

To reduce costs, the commission may use teleconferencing and other electronic means to the extent practicable, in order to gain the widest public participation at minimum cost.

Meetings of the commission shall be conducted in accordance with AS 44.62.310 and 44.62.320 (Open Meetings of Governmental Bodies).

Records of the commission are subject to inspection and copying as public records under AS 40.25.110 - 40.25.220.

This Order takes effect immediately.

DATED at Anchorage, Alaska this 4th day of December, 2008.

/s/Sarah Palin
Governor

About the Commission

The Alaska Health Care Commission was established by Governor Palin on December 4, 2008 under Administrative Order #246. The Commission will serve as the state health planning and coordinating body, providing recommendations to the governor and the legislature on a comprehensive statewide health care policy and on strategies for improving the health of Alaskans.

Creation of the Alaska Health Care Commission follows from the work of the Alaska Health Care Strategies Planning Council. The Council was convened by the Governor in 2007 to develop a set of strategies for improving access to health care in Alaska. One of the Council's seven recommended goals was to develop the leadership necessary to support a comprehensive statewide health care policy through creation of an on-going commission.

The Alaska Health Care Commission consists of 10 members. Membership requirements are specified in the Administrative Order, and include the state's chief medical officer (who also serves as chairperson of the commission), an Alaska health care provider and an Alaska health care consumer, and one representative each from the Alaska tribal health system, the Alaska health insurance industry, the Alaska State Chamber of Commerce, and the Alaska State Hospital and Nursing Home Association. Three nonvoting members are representatives from the state Senate, House of Representatives, and executive branch. Governor Palin announced the appointment of the members to the commission on January 27, 2009.

The commission's first year of study and planning will culminate in a report to the governor and the legislature due January 15, 2010. This web site will be updated regularly with information on the meetings and work of the commission.

Contact the Commission

Deborah Erickson
Executive Director
Alaska Health Care Commission
3601 C Street, Suite 902
Anchorage, AK 99503-5923
(907) 334-2474
(907) 269-0060 - Fax
deborah.erickson@alaska.gov

Members of the Commisssion

Members

Jay Butler M.D., of Anchorage, is the chief medical officer for the state of Alaska. He has previously served as director of public health, state epidemiologist, Director of the Centers for Disease Control's Arctic Investigation Program, and medical director of infection control at the Alaska Native Medical Center. Butler has also been a program manager or professor of epidemiology for top national labs and health agencies, including the Centers for Disease Control, National Center for Infectious Diseases, Emory University School of Medicine, and the University of Wisconsin. He earned a bachelor's degree in zoology from North Carolina State University in 1981, and a medical degree from the University of North Carolina, Chapel Hill, in 1985. He fills a seat designated for the state's chief medical officer, and is the designated Chair of the commission.

C. Keith Campbell, of Seward, is a retired hospital administrator and national leader of the American Association of Retired Persons (AARP). Campbell served as chief executive officer of Seward General Hospital from 1971-90, and also held interim jobs as administrator of Seward's Wesleyan Rehabilitation and Care Center, and of the Seward Chamber of Commerce. As a member of AARP's national board of directors from 1996-2002, he served at different times as chairman and treasurer, and on numerous AARP committees dealing with health care, insurance, finance, and government affairs. He has also been elected to the Seward City Council and school board, and to the Kenai Peninsula Borough Assembly. He fills a seat representing health care consumers.

Valerie Davidson, of Anchorage, is senior director of legal and inter-governmental affairs for the Alaska Native Tribal Health Consortium in Anchorage, with extensive experience working in Bethel on Alaska Native health and tribal governance issues. She has previously worked for the Yukon Kuskokwim Health Corporation and as a state legislative staffer on rural health care issues. Davidson earned a bachelor's degree in elementary education from the University of Alaska Anchorage, and a law degree from the University of New Mexico's School of Law. She fills a seat representing Alaska tribal health care providers.

Jeffrey W. Davis, of Anchorage, has been involved in the delivery and funding of health care services for 25 years. He has served nine years as president of Premera Blue Cross Blue Shield of Alaska, which insures 180,000 Alaskans statewide, and previously was Premera's vice president of network development in Alaska, Washington and Oregon. Davis earned a bachelor's degree in biology from Whitman College and a master's degree in health services administration from the University of Washington. He fills a seat representing Alaska's health insurance industry.

Ryan Smith, of Soldotna, has been chief executive officer of the Central Peninsula General Hospital since 2006, and has worked in chief financial officer or other accounting positions for hospitals in Alaska, Wyoming and Utah since 1987. He currently is chair of the Alaska State Hospital and Nursing Home Association. Smith earned a bachelor's degree in accounting in 1990, and a master's degree in business administration in 1992, both from the University of Utah. He fills a seat designated for the Alaska State Hospital and Nursing Home Association.

Wayne Stevens, of Juneau, has been president and chief executive officer of the Alaska State Chamber of Commerce since 2004. He served as executive director of the Kodiak Chamber of Commerce from 1985 to 2004, and previously worked 11 years in customer service and cargo supervision for Wien Air Alaska. Stevens has served on the Southwest Alaska Municipal Conference, the Governor's Task Force on Regulatory Reform, the Kodiak Island Borough Mental Health Advisory Board, and in various leadership positions for Kodiak's hospital. Stevens has also served three terms on the Kodiak Island Borough Assembly. He fills the seat designated for the Alaska State Chamber of Commerce.

Larry Stinson M.D., of Palmer, is an anesthesiologist and co-owner of Advanced Pain Centers of

Larry Stinson M.D., of Palmer, is an anesthesiologist and co-owner of Advanced Pain Centers of Alaska, which operates clinics in Anchorage, Fairbanks and Wasilla. He has served as an anesthesiologist at Fairbanks Memorial Hospital, a brigade surgeon for the 6th Infantry Division (Light) at Fort Wainwright, and as a university clinical instructor. A board-certified anesthesiologist, he earned a bachelor's degree from the University of Alaska Fairbanks in 1980, and a medical degree from the University of Washington in 1984. He fills a seat representing Alaska health care providers.

Non-Voting Members

Linda Hall, of Anchorage, has been director of the Division of Insurance in the Department of Commerce, Community and Economic Development since 2003, and has 18 years experience as a commercial insurance broker. She is a past president of the Alaska Independent Insurance Agents and Brokers, and represented Alaska on the national organization's board 1997-2003. She is also past chair of the Alaska Workers Compensation Review and Advisory Committee. Hall fills a non-voting seat representing the executive branch of state government.

Representative Wes Keller, of Wasilla, has represented the Wasilla area in the Alaska State House of Representatives since 2007. He is co-chair of the House Health, Education and Social Services Committee, and chair of the Administrative Regulation Review Committee. Keller had previously worked eight years as a legislative aide, and as an Alaska Air National Guard pilot, building contractor, oilfield worker and contracting trainer. He earned a bachelor's degree from the University of Wisconsin in 1986. Keller was appointed by House Speaker Mike Chenault to fill a non-voting seat representing the House of Representatives on the commission.

Senator Donald Olson, of Golovin, has represented Northwest Alaska in the Alaska State Senate since 2000. He is a physician, commercial pilot and reindeer herder. Olson earned a bachelor's degree in chemistry from the University of Minnesota, a medical degree from Oral Roberts University School of Medicine, and a law degree from the University of Colorado School of Law. He chairs the Community and Regional Affairs Committee, and sits on the Senate Finance Committee. Olson was appointed by Senate President Gary Stevens to fill a non-voting seat representing the Senate on the commission.

COMMONWEALTH
NORTH

Resolution 2009-3
In support of continuing the Alaska Health Care Commission as proposed in Senate Bill 172
April 14, 2009

This resolution is based on the 2005 Commonwealth North study entitled "Alaska Primary Health Care: Opportunities and Challenges."

Commonwealth North:

Encourages the Alaska State Legislator to extend the life of the Alaska Health Care Commission

Requests all state legislators to approve authorizing legislation in Senate Bill 172; and

Forwards this resolution to all members of the Alaska State Legislature, Governor Sarah Palin, and Alaska's congressional delegation.

Resolved for the following reasons:

1. A body needs to be vested in the long term interest in understanding and improving the system; consistent advocacy is necessary make needed fundamental changes

2. Through the quality of its participants, and the comprehensiveness and depth of its vision, the body will set a standard of credibility that will sustain its ongoing operations and facilitate implementation of its recommendations

Approved by the Commonwealth North Board of Directors
April 14, 2009

David Wight, President

April 15, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 172 (Olson)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 172, authored by Senator Donald Olson.

As you know, Governor Palin appointed a Health Care Commission that is just beginning to take on its enormous responsibility. Senator Olson serves on that Commission.

SB 172 would basically extend the life of the Alaska Health Care Commission until 2014.

Alaska and our entire country are about to enter a period during which many health issues will have to be considered. Not all decisions will be made in Washington. No matter what the White House and Congress do, it is evident that every state will have to make health care work for its citizens.

As we review the responsibilities of the Commission as outlined in SB 172, it is obvious to us that this will be one of the most important teams that addresses issues that touch every single Alaskan.

We believe that it is critical that SB 172 passes to allow the Commissioners to take on this responsibility, knowing that they will have the support of the Legislature for an extended period.

AARP requests an "AYE" vote on SB 172.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506

Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Donald Olson

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

February 2, 2010

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

Subject: Support for SB 172

Dear Chair Davis:

The Alaska Commission on Aging (ACoA) is pleased to offer our support of SB 172 sponsored by Senator Olson to extend the life of the Alaska Health Care Commission in the Department of Health and Social Services until 2014 with responsibilities to plan and implement strategies related to health care reform for all Alaskans across the life span.

As you know, the Alaska Health Care Commission was first established by Governor Palin in December 2008 to develop a statewide health plan and provide recommendations to address the quality, accessibility, and availability of health care for all Alaskans. We agree with the Commission's findings that the high cost of health care and access to primary care present serious challenges for our state. ACoA supports establishment of a state commission to comprehensively examine the multitude of issues related to improving health care services including improving access to affordable primary care in addition to promoting strategies for preventative care and chronic disease management.

Older Alaskans represent one of the largest consumer groups of health care services of all age categories. Access to primary care is of utmost concern for many Alaska seniors insured by Medicare who are challenged to find a physician particularly if they live in Anchorage, Fairbanks or the Mat-Su Borough. Limited access to essential health care services for older individuals can put these persons at greater health risk who may postpone going to a provider for the care they need only when their medical conditions become serious. Workforce shortages of health care workers, particularly doctors and nurses, pose a serious problem that affects all Alaskans and has a critical impact on people 65 years and older. The ACoA is pleased that these issues were identified in the Alaska Health Care Commission Report (2009) and look forward to working with the Health Care Commission to implement the Commission's recommendations.

We support SB 172 to extend the Alaska Health Care Commission. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879) should you have questions or need additional information.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

Cc: Senator Joe Paskvan, Vice-Chair
Senator Johnny Ellis
Senator Fred Dyson
Senator Donald Olson

Christian Science Committee on Publication for Alaska

P. O. Box 240976, Douglas, AK 99824
Phone: (907) 789-1544 Fax: (907) 364-2468
Email: Alaska@compub.org

To: Senator Bettye Davis, Chair
Members of the Senate Health and Social Services Committee

From: Beverly Smith, Christian Science Committee on Publication for Alaska

Date: February 3, 2010

RE: Senate Bill No. 172
An Act establishing the Alaska Health Care Commission in the Department of Health and Social Services; and providing for an effective date.

Thank you for giving me the opportunity to comment on SB 172.

In my capacity as Christian Science Committee on Publication for Alaska, one of my roles is to ensure that you have accurate information concerning spiritual healing as practiced in Christian Science, so that this cost effective and reliable form of care is not overlooked or restricted in the State's health care reform efforts. With regards to SB 172, I am here to request that access to spiritual care for the treatment and cure of disease be given appropriate consideration during the discussion of the development of a statewide health plan.

To facilitate this discussion I recommend that the bill mandate one of the duties of the Commission to be: **to recommend the extent to which and under what circumstances access to spiritual care should be addressed in a comprehensive statewide healthcare policy.**

Because healthcare reform discussions around the country, both at the federal and state levels, have raised issues that could impact the insurance coverage for spiritual care, it is important that these issues be discussed so as not to create unintended results that subvert this coverage and therefore limit access to spiritual care.

I noticed that the bill does not mandate health insurance for all Alaskans but asks the Commission to develop a strategy that encourages acquisition of health insurance, and that increases the number of insurance options for healthcare services.

Insurance is a topic I am interested in because if Alaskans pay health insurance premiums they should be able to be reimbursed for the healthcare they choose whether that be

medical care or spiritual treatment. Existing law contains numerous examples of programs that offer benefits for spiritual care, including:

- Four plans under the Federal Employees Health Benefits Program (FEHBP) cover religious nonmedical nursing care and/or Christian Science practitioner services:
  - Government Employees' Health Association (GEHA)
  - Mail Handlers Benefit Plan
  - Special Agents Mutual Benefit Association
  - Association Benefit Plan

- Religious nonmedical nursing services are covered under the Medicare and Medicaid programs (see 42 U.S.C. §§ 1395x(ss) and 1395i-5).

- TRICARE (for military dependents) – Covers care in Christian Science nursing facilities, Christian Science nursing services, and Christian Science practitioner services.

- Under Section 223 of the Internal Revenue Code ("IRC"), funds contained in a Health Savings Account may be used to pay for spiritual care. Section 223 references the definition of "medical expenses" in Section 213(d) of the IRC, which has been interpreted to include Christian Science practitioner services and Christian Science nursing care.

- Alaska and a number of other states (e.g., California, Illinois, Kansas, Missouri, Oklahoma, Oregon, Texas) allow coverage of spiritual treatment through prayer in their governmental employees' health insurance plans. The Alaska Care plan for state employees and retired state workers covers treatment by "Christian Science Practitioners authorized by the Mother Church, First Church of Christ, Scientist, Boston, Massachusetts." (See Alaska Care Booklet, pg. 20.)

I would hope that the Commission would preserve the insurance coverage for spiritual care that we have now and recommend that it be expanded to include religious nonmedical nursing services. If the Commission were directed in statute to include access to spiritual care in its discussion of reform, this would prevent such access from being overlooked or minimized.

Christian Science is a method of spiritual care that is available to everyone. For over a century individuals from many different faith traditions have found Christian Science to be reliable and effective in addressing the challenges posed by injury and disease. For this reason, they will often choose religious nonmedical health care in lieu of medical care.

Access to reliable and cost-effective health care should be one of the primary goals of health care reform. For many Americans, the issue at hand is, in some ways, more fundamental: having the option to choose the method of health care that is most effective for them.

I am grateful to the sponsor of this bill for his effort in bringing solutions to the health care challenges in Alaska by seeking to establish an Alaska Health Care Commission, and I respectfully request that this Commission have the responsibility for discussing and recommending how access to spiritual treatment and care can be part of the overall health care plan for Alaska.

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

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F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 16, 2010

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 172 (Olson)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 172, authored by Senator Donald Olson.

As you know, Governor Palin appointed a Health Care Commission that took on this enormous responsibility in 2009. Senator Olson serves on that Commission.

SB 172 would basically extend the life of the Alaska Health Care Commission until 2014 and give it responsibility to develop, adopt and implement the recommendations the Commission comes up with.

Alaska and our entire country have entered a period during which many health issues are being and will continue to be considered. Not all decisions will be made in Washington. No matter what the White House and Congress do, it is evident that every state will have to make health care work for its citizens. Indeed, if Congress does not take significant action, Alaska and the other states will have even greater responsibility to determine how we will deal with our own future health care issues.

As we review the responsibilities of the Commission as outlined in SB 172, it is obvious to us that this will be one of the most important teams to address issues that touch every single Alaskan.

We believe that it is critical that SB 172 passes to allow the Commissioners to take on this responsibility, knowing that they will have the support of the Legislature for an extended period.

AARP requests an "AYE" vote on SB 172.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Donald Olson

ALASKA
PRIMARY CARE ASSOCIATION

February 3, 2010

RE: SB 172 – Designation of a Primary Care Safety Net Seat on Health Commission

Dear Senate HSS Committee Chair Davis and Members of the Committee:

The Alaska Primary Care Association (APCA) wishes to thank the Committee for hearing SB 172. The APCA was part of the Commonwealth North Alaska Health Care Roundtable that issued the report "Alaska Primary Health Care – Opportunities and Challenges" in 2005 which included the recommendation that that an ongoing body be established. Please note that the title of the report includes the words "Alaska Primary Health Care."

The APCA wishes to point out that the composition of the Health Care Commission outlined in the bill does not currently provide expertise and representation for an extremely important and large segment of the health care delivery system: primary care and specifically, the primary care safety net.

Because primary care is the gateway to health care and an "umbrella" of sorts of multiple aspects of care delivery, encompassing the broad spectrum of fundamental medical, dental and behavioral health care; because it is a major part of the key to cost-savings and better health outcomes for Alaskans (prevention, patient responsibility, wise choices, etc. are basic to primary care); and because primary care will be a chief component of whatever plan Alaska develops to move us forward, representation on the Commission of primary care is extremely important. In addition, since a significant part of the Commission's assignment will be to address the uninsured problem and to ensure access to medically underserved Alaskans, representation of the primary care safety net as opposed to representation of solely primary care would provide a dual benefit.

In addition, the three largest health systems in Alaska are the hospitals, tribal health, and the Community Health Center system (the primary care safety net). Currently the bill includes a seat for the Alaska State Hospital and Nursing Home Association and the tribal health community, but it does not include a seat for the Community Health Centers.

As an added note, the APCA would like to point out that the Alaska State Chamber of Commerce adopted a position for this legislative session in favor of the establishment of a health commission in statue with the recommendation that the composition include a seat for primary care.

903 W. Northern Lights Blvd., Suite 200, Anchorage, AK 99503-2400
main: 907.929.2722 *fax:* 907.929.2734 www.alaskapca.org
supporting Alaskans' health care homes

The Alaska Primary Care Association represents 26 Community Health Center (CHC) organizations and other primary care providers throughout the state. The CHCs operate 142 clinic delivery sites in both rural and urban Alaska effectively and efficiently, seeing more than 81,000 patients in communities of all sizes. CHCs accept all patients regardless of their ability to pay, have a sliding fee scale, and are governed by local boards consisting of a majority of members who are patients. CHCs bring savings to the Medicaid system and receive the highest score possible from the Federal Office of Management and Budget for cost-effectively achieving their goal to provide quality access and improve health outcomes. A CHC primary care safety net representative on the Commission could offer invaluable input to the Commission to help improve the health care system in Alaska.

The APCA respectfully requests the Committee add a primary care safety net seat to the composition of the Commission in SB 172.

Promoting health care access to all Alaskans,

Shelley S. Hughes
Government Affairs Director

903 W. Northern Lights Blvd., Suite 200, Anchorage, AK 99503-2400
main: 907.929.2722 *fax:* 907.929.2734 www.alaskapca.org
supporting Alaskans' health care homes

MUNICIPALITY OF ANCHORAGE

Department of Health and Human Services

907-343-6718

Mayor Dan Sullivan

SENIOR CITIZEN ADVISORY COMMISSION

February 9, 2010

The Honorable Donald Olson
State Capitol Room 506
Juneau AK, 99801

Dear Senator Olson,

RE: Letter of Support for SB 172

The Municipality of Anchorage Senior Citizens Advisory Commission strongly supports the passage of SB 172, which would extend the Alaska Health Care Commission until the year 2014.

Health care reform is an issue at the forefront of our country's executive and legislative agenda. Regardless of what shape national health care reform ultimately takes, Alaska will still have to address health care issues in our own state.

The Alaska Health Care Commission will recommend a statewide plan for addressing the availability, accessibility, and quality of health care for all Alaskans. We need an expert team to plan for long-term health care solutions in our state that is supported by our Legislature.

As Alaskans grow older and live longer, it is imperative that quality health care be available and accessible. The Commission supports SB 172 and urges passage of this important legislation.

Respectfully,

Dawnia Clements, Chair
Senior Citizens Advisory Commission
6800 Louise Court
Anchorage, AK 99507

CC: Senator Bettye Davis, Chair, Health and Social Services Committee
Senator Joe Paskvan, Vice-Chair, Health and Social Services Committee

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For more information, visit www.ncsl.org or call NCSL directly 303-364-7700

To: Tom Obermeyer

From: Brenda Erickson

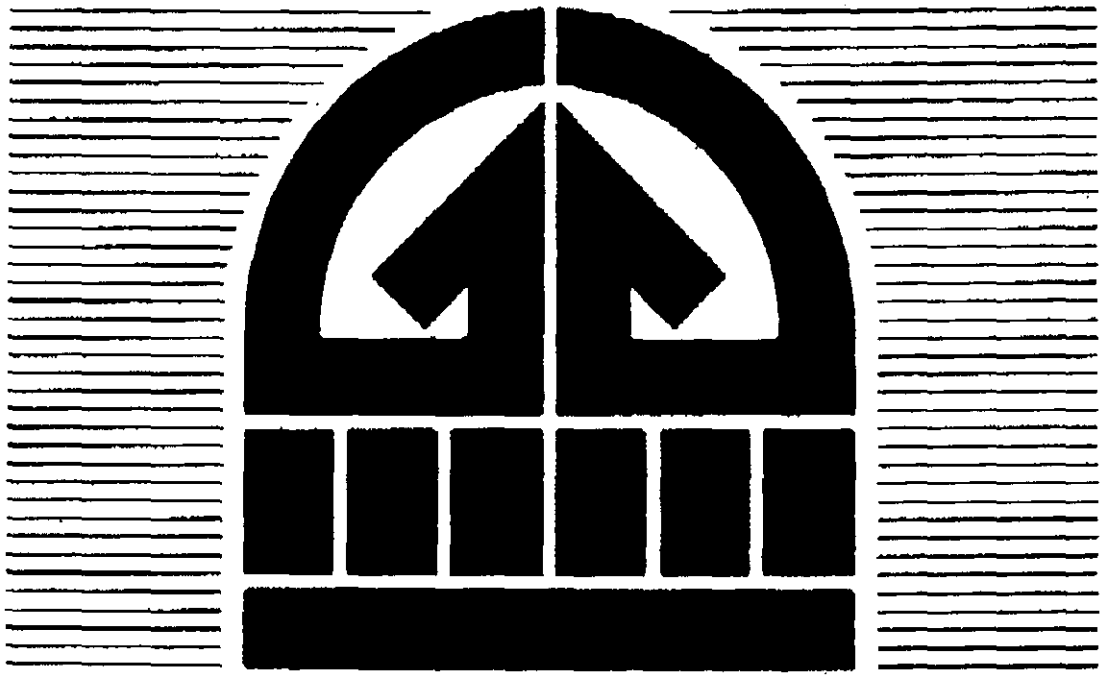
Message: Attached is the older NCSL document about legislators serving on boards & commissions that I mentioned.

Date: 3/17/10 Number of Pages Sent: 10

Denver Office:
7700 East First Place, Denver, CO 80230
Phone: (303) 364-7700 / Fax: (303) 364-7800

Washington, D.C. Office:
444 North Capitol Street, NW, Suite 515, Washington, D.C. 20001
Phone: (202) 624-5400 / Fax: (202) 737-1069

STATE LEGISLATIVE REPORT



Legislative Management Series

LEGISLATORS SERVING ON BOARDS AND COMMISSIONS

Vol. 8, No. 2 February, 1983

by

Rich Jones

An Information Service of the National Conference of State Legislatures
1125 17th Street, Suite 1500, Denver, Colorado 80202. Earl S. Mackey, Executive Director

LEGISLATORS SERVING ON BOARDS AND COMMISSIONS

by

Rich Jones
Legislative Management

The constitutional question of whether legislators may serve on boards and commissions has received considerable attention in 1982. A supreme court decision in North Carolina, an attorney general's opinion in Tennessee and current litigation in Kentucky and Mississippi all challenge the practice.

To document the extent to which legislators serve on boards and commissions and to identify the legal issues raised by this practice, the National Conference of State Legislatures (NCSL) surveyed the states. This report describes the legal issues raised by legislators serving on boards and commissions and discusses the results of the NCSL survey.

LEGAL ISSUES

Legislator service on boards and commissions has been challenged primarily on two grounds: the separation of powers doctrine and dual office holding prohibitions.

Separation of Powers. The separation of powers doctrine holds that the three branches of government have distinct powers and responsibilities. Interpreting this doctrine, the courts have generally ruled that legislators cannot serve as members of boards and commissions that exercise executive authority. Executive duties as defined by the courts include implementing legislative directives, overseeing and managing the daily affairs of administrative departments, setting standards and issuing regulations, tions, and controlling agency expenditures. As early as 1912 the Colorado Supreme Court ruled that the legislature could not create a legislative committee to act as an executive agent in carrying out a law.[1] In 1975, a Georgia court ruled unconstitutional the appointment of legislators to an oversight board responsible for constructing, maintaining and managing the World Congress Center because the appointments represented a legislative attempt to "retain some control over the process of the implementation [of legislation]". [2] Also, in 1976 the Kansas Supreme Court opined that although the separation of powers principle "does not in all cases prevent [legislators] from serving on boards and commissions", a legislatively controlled council that oversees the day-to-day operations of the department of administration unconstitutionally usurps powers of the executive.[3]

North Carolina. In January 1982, the North Carolina Supreme Court ruled that legislators serving on the Environmental Management Commission (EMC) violated that state's separation of powers provision. In State of North Carolina ex rel. v. Bone and Nash, the court determined that the EMC's duties, which include setting standards, adopting regulations, and issuing permits, "are administrative and executive in character and have no relation to the function of the legislative branch of government." The court also agreed with an earlier Georgia court's decision that "the legislature cannot constitutionally create a special instrumentality of government to implement specific legislation and then retain some control over the process of implementation by appointing legislators to the governing board of the instrumentality." While recognizing the value of cooperation between the legislative and executive branches, the court implied that cooperative efforts were constitutionally limited to study commissions and advisory bodies.

4956

The court did not address the question of legislators serving on boards and commissions other than the EMC, but its decision has been interpreted to apply to all North Carolina boards and commissions. As a result, the Legislative Research Commission completed an exhaustive study of the powers and duties of the boards and commissions on which legislators served and made three fundamental policy changes. First, legislators were removed from boards and commissions that exercise executive powers. Second, boards and commissions that could function effectively without executive authority, were made advisory and legislators retained their membership. Third, the power to appoint nonlegislative members to executive boards was removed from the legislative leaders and granted to the entire General Assembly.

Mississippi. The Mississippi attorney general filed suit in August 1982 to remove legislators from nine specific boards and commissions. In State of Mississippi v. William B. Alexander, et al., the attorney general argues that the boards in question exercise executive authority and the legislature, in violation of the separation of powers principle, is attempting to retain control over the process of implementing legislation by appointing legislators to them. He also contends that a violation of separation of powers occurs when a person serving in one branch exercises any power or function of another branch.

In its legal briefs, the legislature has taken the position that the separation of powers does not require an absolute division between the legislative and executive branches of government. Because this division is less than exact, a violation occurs only when a person serving in one branch "usurps the whole of the power of another branch." In the legislature's view, if the primary functions of a board or commission are legislative in nature, legislative members do not violate the separation of powers principle. In addition, Mississippi legislators contend that even if the primary functions are executive, the court should consider who performs the executive functions, whether the legislators constitute a minority position on the board, and what benefits accrue to the state through legislator service before ruling on the separation of powers questions.

In January, 1983, the Hinds County Circuit Court ruled that the legislators serving on the nine boards and commissions in question violated Mississippi's separation of powers constitutional provision. The legislature is expected to appeal the decision.

Kentucky. In Legislative Research Commission, et al. v. John Y. Brown, Jr. the Kentucky legislature asked the court to rule on the constitutionality of several acts passed during the 1982 session, including acts that appoint the Speaker of the House of Representatives and President Pro Tempore of the Senate to two boards and commissions and acts that empower the legislative leaders to make appointments to boards and commissions. The Franklin Circuit Court in November 1982 ruled that legislators could not serve on boards or agencies within the executive department without violating Kentucky's separation of powers provisions. The court also ruled that, "the powers to appoint members of boards is an essentially executive power which cannot be exercised by any member of the legislative department."

The case has been appealed by the Legislative Research Commission directly to the Kentucky Supreme Court which has agreed to hear it in early 1983.

Dual Office Holding Prohibitions. The second legal argument against legislator service on boards and commissions is based on constitutional prohibitions against dual office holding. Courts have generally defined a public office as one in which a person has independent authority to act under the law, either alone or with others of equal authority, to exercise the sovereign powers of the state. In a 1944 opinion, the Ohio Supreme Court ruled that state's dual office holding prohibition would preclude legislators from serving on boards and commissions that exercise sovereign powers of the state.[4] In California and Minnesota, attorneys general used court interpretations of

what constitutes a public office to determine whether legislators can serve on certain boards and commissions.

In January 1982, citing a provision of the Tennessee constitution that specifically prohibits legislators from holding any "office or place of trust, the appointment to which is vested in the executive or the General Assembly..." the Attorney General advised legislators that their service on nine boards and commissions was unconstitutional. The major dispute involved the speakers of the House and Senate serving as members of the State Building Commission. In light of this opinion, the leaders retained their membership but relinquished their voting privileges. This action has apparently resolved the question and no court challenge is expected.

RESULTS OF THE NCSL SURVEY

To gather information about the extent to which legislators serve on boards and commissions, the National Conference of State Legislatures surveyed research directors in all 50 states in 1982. NCSL asked about the types of boards on which legislators serve, whether there are restrictions placed on their service, how legislators are appointed to boards and commissions, and whether legislative leaders can appoint nonlegislators to boards and commissions. NCSL did not attempt to determine the number of boards and commissions with legislative members or the number of legislators serving on boards and commissions.

Types of Boards on Which Legislators Serve. NCSL grouped the different types of boards and commissions into five broad categories and asked whether legislators serve on any of these boards:

QUASI-JUDICIAL--boards that hear claims and issue decisions, promulgate rules and regulations, issue orders and act as appeal boards for administrative decisions.

BUDGETING--boards that formulate state budgets, allocate funds between departments, receive and allocate federal funds, and oversee agency expenditures.

POLICYMAKING--boards that gather data on the status of specific problems, advise and assist executive agency personnel and the legislature, recommend state actions, set priorities for state action and coordinate programs in a specific area.

REGULATORY--boards that set rates for services and products, determine eligibility for professions and trades, and approve applications for licenses.

MANAGEMENT--boards that oversee and administer state policy in specific areas, hire and oversee the performance of a full-time administrator and staff, award contracts and expend state funds, purchase equipment and services, and prepare an annual budget to carry out assigned responsibilities.

Although not included in the written descriptions, the NCSL staff also asked respondents whether legislators serve on advisory boards and commissions. Table 1 lists the types of boards and commissions on which legislators serve in each state.

Several observations can be drawn from the data:

1. Four states (Massachusetts, Michigan, New Mexico, and Virginia) indicate that legislators are strictly prohibited, either through constitutional provisions, statutes, or by court decisions, from serving on boards and commissions.

2. The most common state practice is for legislators to serve on advisory boards, a practice followed in 37 states. In 11 states, lawmakers can only serve on advisory bodies.

3. Although legislators serve on policymaking boards and commissions in 24 states, many respondents emphasized the advisory functions of these bodies thus reflecting further the tendency of legislators to serve on advisory bodies.

4. In 20 states, legislators serve on boards and commissions that exercise management responsibilities.

5. Except for rare exceptions, legislators do not serve on quasijudicial or regulatory boards and commissions.

Restrictions on Legislators' Service. Legislators tend to be treated the same as nonlegislative board members. For the most part, legislators have voting privileges and receive the same compensation as other members. In some states, legislators receive a per diem or expense reimbursement at the legislative rate which is unavailable to other board members. Only Maine and New Jersey prohibit legislators from receiving compensation.

Legislators' board terms generally coincide with their legislative terms. If they are defeated for election, their board term ends. In Texas and Utah, there are a few exceptions where a legislator's board term extends beyond the legislative term. Where legislators are appointed by legislative leaders, they generally serve at the pleasure of the leadership.

By California law, legislators are permitted to serve on boards and commissions "only to the extent that participation is not incompatible with their positions as members of the General Assembly."[5] The Virginia General Assembly enacted a statute precluding its members from serving on "boards and commissions within the executive branch which are responsible for administering programs established by the General Assembly."[6]

Appointments to Boards and Commissions. Table 2 lists how legislators are appointed to boards and commissions in each state and whether legislative leaders can make nonlegislative appointments.

The survey revealed that legislative leaders appoint legislators to boards and commissions in 38 states. Legislators are appointed by governors in 20 states and serve on boards and commissions by reason of their legislative position in 23 states. Most states use a combination of the methods to appoint legislators to boards and commissions.

In 26 states, legislative leaders can appoint nonlegislators to boards and commissions. This practice was changed as a result of the recent North Carolina litigation and is currently being challenged in Kentucky.

CONCLUSION

The recent cases pose significant challenges to the legislatures' authority and practice in Kentucky, Mississippi and North Carolina. For several reasons, however, the impact of these cases on other legislatures does not appear to be as significant. First, the recent Kentucky and North Carolina court rulings reaffirm previous state court decisions precluding legislators from serving on boards and commissions that exercise executive authority. Second, a review of current state practices clearly demonstrates a strong tendency for legislators to serve only on advisory bodies. The

combination of legal precedents and state practices indicate that, for the most part, legislators currently confine their service to advisory boards and commissions and that the rulings in the current cases would only apply to limited situations in the other states.

TABLE 1
TYPES OF BOARDS AND COMMISSIONS ON WHICH LEGISLATORS SERVE

STATE	QUASI-JUDICIAL	BUDGETING	POLICY-MAKING	REGULATORY	MANAGEMENT	ADVISORY
AL			X		X	
AK			X			X
AZ	X		X			X
AR			X	X		X
CA			X		X	
CO		X	X		X	X
CT		[7]	X			X
DE		X				X
FL						X
GA						X
HI			X			X
ID			X		X	X
IL					X	X
IN		[8]				X
IA		X	X		X	X
KS		X			X	X
KY[*]						
LA						X
ME			X			X
MD			X			X
MA	LEGISLATORS DO NOT SERVE ON BOARDS AND COMMISSIONS					
MI	LEGISLATORS DO NOT SERVE ON BOARDS AND COMMISSIONS					
MN			X		X	X
MS						
MO			X		X	
MT						X
NE			[9]			
NV						X
NH	X		X			
NJ		X			X	X
NM	LEGISLATORS DO NOT SERVE ON BOARDS AND COMMISSIONS					
NY[*]						
NC		X		X		X
ND		X	X		X	
OH		X	X		X	X
OK			X			X
OR			X		X	X
PA			X		X	X
RI						X
SC		X			X	
SD			X			X
TN					X	X
TX		X	X		X	X
UT	X		X		X	X
VT			X		X	X
VA	LEGISLATORS DO NOT SERVE ON BOARDS AND COMMISSIONS					
WA						X
WV						X
WI						X
WY					X	

[*] State did not return survey.

LEGISLATIVE APPOINTMENTS TO BOARDS AND COMMISSIONS

	HOW LEGISLATORS ARE APPOINTED			
STATE	LEADERS	GOVERNOR	POSITION	LEADERS POWERS TO APPOINT NONLEGISLATORS
AL	X	X	X	YES
AK	X	X		NO
AZ	X		X	NO
AR	X	X		YES
CA	X		X	YES
CO	X			YES
CT	X		X	YES
DE	X	X	X	YES
FL	X	X	X	YES
GA	X			NO
HI	X	X		NO
ID		X		YES
IL	X		X	YES [10]
IN	X	X	X	NO
IA	X	X		NO
KS	X		X	YES
KY[*]				
LA	X	X	X	[11]
ME	X	X		YES
MD	X	X		YES
MA	LEGISLATORS DO NOT SERVE ON B/C			NO
MI	LEGISLATORS DO NOT SERVE ON B/C			NO
MN	X		X	NO
MS	X		X	YES
MO	X			NO
MT		X		NO
NE	X		X	NO
NV	X	X		NO
NH	X			NO
NJ	X			YES
NM	LEGISLATORS DO NOT SERVE ON B/C			NO
NY[*]				
NC	X	X	X	NO [12]
ND	X			YES
OH	X		X	YES
OK	X			YES
OR	X	X		YES
PA	X	X	X	YES
RI	X		X	YES
SC			X	[13]
SD		X	X	YES
TN		X	X	NO
TX	X		X	YES
UT	X	X	X	YES
VT	X		X	NO
VA	LEGISLATORS DO NOT SERVE ON B/C			NO
WA	X			NO
WV	X			NO
WI	X		X	YES
WY	X			NO

[*] State did not return survey.

[1] Stockman v. Leddy, 129 P. 220 (1912).

[2] Greer v. Georgia, 212 S.E. 2d 836 (1975).

[3] State ex rel. Schneider v. Bennett, 547 P 2d 786 (1976).

[4] State ex rel. Herbert v. Ferguson, 142 Ohio St. 496 (1944).

[5] Government Code, Sections 14502, 14999.1, and 15770.

[6] Code of Virginia, Section 9-6.23

[7] Legislators serve on the Finance Advisory Committee which can only approve the transfer of funds between executive departments and between line item appropriations.

[8] Legislators serve on the Budget Committee which advises the budget director; powers are advisory only. Legislators also serve on the Commission on State Tax and Finance Policy; again, its powers are advisory only.

[9] Legislators generally serve on special study committees created by the legislature to advise the legislature. There is only one statutory board on which legislators serve that functions as an advisory committee to an executive body. However, no appointments to that board have been made in a number of years.

[10] Leaders can only make appointments to advisory boards and commissions.

[11] The legislature, by resolution, can make appointments to the board of ethics.

[12] As a result of the Bone decision, the power to appoint nonlegislators to executive boards and commissions is vested in the entire legislature instead of the leadership.

[13] Leaders can only make appointments to the Basic Skills Assessment Commission.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 17, 2010

SUBJECT: Legislative Confirmation of Commission Members (CSSB 172(HSS), (Work Order No. 26-LS0790\P))

TO: Senator Bettye Davis
Chair of the Senate Health and Social Service Committee
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

Tom Obermeyer has asked for a memo that describes the limits of the legislature's role of confirmation in the review of the appointment of persons for positions in the executive branch.

*

Constitutionally, the underpinnings of the legislature's role in the confirmation of certain executive branch appointees to hold the office are to be found in two sections of article III of the Alaska Constitution, sections 25 and 26:

> **Department Heads.** The head of each principal department shall be a single executive unless otherwise provided by law. He shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session, and shall serve at the pleasure of the governor, except as otherwise provided in this article with respect to the secretary of state. The heads of all principal departments shall be citizens of the United States.
>
> **Boards and Commissions.** When a board or commission ***is at the head of a principal department or a regulatory or quasi-judicial agency***, its members shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session, and may be removed as provided by law. They shall be citizens of the United States. The board or commission may appoint a principal executive officer when authorized by law, but the appointment shall be subject to the approval of the governor.

(Emphasis added.)

In *Bradner v. Hammond*, 553 P.2d 1 (Alaska 1976), the Alaska Supreme Court reached the conclusion that

> . . . ***the appointment of executive officers is an executive function***; for without such a power, the responsibility for executing executive duties would be diffused and the goal of separation of branches of government, avoiding too great a concentration of power in one branch, would be defeated.

and, further that

> . . . under Alaska's constitution confirmation is a specific attribute of the appointive power of the executive. Other courts which have been called upon to resolve this issue have been unanimous in their holdings that ***confirmation is not a distinct legislative power, but rather a part of the executive power of appointment which has in turn been delegated in some specific instances by constitution to the legislative branch of government.***

Bradner, at 6 - 7 (emphasis added; notes omitted).

*

Procedurally, the legislature's role in confirmation is spelled out almost entirely in AS 39.05.080.

The Alaska Health Care Commission established in CSSB 172(HSS) is an advisory board that does not sit at the head of a principal department, a regulatory agency, or a quasi-judicial agency. Therefore, the appointees to the commission are not subject to legislative confirmation by operation of the constitution. The legislative role is limited to establishing such commissions and to providing guidance to the legislature on the qualifications of commission members. The appointment itself is otherwise an executive function in which the legislature plays no role.

If I may be of further assistance, please advise.

JMM:lmb
10-009.lmb

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 240249
ANCHORAGE, ALASKA 99524-0249
PHONE: (907) 269-7800
FAX: (907) 269-0060

March 11, 2010

The Honorable Bettye Davis
Chair, Senate Health & Social Services Committee
Alaska State Senate
State Capitol Building, Rm. 30
Juneau, Alaska 99801

Re: SB 172 Alaska Health Care Commission

Dear Senator Davis,

This letter serves to update the letter I sent to you dated March 10 on this subject. The department's intent remains the same - to support the addition of two new seats in the bill to establish the Alaska Health Care Commission in statute, one each for a primary care physician and one for the behavioral health community. I agree with the language the bill's sponsor supports and I'm documenting that here in the interest of clarity and with the intent of supporting the work of the Senate HSS Committee to identify the appropriate membership of the commission.

The department's suggested language for Sec. 18.09.020 of SB 172 is provided on the following page. Please contact me at 465-3030 if you have any questions. Thank you.

Sincerely,

William H. Hogan
Commissioner

cc: Senator Donny Olson, Alaska State Senate

Sec. 18.09.020. Composition; chair. The commission consists of 12 members as follows:

(1) nine voting members appointed by the governor as follows:

(A) the state officer assigned the duties of medical director for the department, who shall serve as chair;

(B) one member representing the tribal health community in the state;

(C) one member representing a statewide chamber of commerce who is not associated with health care;

(D) one member representing the Alaska State Hospital and Nursing Home Association;

(E) one member who is a health care provider
- (i) actively practicing the provider's profession in the state;
- (ii) licensed to practice in the state; and
- (iii) not affiliated with the Alaska State Hospital and Nursing Home Association;

(F) one member who is a representative of the health insurance industry in the state;

(G) one member who is
- (i) a health care consumer;
- (ii) a resident of the state; and
- (iii) not employed by and does not have a business interest in the health care industry;

(H) one member who is a primary care physician licensed to practice in the state, and who practices family medicine, primary care internal medicine, or pediatric medicine;

(I) one member representing the Alaska Mental Health Trust Authority; and

(2) three nonvoting members appointed as follows:

(A) one ex officio member from the house of representatives, appointed by the speaker of the house of representatives;

(B) one ex officio member from the senate, appointed by the president of the senate;

(C) an ex officio member representing the Office of the Governor.

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON

ALASKA
STATE CAPITOL
ROOM 508
JUNEAU, ALASKA 99801-1182

(907) 465-3707
FAX (907) 465-4821

MEMORANDUM
Distributed via email

DATE: March 10, 2010

TO: Senator Bettye Davis, Chair
Senate Health and Social Services Committee

FROM: Senator Donald Olson
District T

SUBJECT: SB 172 Alaska Health Care Commission

At today's hearing, there was some confusion regarding the composition of the proposed Alaska Health Care Commission. For the sake of clarity, the nine voting members I requested and would like to see named for inclusion on the Commission are as follows:

- The state officer assigned the duties of medical director for the department, who shall serve as chair;
- One member representing the tribal health community in the state:
- One member representing a statewide chamber of commerce who is not associated with health care;
- One member representing the Alaska State Hospital and Nursing Home Association;
- One member who is a health care provider:

  a) actively practicing the provider's profession in the state;
  b) licensed to practice in the state; and
  c) not affiliated with the Alaska State Hospital and Nursing Home Association;

- One member who is a representative of the health insurance industry in the state;
- One member who is:

  a) a health care consumer;
  b) a resident of the state; and
  c) not employed by and does not have a business interest in the health care industry;

- One member who is a primary care physician licensed to practice in the state, and who practices family medicine, primary care internal medicine, or pediatric medicine; and
- One member representing the Alaska Mental Health Trust Authority.

With the confusion on the specific seats and the wording of each, I thought it would be best to clarify my intentions as the sponsor of the legislation being debated. Thank you for hearing my bill, and for working with me and my staff to try to establish the Alaska Health Care Commission in statute.

Cc: Senator Joe Paskvan, Vice-Chair, Health & Social Services Committee
Senator Johnny Ellis, Health & Social Services Committee
Senator Joe Thomas, Health & Social Services Committee
Senator Fred Dyson, Health & Social Services Committee
William Hogan, Commissioner, Department of Health & Social Services
Wilda Laughlin, Legislative Liaison, Department of Health & Social Services
Deborah Erickson, Executive Director, Alaska Health Care Commission
Jeff Jessee, CEO, Alaska Mental Health Trust Authority

PROPOSED HEALTH COMMISSION MEMBERS

Sec. 18.09.020 Composition; chair. The commission consists of 12 members as follows:

Nine voting members appointed by the governor as follows:

(1) The state officer assigned the duties of medical director for the department, who shall serve as chair;

(2) One member representing the tribal health community in the state;

(3) One member representing a statewide chamber of commerce who is not associated with health care;

(4) One member representing the Alaska State Hospital and Nursing Home Association

(5) One member who is a health care provider

(i) Actively practicing the provider's profession in the state;
(ii) Licensed to practice in the state; and
(iii) Not affiliated with the Alaska State Hospital and Nursing Home Association;

(6) One member who is a representative of the health insurance industry in the state;

(7) One member who is

(i) A health care consumer;
(ii) A resident of the state; and
(iii) Not employed by and does not have a business interest in the health care industry; and

(8) One member who is a primary care physician ~~(i)~~ licensed to practice in the state~~;~~ ~~(ii) board-certified in family medicine or pediatric medicine;~~ and ~~(iii)~~ who practices family medicine, primary care internal medicine, or pediatric medicine.

(9) ~~One member who is a behavioral health care provider (i) licensed as a behavioral health practitioner is the state or (ii) employed as an administrator of an organization that provides behavioral health care services.~~ One member representing the Alaska Mental Health Trust Authority.

(2)Three nonvoting members appointed as follows:

(A)One ex officio member from the house of representatives, appointed by the speaker of the house of representatives;

(B)One ex officio member from the senate, appointed by the president of the senate;

(C)An ex officio member representing the Office of the Governor.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 240249
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FAX: (907) 269-0060

March 10, 2010

The Honorable Bettye Davis
Chair, Senate Health & Social Services Committee
Alaska State Senate
State Capitol Building, Rm. 30
Juneau, Alaska 99801

Re: SB 172

Dear Senator Davis,

I understand the Senate HSS Committee will this afternoon consider potential amendments to SB 172, the bill that would establish the Alaska Health Care Commission in statute, to modify the composition of the membership and chair of the group. I write to offer the Department of Health & Social Services' position on the size, composition and chair of the commission.

The department believes the size of the body should remain relatively small to facilitate communication and decision-making among the group, and to maintain the intent of this body as an expert analysis and advisory body and not an advocacy group. In that vein, the department would agree with the addition of two additional seats, and believes the additional seats should be representative of primary care physicians and of the behavioral health provider community in Alaska. Additional expertise on primary medical care practice and behavioral health practice and administration are justified due to the importance of these two fields to access, delivery and cost of health care in Alaska.

The department also believes the commission should be chaired by the representative from the department to avoid the possibility of adverse perceptions of the work of the body if it were chaired by a member of one particular sector within the health care industry. It is also necessary to ensure there is adequate accountability in moving the work of this body forward – the department should ultimately be held accountable for compliance of this body with the law that establishes it.

The suggested language maintaining the composition as currently delineated in SB 172 with the addition of two seats, one each for primary care and behavioral health (highlighted), is provided on the following page. Please contact me at 465-3030 if you have any questions. Thank you.

Sincerely,

Bill

William H. Hogan, Commissioner
Department of Health & Social Services

Sec. 18.09.020. Composition; chair. The commission consists of 12 members as follows:

(1) nine voting members appointed by the governor as follows:

(A) the state officer assigned the duties of medical director for the department, who shall serve as chair;

(B) one member representing the tribal health community in the state;

(C) one member representing a statewide chamber of commerce who is not associated with health care;

(D) one member representing the Alaska State Hospital and Nursing Home Association;

(E) one member who is a health care provider
- (i) actively practicing the provider's profession in the state;
- (ii) licensed to practice in the state; and
- (iii) not affiliated with the Alaska State Hospital and Nursing Home Association;

(F) one member who is a representative of the health insurance industry in the state;

(G) one member who is
- (i) a health care consumer;
- (ii) a resident of the state; and
- (iii) not employed by and does not have a business interest in the health care industry;

(H) one member who is a primary care physician who practices family medicine, primary care internal medicine, or pediatric medicine in the state;

(I) one member representing the behavioral health provider community in the state; and

(2) three nonvoting members appointed as follows:

(A) one ex officio member from the house of representatives, appointed by the speaker of the house of representatives;

(B) one ex officio member from the senate, appointed by the president of the senate;

(C) an ex officio member representing the Office of the Governor.

State of Alaska

Transforming Health Care in Alaska

2009 Report/2010 – 2014 Strategic Plan

Alaska Health Care Commission

2009

4974

Transforming Health Care in Alaska
2009 Report/2010-2014 Strategic Plan

Alaska Health Care Commission

Ward Hurlburt, MD, MPH, Chair
C. Keith Campbell
Valerie Davidson
Jeffrey Davis
Ryan Smith
Wayne Stevens
Lawrence Stinson, MD
Linda Hall
Senator Donny Olson, MD
Representative Wes Keller

Deborah Erickson, Executive Director

Prepared for
Governor Sean Parnell and
The Alaska Legislature
Under Administrative Order #246

January 2010

4975

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

ALASKA HEALTH CARE COMMISSION

SEAN PARNELL, GOVERNOR
Bill Hogan, Commissioner

3601 C Street, Suite 902
ANCHORAGE, ALASKA 99503
PHONE: (907) 269-7800

January 15, 2010

To: The Honorable Sean Parnell, Governor, State of Alaska
The Honorable Gary Stevens, President, Alaska State Senate
The Honorable Mike Chenault, Speaker of the Alaska House of Representatives

We are pleased to present this report by the Alaska Health Care Commission in accordance with Administrative Order 246. The Commission was chartered by Governor Palin last winter to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility and availability of health care for all citizens of the state. This report represents the efforts of the Commission over this past year to identify and analyze problems with Alaska's health care system, develop an initial set of recommendations, and chart a course for the future.

The health care challenges faced by Alaska at this time are daunting. Costs have reached unaffordable levels, more and more Alaskans have difficulty accessing care, the delivery system is fragmented, vacancy rates among the health care workforce are high, financing and payment mechanisms make no sense, variations in medical practice and quality are not well understood, and providers are becoming more and more frustrated as they become buried under layers of government rules intended to help fix these problems.

Action is required, but these problems are complex. There are no magic bullets, there is no one solution, and the improvements required will not occur overnight. A process of transformational change must be implemented that will guide Alaska's health care system down a path to become more patient-centered, more evidence-based, more coordinated, and more efficient. Health care providers need to be supported and provided the appropriate tools they need along the way.

At the same time we need to start getting a handle on cost sooner rather than later. The health care industry represents an important part of our state's economy and we need to be careful about forcing too much change too quickly, but the continuing escalation in health care costs poses a significant and real threat to Alaska's economy and the sustainability of state government. Continuing work on the part of a future Commission must focus on this challenge.

We are optimistic that this report offers hope for the future and will lead to a health care system that focuses on creating health and not just treating illness and injury, will provide value for Alaskans' health care dollar, meets the needs of both consumers and providers, and is sustainable over the long term.

Sincerely,

Ward B. Hurlburt III, MD, MPH
Chair, Alaska Health Care Commission
Chief Medical Officer
Department of Health & Social Services

Deborah Erickson
Executive Director
Alaska Health Care Commission

Acknowledgements

This report represents the contributions of numerous individuals to whom the Commission would like to extend our thanks.

The Commission greatly appreciates the foresight of Governor Sarah Palin in establishing the Commission under Administrative Order 246.

The Commission is grateful for the leadership of our first Chair, Dr. Jay Butler, who was called to duty last spring by the U.S. Centers for Disease Control and Prevention to lead the nation's effort to develop and distribute vaccine to combat the novel H1N1 influenza pandemic. Dr. Butler was instrumental in launching the Commission, laying the groundwork and leading the critical first steps.

Special thanks goes to Department of Health & Social Services Commissioner William Hogan, who supported the Commission by loaning staff and providing information to the effort, and who stepped in as interim Chair on Dr. Butler's departure until the department's new Chief Medical Officer was named. The Commission would like to thank department staff who helped provide administrative and logistical support in their "spare time": Bonnie Caress, Nina Hauptman, Lucy Hansen, Shane Miller, Sherri Stears, and Serafine Bourne.

The Commission is most grateful to the Section of Health Planning and Systems Development in the Division of Health Care Services, who prepared a "primer" on health care in Alaska for the Commission (included as Appendix A of this report), and also supplied additional data, information and guidance in support of health care research and analysis by the Commission, including Deputy DHSS Commissioner William Streur, Pat Carr, Alice Rarig, Faith Allard, Neal Gilbertsen, Mark Millard, Mark Doughty, Karen Lawfer, and Jean Findley.

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Alaska Health Care Commission
2009 Report/2010-2014 Strategic Plan

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Executive Summary

A healthy citizenry is vital to the economy and governance of the state of Alaska. Good health, both physical and mental, is essential to all Alaskans' ability to actively participate in and contribute to their families, schools, places of employment, and communities. Access to quality health care is an important contributor to the health of Alaskans.

The Alaska Health Care Commission was created to address growing concern over the condition of Alaska's health care system. The delivery of care is fragmented. Costs are unaffordably high and continue to climb, seemingly out of control. Too many Alaskans lack health care coverage, or have coverage but can't find a doctor who will accept them as a patient. Levels and variations in the quality of care are not well understood. Consumers aren't happy. Providers are frustrated. The system as currently designed is not sustainable.

The health care system has come together in a piecemeal fashion over many decades. It is funded by a conglomeration of numerous public and private payers. Care is provided under layers of government rules and regulations. Some provider organizations are government, some are quasi-government, some are non-profit, and some are private for-profit businesses. Providers trained in different regions of the country and in different fields don't have a consistent approach to diagnosis and treatment.

A system this complex cannot be fixed over night. A journey of transformation that will be many years in the making is required to redesign and implement a more rational, coherent and sustainable system that will deliver the highest quality of care at the most reasonable price in a way that protects providers and their business interests, while protecting the interests of Alaska's health care consumers.

The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center of their health care experience and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at a reasonable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system will be sustainable.

The Commission also identified four goals for a transformed health care system – that it will:

I. **Improve access** to health care services and affordable health insurance coverage.
II. Turn the curve on Alaska's medical inflation rate so that it is at least below the national rate, in order to **contain cost growth**.
III. Assure that health care services delivered in Alaska meet the highest **quality and safety** standards.
IV. **Focus on prevention**, not just clinical preventive services for individuals, but public health community-based policies and programs, to support improved health status and to control costs by reducing the burden of preventable illness and injury.

Understanding and supporting the consumer's role in health care was a primary interest of the Commission's, and became the central focus of their strategic approach to transformation of Alaska's health care system. Two aspects emerged as critical to addressing the goals of increased access, improved value (high quality at a reasonable price), and a focus on prevention – 1) individual lifestyle

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choices and the impact those choices have on health outcomes and demand for health care services; and 2) the role of primary care in placing the patient at the center of their health care experience.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and a strong innovative primary care system depends. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. On-going study, planning, and policy development is necessary to ensure Alaska's health care system is able to adapt to national health care reform, and to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

To achieve these goals the Commission recommends the following to the Governor and the Legislature:

A. Strengthen the consumer's role in health and health care
    - Support healthy lifestyles and create cultures of wellness
    - Develop patient-centered primary care models through payment reform, removal of barriers, and support for pilot projects
B. Foster statewide leadership to support health care transformation
    - Invest in the health policy infrastructure needed to respond to national reform
    - Establish a permanent state health planning and policy body in statute
C. Develop the health care workforce
    - Make workforce a priority on health care reform and economic development agendas
    - Strengthen the pipeline of future health care workers
    - Support workforce innovation and adaptation as patient care models evolve
    - Direct workforce planning to be more coordinated
    - Increase the supply of primary care physicians by
        - Supporting educational loan repayment and financial incentives for recruitment
        - Expanding the WWAMI Alaska medical school program as resources allow
        - Supporting planning for primary care residency programs
D. Deploy health information technology
    - Support health information technology adoption and utilization
    - Ensure public health connectivity
    - Ensure resulting information is used for optimization of medical care
    - Ensure privacy and security
    - Facilitate broadband telecommunications service access
    - Improve reimbursement for telemedicine
E. Improve access to primary care for Medicare beneficiaries
    - Increase the supply of primary care providers
    - Support Federally Qualified Health Centers and Rural Health Clinics
    - Request relief from federal reimbursement inequities and administrative burdens
    - Develop a PACE (Program of All-Inclusive Care for the Elderly) program

The Commission provides in this report an action plan suggesting the operational steps and resources required to implement each of these recommendations. The Commission also lays out a 5-year strategic planning framework designed to facilitate an ongoing comprehensive approach to health care system transformation. Also included is a description of additional strategies for potential inclusion in continued planning efforts, such as cost and quality transparency, evidence-based medicine, payment reform, fraud and abuse control, and public health system support. Finally – as the work represented in this report is only a beginning – a one-year work plan for this or a future health care commission is outlined for 2010 to guide the continuing journey of health care system transformation for Alaska.

PART I: Introduction

A. Purpose of this Report

The purpose of this report is to convey the findings and recommendations of the Alaska Health Care Commission to Governor Parnell and the Alaska Legislature as required under Administrative Order (A.O.) 246. This report is intended to serve as a five-year strategic plan for strengthening Alaska's health care delivery system, and is meant to be a living document that will evolve each year over the course of the coming five years as problems are studied, various approaches are analyzed, and implemented strategies are evaluated. This plan will be updated and conveyed to the Governor and Legislature in subsequent annual reports of the Commission if the Commission is continued beyond this first year.

Included in this report are:

- Part I: an introduction including background on the Commission, a summary of the Commission's 2009 activities, and a description of the Commission's vision, goals and values;
- Part II: information on the challenges of delivering and accessing health care in Alaska;
- Part III: the Commission's proposed strategy for transformation of Alaska's health care system, including findings and recommendations on key issues analyzed during the year;
- Part IV: a brief explanation of the design elements required for health care system transformation identified this year that are recommended for future analysis;
- Part V: the strategic plan – laying out a framework for the five-year plan, providing a suggested action plan for implementation of the Commission's 2009 recommendations, and setting the Commission's work plan for 2010;
- Appendices: Background information on health and health care in Alaska, and additional documents produced by the Commission.

B. Background on the Alaska Health Care Commission

The Alaska Health Care Commission was established by Governor Palin on December 4, 2008 under A.O. 246 to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. The duties of the Commission as outlined in the Administrative Order are to:

I. Serve as the state health planning and coordinating body;
II. Provide recommendations for and foster the development of a:
    A. Comprehensive statewide health care policy;
    B. Strategy for improving the health of Alaskans that includes
        i. Encouraging personal responsibility in prevention and healthy living for all residents of the state;
        ii. A reduction in health care costs for all residents of the state to be below the national average;
        iii. Access in communities of the state to safe water and wastewater systems;
        iv. The development of a sustainable health care workforce in the state;
        v. Quality health care being accessible for all residents of the state; and,
        vi. Increasing the number of residents of the state who are covered by health care insurance; and,
III. Submit a report to the Governor and the Legislature on or before January 15, 2010 regarding the Commission's recommendations and activities.

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Commission members were appointed by Governor Palin (with legislative representatives appointed by their respective bodies) January 27, 2009. Short biographies for each of the Commission members are included in Appendix D. The members of the Commission are:

Ward Hurlburt, MD, MPH[1]**:** Designated Chair; Chief Medical Officer for the Alaska Department of Health & Social Services; Anchorage.
C. Keith Campbell: Representing Consumers; Retired; Seward.
Valerie Davidson: Representing Alaska tribal health care providers; Senior Director of Legal and Inter-Governmental Affairs for the Alaska Native Tribal Health Consortium; Anchorage.
Jeffrey Davis: Representing Alaska's health insurance industry; President of Premera Blue Cross Blue Shield of Alaska; Anchorage.
Ryan Smith: Representing the Alaska State Hospital & Nursing Home Association; Chief Executive Officer of the Central Peninsula General Hospital; Soldotna.
Wayne Stevens: Representing the Alaska State Chamber of Commerce; President & CEO of the Alaska State Chamber of Commerce; Juneau.
Lawrence Stinson, MD: Representing Alaska health care providers; Anesthesiologist and co-owner of Advanced Pain Centers of Alaska.
Linda Hall (Ex-Officio): Representing the executive branch; Director of the Division of Insurance; Anchorage.
Representative Wes Keller (Ex-Officio): Representing the Alaska House of Representatives; Wasilla.
Senator Donny Olson (Ex-Officio): Representing the Alaska Senate; Golovin.

Creation of the Commission followed from the work of an earlier group convened by Governor Palin – the Alaska Health Care Strategies Planning Council – established under A.O. 232 in 2007. The Planning Council consisted of 17 members who met for 6 months, during which time they identified a series of goals and strategies for improving the health of and health care for Alaskans. The Council's recommendations included a strategy for creation of a permanent health planning commission established in state statute.

Governor Palin's issuance of A.O. 246 was meant to jump-start the Planning Council's recommendation for a permanent body while legislation to establish the Commission was pending in the Alaska Legislature. There are currently three bills under consideration by the legislature that would create a health care commission in statute – HB 25 (Hawker), HB 75 (Cissna), and SB 172 (Olson)[2]. If one of these bills passes during the 2010 session and is signed into law by Governor Parnell, the work of the current Commission will continue, but potentially with a slightly different charge and different members. If none of these bills pass, and unless Governor Parnell extends the life of the Commission through Administrative Order, the work of this Commission will end, but hopefully their one year of work and this report will add some value to on-going efforts to strengthen Alaska's health care delivery system and improve the health of Alaskans.

[1] Dr. Jay Butler served as Chair of the commission through mid-June. Commissioner William Hogan assumed the role of Chair in June through September. Dr. Hurlburt was appointed Chair of the commission following his appointment as Chief Medical Officer of DHSS in September.
[2] A table comparing the purpose, duties and membership of the bodies that would be created under each of these bills and A.O. 246 is included in Appendix D of this report.

C. Summary of 2009 Activities

The Commission experienced a number of challenges during their first year, including lack of funding, turnover in the Chairperson's role, temporary reassignment of their one staff person, uncertainties caused by the efforts at the federal level to reform the nation's health care system, and unknowns about the future of the Commission itself. Despite these limitations the Commission was successful in analyzing a number of critical issues and developing the recommendations contained in this report.

The Commission focused this year on:

1. Developing a vision of a transformed health care system for Alaska, including goals and values for guiding decision making;
2. Defining a comprehensive health care system transformation strategy;
3. Identifying, analyzing and developing recommendations regarding a few critical priority issues;
4. Outlining a 5-year strategic planning framework, including identification of:
   a) a preliminary set of measures for tracking the performance of Alaska's health care system, and
   b) issues and strategies for future analysis and policy recommendation development.

The Commission identified as their initial priorities for analysis and policy recommendation development for this year the following issues:

- The consumer's role in health care
- Statewide leadership for strengthening the health care system
- Health care workforce development, with a focus on the physician workforce
- Health information technology
- Primary care access for Medicare patients

2009 Accomplishments

Meetings and public hearings: During 2009 the Commission held four face-to-face meetings: February 27-28 in Juneau; and May 1-2, August 25-26, and November 6-7 in Anchorage. All of these meetings were open to the public, and teleconferenced for members of the public unable to attend in person but interested in listening to the meeting or providing public testimony. A number of teleconferences were held during the year as well. Summaries of the meetings and teleconferences are included in Appendix D of this report. Four public hearings were held, three during the May, August, and November meetings, and one on December 14 through the Legislative Information Office teleconference system.
Administration: In their first months the Commission established meeting rules, a set of by-laws, a job description for the Executive Director, and appointed an Executive Director (initially hired by DHSS in February to expedite the first meeting of the Commission). A copy of the Commission's meeting rules, by-laws, and Executive Director job description are included in Appendix D of this report.
Communication and coordination: The Commission developed a website for posting information regarding their meetings as well as reference documents related to their priority focus areas (http://hss.state.ak.us/healthcommission/). A listserv was established to maintain communication with system stakeholders and members of the public interested in receiving periodic updates. As an initial step toward assuming the health planning coordination role noted in the Administrative Order, the Commission compiled an inventory of boards, committees, coalitions, and other organizations in Alaska involved in health planning in some way, as well as a list of health reports and plans (in Appendix C).
Products: The primary product developed by the Commission is this, their first report to the Governor and Legislature, which includes the Commission's vision, values and goals; findings and recommendations on the priority issues noted above, and a planning framework for the next five years.

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D. The Commission's Vision for Transformation of Alaska's Health Care System

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend." Benjamin Disraeli

A healthy citizenry is vital to the economy and governance of the state of Alaska. Good health, both physical and behavioral, is essential to all Alaskans' ability to actively participate in and contribute to their families, schools, places of employment, and communities. Access to quality health care is an important contributor to the health of Alaskans.

The Alaska Health Care Commission was created to address growing concern over the state of Alaska's health care system. The delivery of care is fragmented. Costs are unaffordably high and continue to climb, seemingly out of control. Too many Alaskans lack health care coverage, or have coverage but can't find a doctor who will accept them as a patient. Levels and variations in the quality of care are not well understood. Consumers aren't happy. Providers are frustrated. The system as currently designed is not sustainable.

The health care system has come together in a piecemeal fashion over many decades. It is funded by a conglomeration of numerous public and private payers. Care is provided under layers of government rules and regulations. Some provider organizations are government, some are quasi-government, some are non-profit, some are private business. Providers trained in different regions of the country and in different fields don't have a consistent approach to diagnosis and treatment. A system this complex cannot be fixed over night. A journey of transformation that will be many years in the making is required to redesign and implement a more rational, coherent and sustainable system that will deliver the highest quality of care at the most reasonable price in a way that protects providers and their business interests, while protecting the interests of their consumers.

Vision

Alaska's Health Care System

- Produces improved health status
- Provides value for Alaskans' health care dollar
- Delivers consumer and provider satisfaction
- Is sustainable

The first step this year in the Commission's journey toward transformation of Alaska's health care system was to design a picture of the ideal system. The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at a reasonable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system will be sustainable.

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Health Care Goals

I. Improved Access
II. Contained Cost
III. Safe, High Quality Care
IV. Prevention-Based

The Commission also identified four goals for a transformed health care system to support a targeted approach to identification of improvement strategies and performance measurement. The first goal is to improve access to 1) affordable health care insurance coverage, and 2) the services of a health care delivery system that is, itself, healthy. The second goal is to turn the curve on Alaska's medical inflation rate so that it is at least below the national rate, in order to contain cost growth. The third goal is to assure that health care services delivered in Alaska meet the highest quality and safety standards. The fourth goal is to focus on prevention, not just clinical preventive services for individuals, but public health community-based policies and programs, to support improved health status and to control costs by reducing the burden of preventable illness and injury.

Values

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

The Commission agreed to the following set of values to guide planning and policy recommendation decisions for transformation of Alaska's health care system:

Sustainability: A redesigned health care system for Alaska must be sustainable in terms of: 1) government, private sector, and individual ability to financially support implementation over the long term; and, 2) health care provider ability to deliver quality care while maintaining a sound business operation.
Efficiency: A redesigned health care system for Alaska will minimize waste in clinical care and administrative processes.
Effectiveness: A redesigned health care system for Alaska will support practices best known to produce the best outcomes.
Individual Choice: A redesigned health care system for Alaska will provide information and options for Alaskans in terms of health care coverage and service providers.
Personal Engagement: A redesigned health care system for Alaska encourages and empowers Alaskans to exercise personal responsibility for healthy living and for obtaining and participating in their health care.

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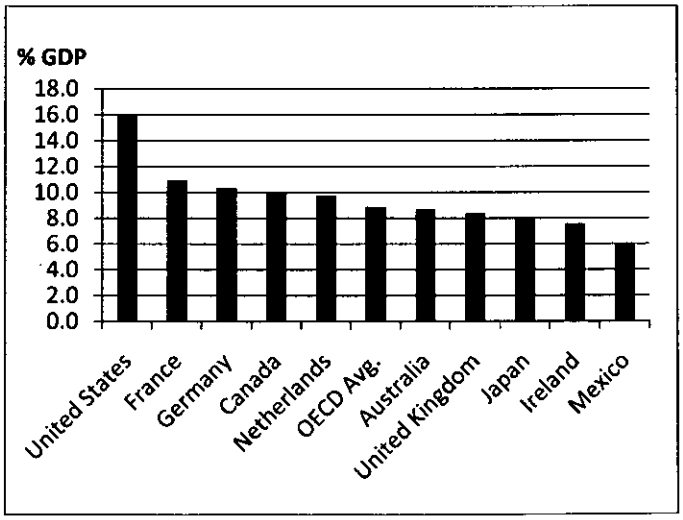
PART II: Health Care Delivery and Access Challenges in Alaska

The effort to transform Alaska's health care system to achieve the Commission's vision requires an accurate and complete understanding of the current condition of the system. A description of health care in Alaska – how it is structured, provided and funded – is included as Appendix A of this report. Here in Part II a discussion of some of the particular challenges associated with delivering and accessing health care in Alaska is discussed.

A. The Cost of Health Care in the U.S.

Health care spending in the United States has been growing faster than the economy for decades, doubling from 8% of the nation's gross domestic product (GDP) in 1970 to 16% in 2006. It is projected to increase to 20% of GDP, with total spending doubling from $2 trillion in 2006 to $4 trillion, by the year 2016.[i] A comparison of national health expenditures in the United States to other member countries of the Organization for Economic Cooperation and Development (OECD)(Figure 1) illustrates the challenge our nation faces in maintaining a competitive edge in today's global market place, as the increasing cost of health care contributes to higher prices for goods and services produced in the U.S.

FIGURE 1: National Health Expenditures as Percentage of National Gross Domestic Product, 2009



Source: OECD Health Data 2009, OECD (http://www.oecd.org/health/healthdata).

Higher costs in the United States do not necessarily reflect greater levels of health care resources. The U.S. has fewer physicians per capita than most other OECD countries, with 2.4 practicing physicians per 1,000 Americans compared to the OECD average of 3.1. The U.S. also has fewer hospital beds, with 2.7 acute care hospital beds per 1,000 Americans compared to the OECD average of 3.8 beds.[ii] Nor do higher costs mean that Americans have greater access to care. In 2004 97% of U.S. residents reported seeing at least one doctor in the previous 2 years, compared to 95% of Canadians and 98% of Australians. 84% of Americans reported having had a blood test, x-ray, or other diagnostic test in the past 2 years, compared to 84% of Canadians and 83% of Australians.[iii]

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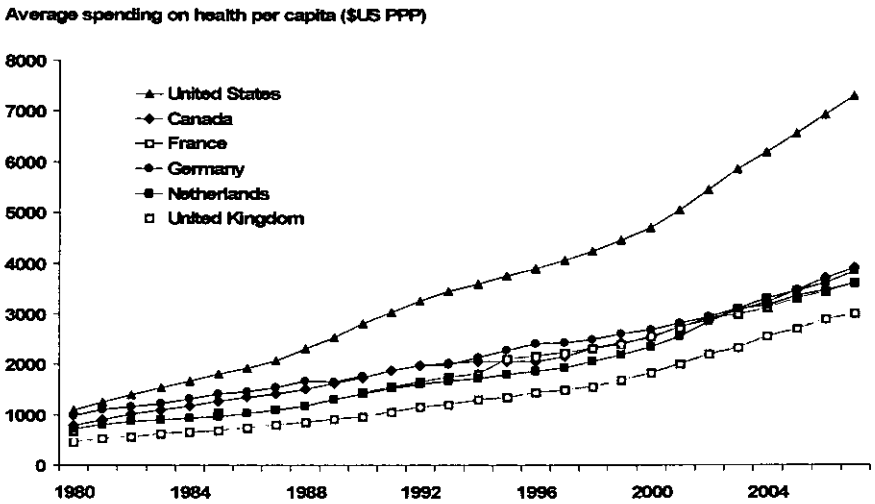
Higher health care spending does not translate into better outcomes in terms of health status. Life expectancy and infant mortality are not necessarily reflective of the quality of health care, but are two general measures of population health that indicate Americans, for all the investment in health care services, are not healthier overall. Life expectancy in 2007 was at 78.1 years in the U.S., placing it 24th among the 30 OECD nations; and the U.S. ranked 28th in infant mortality at 6.7 per 1,000 live births, ahead of only Mexico and Turkey.[iv]

Health care spending in the United States not only represents a higher proportion of our economy compared to other countries, average spending per person is significantly higher. Per capita national health expenditures in the United States increased 850% over the past three decades to $7,290 (Figure 2). The average OECD national health expenditure in 2007 was less than half that amount, at $2,984 per person.[v]

FIGURE 2: National Health Expenditures per Capita, 1980–2007



Source: OECD Health Data 2009, OECD (http://www.oecd.org/health/healthdata).

Just one result of the escalation in health care costs is the impact on the personal finances of America's families. In 1981 medical problems contributed to just 8% of personal bankruptcies in this country. By 2007 the share of bankruptcies attributable to a medical cause had increased to 62.1%.[vi]

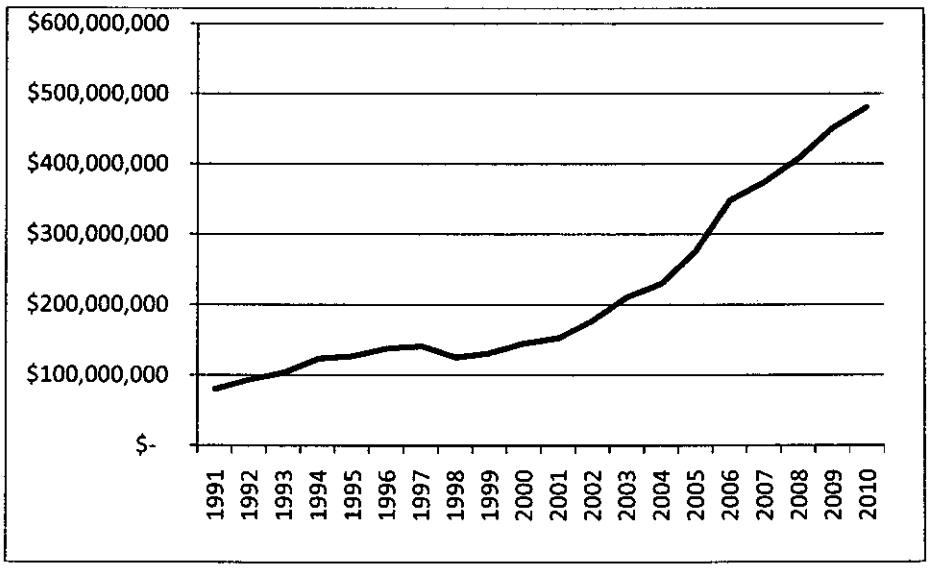
B. The Cost of Health Care in Alaska

The rapid rise in the cost of health care in the U.S. is reflected in Alaska as well. In 1993 the Health Resource & Access Task Force, a group convened by the Alaska Legislature to address questions of health care cost and access, projected health care spending in Alaska would "sky-rocket" from slightly below $1.6 billion in 1991 to nearly $5.6 billion in 2003. The HRATF determined that this "alarming" level of spending was inevitable if nothing was done to change the status quo.[vii] Today in 2009 estimated spending for health care in Alaska is over $6 billion.

Government (all levels – federal, state and local) pays 64% of Alaska's health care bill, including public insurance programs (Medicaid and Medicare), government employee and retiree insurance premiums, medical care for military personnel and dependents, Indian Health Service support of tribal programs, medical care provided through the Veterans' Administration, grants to Community Health Centers, operation of the state psychiatric hospital and Pioneers' Homes, and care for offenders incarcerated by the Department of Corrections. Private employers pay 17% of Alaska's health care bill in the form of health insurance premiums, self-insured costs, and Workers' Compensation medical benefits for their employees. Individual Alaskans pay the remaining 19% through premium contributions, co-payments, deductibles, and direct payment to providers.[viii]

The high cost of health care presents a significant fiscal challenge for the state of Alaska. State government is currently responsible for administering over $1.5 billion annually for all health care related expenditures (inclusive of costs for employees and retirees, Medicaid (including federal funds), a variety of grant programs, state health facilities, and services for inmates in state prisons). In 2004 Alaska had the highest annual Medicaid expenditure level per enrollee in the United States, at $10,417.[ix] State general fund expenditures for Medicaid grew from a little over $80 million in FY 1991 to over $408 million in FY 2008 – an increase of 410% during that 17 year period (Figure 3).[x]

FIGURE 3: Alaska State General Fund Medicaid Expenditures, 1991-2010



Source: FY 2010 DHSS Budget Overview
* FY 2009 and 2010 were estimated expenditures as of Nov 2008

Contributors to health care spending are numerous and varied, but there are two basic components driving total cost – price and utilization. Population increases and inflation are partly responsible for driving upward trends in utilization and pricing, but do not account fully for the rapid rise in health care spending in Alaska – which increased at an average annual growth rate of 8.9% per year between 1990 and 2005. Increased utilization due to a greater number of people living in Alaska made up 1.2% of the average annual spending increase, and general inflation contributed 2.4%. The reasons behind the remaining 5.3% average annual growth rate are not well understood.[xi]

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Increased utilization of the health care system is partly driven by the rising prevalence of health problems and the aging of the state's population. It is also influenced by payment systems that do not present incentives for patients and providers to keep spending in check. New technologies that provide additional diagnostic and therapeutic opportunities are another factor. Also contributing to utilization that may be higher than necessary is the practice of defensive medicine due to concern over medical liability. Fraudulent claims for medical services never rendered also play a role. One factor that may be a key in understanding and controlling utilization is waste in the system – by some estimates as much as 30% of total health care costs are for medical goods and services that are not medically necessary or are ineffective.

Prices of health care services and medical equipment, supplies and pharmaceuticals make up the other component contributing to total spending. The higher cost of living in Alaska contributes somewhat to higher health care prices, but the Consumer Price Index (CPI) for Anchorage increased a total of 38% for all items between 1991 and 2005, while the CPI for medical care in Anchorage increased 98% during that same period. Lack of economies of scale due to Alaska's small, widely dispersed population and also fragmentation and duplication in Alaska's health care system are assumed to contribute to higher prices. Medical liability is a component of price, as the cost of malpractice insurance premiums is passed on to the consumer. New medical technologies also play a role in higher prices, as the cost to providers of implementation is passed on to consumers.[xii]

One sign that the price of health care in Alaska is higher than in other states is the difference in reimbursement rates between Alaska and Washington State's Medicaid programs. Many of the professional fees paid by Alaska's Medicaid program are nearly three-times higher than those paid in Washington – Figure 4 provides just a few examples from the two states' 2009 Medicaid Fee Schedule.

FIGURE 4: Differences in Medicaid Fees, Washington State and Alaska, 2009

Description	Code	AK Fee	WA Fee	% Difference
Outpatient Office Visit – Lower Level	99212	$62.46	$22.69	175%
Outpatient Office Visit – Highest Level	99215	$221.58	$76.00	192%
Emergency Department Visit	99283	$109.14	$37.48	191%
Knee arthroscopy/Surgery	29881	$976.77	$358.08	173%
Gall bladder removal, laparoscopic	47563	$1,175.10	$412.29	185%
Cataract Surgery w/ lens implant	66984	$1,141.23	$394.44	189%

Source: Alaska Department of Health & Social Services, Division of Health Care Services, December 2009

Another indicator that Alaska's health care prices are generally higher is a comparison of spending for inpatient hospital services. In 2007 the average hospital adjusted expenses per inpatient day was $2,104 in Alaska – 24% higher than the national average of $1,696.[xiii] The average hospital cost per stay in Alaska was $27,171 compared to the 2007 national average of $15,455.[xiv]

And one more example of higher prices and overall costs comes from the Workers' Compensation program. Alaska has ranked 1st in the nation for cost of workers' compensation premium rates since 2005. Medical costs made up 72% of total benefit claims in Alaska in 2008, compared to the national average of 58%. The average medical cost per workers' compensation claim in Alaska was $40,000 per injury in 2008 compared to the national average of $26,000. Alaska's Workers' Comp medical fee schedule rates were the highest in the nation in 2006 – on average 3.5 times higher than Massachusetts, the state with the lowest rates.[xv] Below are a few examples of fees paid by Alaska's program compared to Washington's and Hawaii's.

FIGURE 5: Differences in Workers' Comp Fees, Alaska, Washington and Hawaii 2006

Description	Code	AK Fee	WA Fee	HI Fee
Outpatient Office Visit – Mid Level	99213	$127.00	$76.00	$61.00
Radiology (MRI, spinal canal cervical)	72141	$2,339.00	$769.00	$634.00
General Medicine (nerve conduction)	95904	$219.00	$81.00	$66.00
Knee arthroscopy/Surgery	29881	$4,181.00	$869.00	$693.00
Physical Medicine (therapeutic proc)	97110	$83.00	$40.00	$32.00

Source: November 2009 Report of the Workers' Compensation Medical Services Review Committee, AK Dept of Labor & Workforce Development

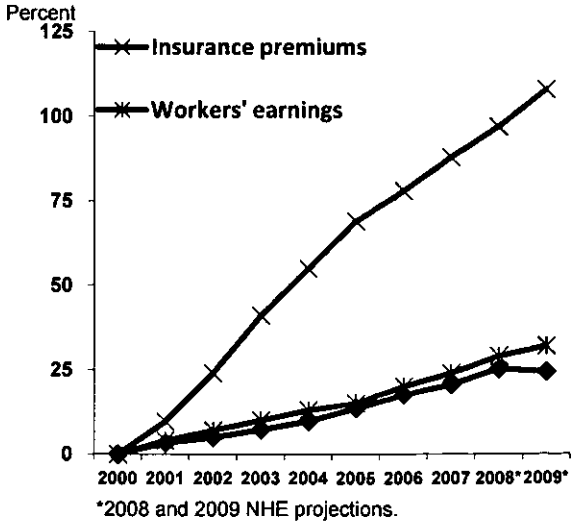
More research is required to understand the disparity in health care prices between Alaska and other states. A more comprehensive analysis of fees paid by all major payers and programs should be conducted. An analysis of variations in fees paid within Alaska as well as comparisons to other states should be included. Note the example from the above two tables in the disparity between fees paid by two different Alaskan programs for the same procedure – Alaska's Workers' Compensation program pays a professional fee for arthroscopic knee surgery (CPT 29881) that is more than four times higher than the fee paid by Alaska's Medicaid program. One other issue related to price and total cost that is not widely understood and should also be investigated is the difference between charges billed by providers and actual reimbursement levels, and how cost shifting occurs as providers adjust to changes in their payer mix and volume.

C. Health Insurance Coverage of Alaskans

Increased spending for health care translates into higher insurance premiums, as health insurance providers adjust to cover rising prices and growing utilization. Naturally therefore, as the overall cost of health care has increased over the years, the price of health insurance premiums has kept track. Unfortunately workers' wages have not kept pace with the rise in the cost of health insurance (Figure 6), and health care-related expenses are consuming a larger proportion of Americans' household income each year.

FIGURE 6: Premiums Rising Faster than Wages and Inflation[xvi]

Cumulative Changes in Components of U.S. National Health Expenditures and Workers' Earnings, 2000–2009



In Alaska health insurance premiums for working families grew by 90.8% between 2000 and 2009. In comparison, the median earnings of Alaska's workers rose 17% during the same period. The average annual insurance premium for family health coverage in Alaska rose from $7,456 in 2000 to $14,226 in 2009. The average annual premium for individual health coverage rose from $2,923 to $5,626 during that same period.[xvii] The percentage of income spent on health care in Alaska (based on per capita averages) increased steadily from 11% in 1991 to 19% in 2004.

14% of Alaskans are uninsured or do not have access to military, Veteran's Administration or Indian Health Service-funded health care services. The following table (Figure 7) illustrates the proportion of Alaskans covered by various types of health care coverage.

FIGURE 7: Health Insurance Coverage by Type of Coverage in Alaska and the U.S.

Health Insurance Coverage Type Average for data years 2006-2008	**Alaska**		**United States**
	Count	**Percent of Total**	**Percent of Total**
Covered by Any Source	575,269	86.0%	85.0%
Employer	388,381	58.0 %	59.0%
Individual (self-purchased)	42,891	6.4 %	9.0%
Medicaid & Denali KidCare	78,636	11.8 %	13.4%
Medicare	57,384	8.6 %	13.9%
Military/VA	88,944	13.2 %	3.7%
Indian Health Service only[3]	28,095	4.2%	0.5%
Uninsured all year	93,648	14.0%	15.0%
Total	**668,917**	(percentages add up to more than 100% because of overlapping coverage types)	

Source: Current Population Survey (CPS), 2007-2009 surveys, 2009 data released September 2009.

84% of uninsured Alaskans belong to households with one or more workers. Most uninsured workers are self-employed, or employed by small businesses that do not offer health benefits or offer coverage they cannot afford. While nearly all firms with more than 100 employees provide health benefits, less than a quarter of Alaska's smallest businesses (those with fewer than 10 employees) offer health insurance. The seasonal nature of Alaska's workforce is an important factor in employer health coverage. The CPS survey data in the Figure 7 table does not capture Alaskans who only have coverage part of the year in the reported uninsured amount. It also does not account for Alaskans who are underinsured – those who have coverage but with such high deductibles and co-pay that they still face financial barriers to health care.[xviii]

[3] Figures in this table are adjusted to include as "covered" people of Alaska Native/American Indian race who may have access to IHS-Funded services. The CPS Survey includes IHS beneficiaries in the uninsured category if they have no 3rd-party health insurance coverage. The "Indian Health Service only" amount included here is an estimate based on respondents to the survey identified as "AI/AN only."

4992

D. Health Care Delivery System Challenges

Alaska experiences many health care delivery challenges, including the logistical difficulties and costs involved in providing care for a relatively small number of people spread over vast geographic distances, a delivery system that is highly fragmented, and an inadequate supply and distribution of health care workers.

Logistical Challenges

Alaska is the largest state in the nation geographically, encompassing an area greater than the next three largest states – Texas, California and Montana – combined. At the same time Alaska's population is among the smallest of the states. Alaska has the lowest population density in the U.S. with 1.2 persons per square mile compared to the U.S. average population density of 79.6. 26.1% of the state's population lives in communities of fewer than 2,500 people.[xix] The dispersion of such a small number of people over such a large area increases the difficulty and cost of delivering care here.

Approximately 75% of Alaska's more than 300 communities are not connected by road to a community with a hospital. Nearly a quarter of the state's population lives in towns and villages that can only be reached by boat or aircraft.[xx] Transportation costs are high – air travel between a village and the nearest community with a hospital generally costs more than $100, with airfare from some of the more remote villages to the tertiary care centers in Anchorage costing as much as $1,200. Geography and harsh weather conditions pose additional transportation barriers, and can be especially problematic in an emergency situation.

Transportation is not just an issue in terms of patients' ability to reach needed services. The cost of moving supplies, staff and equipment required to operate clinics and hospitals in rural Alaska can be formidable. For example, the price of heating fuel and gasoline in the most remote communities of the state reached as high as $10.00 per gallon this year – the cost of transporting the fuel to these communities was higher than the cost of the fuel itself.[xxi]

The cost of delivering services is also made higher by a loss of economies of scale associated with operating hospitals in sparsely populated regions and clinics in nearly every small community in the state – a necessity due to the remoteness and isolation of those locations. Some of Alaska's smallest communities with a clinic have as few as 50 residents. However, the loss of economies of scale to maintain the facilities is off-set somewhat by the innovative workforce solutions used to staff them, such as the Community Health Aide/Practitioner Program, and the use of telehealth technologies. Many of Alaska's most rural facilities are also highly subsidized by the federal government.

System Fragmentation and Duplication

Alaska's health care "system" is not a system, but an assortment of private, for-profit and non-profit, large and small medical businesses; hospitals and clinics to serve military personnel, retirees and their dependents; and hospitals and clinics owned and operated by tribal organizations. Health care organizations within the same sector (military, tribal health system, or private sector) do not have interoperable electronic information systems, care coordination systems, or business management processes. In addition to fragmentation in the delivery of services, there are a variety of payers financing health care services, including Medicare, Medicaid, private insurers, self-insured employers, the military and VA, the Indian Health Service, and individuals.

Alaska has benefited from a strong military presence due to the state's strategic location, a strong tribal health system presence, and decades of representation in senior leadership in the U.S. Senate. Because of these three factors the federal government has played a lead role in development of Alaska's health care system, especially in rural Alaska as well as for medically underserved Alaskans statewide. And all Alaskans, not just the targeted service population, benefit from the presence of these services in communities where there might not otherwise be any health care delivery system. For example, the tribal health system provides care for non-Native individuals in remote communities where there are no other health care providers.

The downside of heavy federal investment in building the health care infrastructure is there are some communities that have multiple health care systems operating side-by-side. For example, one community of 9,000 people has both a community hospital and a tribal health system hospital. Another community of just 6,000 people has a community hospital, a tribal health system clinic, and a military clinic. Alaska's largest city, with a relatively small population of 285,000, has four hospitals – one military, one tribal, one for-profit, and one non-profit (plus two psychiatric hospitals). The facilities in these communities also serve regional (and in the largest city's case statewide) populations, but there is still an overabundance of infrastructure that leads to higher costs.

The duplication and fragmentation in Alaska's health care "system" is inefficient, and potentially unsustainable in the long-run if mechanisms for improved coordination and perhaps integration where appropriate are not implemented.

Health Care Workforce Shortages

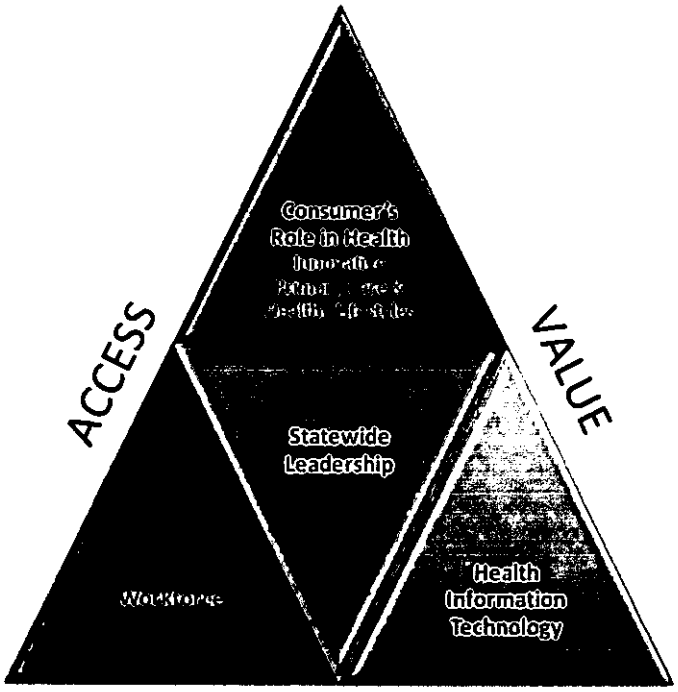
Demand for health care workers rose sharply over the past decade. Alaska's health care employment sector experienced 40% job growth between 2000 and 2007, compared to 13% for all other industries, outpacing the state's population growth during that same period by five times.[xxii] The supply of new workers produced by Alaska's training and education programs plus those imported from outside Alaska cannot keep up.

Alaskan health care employers had an estimated 3,529 number of vacant positions in 2007. Primary care occupations are experiencing vacancy rates of 15% - 20%. Pharmacist, therapist and certain nurse specialist positions are also experiencing high vacancy rates. Behavioral health occupations have a somewhat lower vacancy rate overall, but made up the highest proportion of vacancies with 1,033 vacant positions in 2007.[xxiii]

The costs health care organizations incur associated with recruitment and contracting for the services of temporary employees to cover vacancies is high. 80 Alaska health care organizations surveyed in 2005 reported spending $24 million in the preceding year for vacancies in 12 key health occupations.[xxiv] At least a portion of these costs may be passed on to consumers and insurers in the form of higher prices.

Delivery of health care is dependent on an adequate supply and distribution of qualified health care workers. 27 of Alaska's 30 boroughs and census areas contain federally designated health professional shortage areas. Staff shortages are one of the many challenges the Alaska health care delivery system is dealing with as it faces the future.

PART III: 2009 Health Policy Findings & Recommendations



PREVENTION-BASED

Alaska Health Care Commission's Health Care Transformation Strategy

The Commission identified five priority issues for analysis this year:

A. The Consumer's Role in Health and Health Care

B. Statewide Leadership

C. Healthcare Workforce

D. Health Information Technology

E. Access to Primary Care for Medicare Patients

Understanding and supporting the consumer's role in health care was a primary interest of the Commission's, and became the central focus of their strategic approach to transformation of Alaska's health care system. Over the course of learning and discussions two aspects emerged as critical to addressing the goals of increased access, improved value (cost and quality), and a focus on prevention – 1) individual lifestyle choices and the impact those choices have on health outcomes and demand for health care services; and 2) the individual's central position in their health care experience. Support for healthy lifestyles and new innovations in patient-centered primary care are the pinnacle of the Commission's health care transformation strategy.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and a strong innovative primary care system depends. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. On-going study, planning, and policy development is necessary to ensure Alaska's health care system is able to adapt to national health care reform, and to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

The fifth priority issue identified this year is not part of the comprehensive strategy, but was recognized as an immediate crisis worthy of special attention – the problem Medicare beneficiaries in urban Alaska are experiencing with access to primary care. This problem just may be an early indicator – "the canary in the mine" – warning us of the looming health care crisis in our state if we don't take decisive action.

4995

A. The Role of Consumers in Health Care

1. Healthy Lifestyles

Finding A1a: Chronic disease is the leading cause of death and disability in the U.S. and Alaska.

Finding A1b: The majority of health care spending in the U.S. is for chronic disease.

Finding A1c: Three risk factors – tobacco use, poor diet and inactivity – contribute to the four leading chronic diseases – heart disease, diabetes, lung disease and cancer.

Finding A1d: Individual behavior is now the leading determinant of the health status of the population and contributor to premature death.

Finding A1e: Childhood obesity is a growing concern; for example, 33% of kindergarten and 1st grade students in the Anchorage School District are overweight or obese.

Finding A1f: Employee health risk behaviors can be changed through financial incentives coupled with other supports (e.g., coaching).

1.7 million Americans die each year from chronic disease, which cause 70% of all deaths. Cancer, heart disease, stroke, and lung disease are four of the top five leading causes of death in Alaska. 133 million Americans – nearly half our nation's population - live with at least one chronic condition. Individual health behaviors are the leading contributors to chronic disease. The World Health Organization estimates that 80% of heart disease, stroke and type 2 diabetes, and 40% of cancer, would be prevented if Americans stopped smoking, ate a healthy diet, and participated regularly in physical activity.

Complex medical care required over the prolonged course of illness and disability due to these conditions is costly. 75% of all health care expenditures are related to chronic disease. In Alaska, $600 million is spent annually for hospitalizations due to heart disease and stroke, and $419 million for all costs due to diabetes. The state of Alaska incurs an estimated $9-10 million in medical costs due to obesity for state employees alone each year. The doubling in the prevalence of obesity in the U.S. between 1985 and 2004 accounted for nearly 30% of the increase in annual health expenditures.

It is not possible to address the escalation in health care costs without addressing the problem of chronic disease. The Commission began an inquiry into strategies known to be effective at supporting behavior change and learned about the success of Alaska's Tobacco Program, which led to a reduction in adult smoking from 27% in 1991 to 22% in 2008. They also learned about successful worksite wellness programs. There is much more work to be done however - understanding what government, schools, work sites, and communities can do to support healthy choices requires on-going attention.

Recommendation A1a: The Commission recommends that the Governor and Alaska Legislature investigate and support additional strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.

Recommendation A1b: The Commission recommends that the 2010 Alaska Health Care Commission continue evaluating the question of what works to support behavior change, and identify additional recommendations for future improvement.

4996

2. Primary Care Innovation

Finding A2a: Patient-centric health care delivery models based on a longitudinal relationship-based platform are effective at reducing unnecessary utilization of services by empowering patients to take more responsibility for their health and health care.

Primary care is the foundation of the health care delivery system – providing the main point of entry for secondary and tertiary care, and meeting the majority of patient needs for health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health conditions, and overall management of a patient's health care services. There is increasing evidence that access to high-quality primary care improves health outcomes and reduces costs. However, the rising demand for services from an aging population and increasing chronic disease, coupled with the decreasing supply of primary care physicians, is sweeping our primary care system toward a crisis.

National health care reform discussions emphasize the importance of primary care, but tend to oversimplify the issues and solutions. Some suggest all that is required to improve access to primary care is increased reimbursement levels for primary care practitioners. Others suggest that primary care practitioners must be paid for additional services that are not currently reimbursable – those services they provide to assist with the coordination and management of a patient's care and health conditions over and above the time spent during the actual patient encounter. Reimbursement is part of the solution, but increases need to come through a restructured payment system that supports and rewards practitioners for delivering patient care in a new way.

The Commission believes that strengthening the provision of primary care is the key to transformation of the health care system, but they also determined that the current primary care model is antiquated. The traditional medical model based on episodic acute care is no longer the most effective and efficient approach to meeting patients' needs. They learned about a new patient-centered care model tried in our own backyard, the Southcentral Foundation's Nuka Model of Care, that's proven successful - demonstrating reductions in hospital days by 40% and emergency room and specialty visits by 50%.

The "Medical Home Model" is a term meant to describe the ideal concept for how primary care should be provided, but the Commission felt as though this term has become too much of a buzz word in the health care reform debates and that for many it simply implies paying primary care practitioners more for working in the same way. And so the Commission is avoiding use of that term, and is focusing on key characteristics of a modernized high quality primary care model:

- Patient and family centered
- Stable trusting relationship between care team and patient/family that continues over time
- Comprehensive, coordinated, and accessible care provided by integrated multidisciplinary teams
- Focus on health and wellness (physical, behavioral, social) rather than disease care

Alaskans need to be empowered to partner with their health care providers so they can be better stewards of their own health. This will require innovation in patient care at the primary care level.

Recommendation A2a: The Commission recommends that the Governor and Alaska Legislature aggressively pursue development of patient-centric care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects. Development of pilot projects should include definition of the patient-centric model, identification of performance standards and measures, and payment models that are outcome-based.

B. Statewide Leadership

1. Response to National Health Care Reform

Finding B1a: National health care reform proposals under consideration by Congress will have a significant impact on Alaska's state and local governments, health care system, business community, citizens, and families.

Reform of the nation's health care system has been a top priority during 2009. The issue has been politically charged, with proponents stressing the importance of the increased access to health care coverage that would be afforded millions of Americans under the proposed reforms, and opponents decrying the increased national debt burden and inadequate attention to control of health care costs. At the core of the debate is a strong ideological divide over the appropriate role of government in health care.

Emotions are strong on both sides of the argument. The town hall meetings held by Alaska's U.S. Senators this summer and fall drew thousands of Alaskans – many with stories of desperation related to inadequate access to health care, and many others expressing fear and frustration over federal intrusion into what they believe is a personal matter. There's considerable misinformation and rhetoric from either side, with heavy use of popular media to attempt to sway public opinion. Over $150 million has been spent on TV ads alone this year by both sides.

Unfortunately there is no one entity in Alaska responsible for objectively analyzing the potential impacts of various reform proposals on our state government, health care system, businesses, and citizens. The federal legislation currently under consideration will dramatically change the federal structure within which state health systems operate, and state governments will play a significant role in implementation of federal health care reforms if and when they pass. New responsibilities states can expect to inherit under federal reforms will be both financial and administrative.

State government will incur additional financial responsibilities if Medicaid expansion is mandated. The Alaska Department of Health & Social Services (DHSS) estimates the fiscal impact of the proposed Medicaid expansion at nearly $450 million over a five year period. One considerable new administrative responsibility that appears likely is creation and operation of a state health insurance exchange. While many of the proposed changes are not slated to take effect until 2013 or 2014, a lot of work will be required during the interim to plan for implementation of new programs and systems.

Except for the ability to evaluate impacts of changes to Medicaid specifically, the state does not have capacity to analyze the effects of federal reform on our state. Regardless of whether federal reforms pass this year or not, the crisis in the nation's health care system will continue to drive federal proposals that will require analysis that could be provided by some form of a state health policy infrastructure.

Recommendation B1a: The Commission recommends that the Governor and Alaska Legislature invest in the state health policy infrastructure required to study, understand, and make recommendations to respond to the implications of national health care reform for Alaska.

4998

2. Permanent State Health Planning Board

Finding B2a: The systems and policies for financing and delivering health care in Alaska are fragmented and complex, and the scope of the challenges involved in improving these systems is huge. Past efforts to improve health care in Alaska have been ad hoc in nature. A planning process to achieve health care system improvement must be sustained over time in order to ensure accountability for the achievement of meaningful change.

Over the two decades preceding the creation of the Commission, four groups have been formally convened to address the problems of access to and cost of health care. All of these entities were ad-hoc in nature with a limited lifespan, meeting over periods ranging from 6 months to 2 years. They all had limited time to study the issues and develop recommendations, and in the end no real authority or accountability for following through on their findings and proposed strategies.

In 1987 Governor Cowper created The Governor's Interim Commission on the Status of Health Care and the Health Care Industry in Alaska ("The Governor's Interim Health Care Commission" for short) under Administrative Order (A.O.) #100. The Governor's Interim Health Care Commission had 11 members and four staff, and held eight 2 to 3-day meetings over the course of nine months. The report they published in 1988 made 39 recommendations to the Governor and Alaska Legislature addressing insurance coverage expansion, access to long term care, cost controls, and state health planning.

In 1991 the Alaska Legislature created the Health Resources & Access Task Force. The 17-member HRATF held 14 monthly two-day meetings, producing a report calling for the creation of a single-payer system for Alaska. While their primary recommendation was never adopted, creation of a high-risk pool for Alaskans with pre-existing conditions who cannot otherwise obtain health insurance coverage – the Alaska Comprehensive Health Insurance Association (ACHIA) – followed from their work.

Ten years following the publication of HRATF's final report in 1993, a private group – Commonwealth North – created the Alaska Health Care Roundtable to improve access, quality and cost of health care in Alaska. The Roundtable had a 17-member executive committee representing public and private sector interests. They produced a report in 2005 focused on the improvement of primary care.

In 2007 Governor Palin created the Alaska Health Care Strategies Planning Council under A.O. #232. The Planning Council consisted of 17 members who met for 6 months, during which time they identified a series of goals and strategies for improving the health of and health care for Alaskans.

The two most recent groups recognized two problems with their ad hoc nature – 1) one year isn't long enough to get a handle on the complexity of the problems in our health care system and come up with a comprehensive approach to solutions; and 2) there was no way to ensure accountability for their efforts. Both groups recommended that a permanent health planning and policy body be established in statute to provide sufficient time for gathering information, studying the issues, and developing comprehensive solutions. The Commission concurred with their recommendation.

Recommendation B2a: The Commission recommends that the Alaska Legislature establish an Alaska Health Care Commission in statute, similar in size to the Commission established under Administrative Order #246, to provide a focal point for sustained and comprehensive planning and policy recommendations for health care delivery and financing reform, and to ensure transparency and accountability for the public in the process.

C. Health Workforce Development

1. General Workforce Development Findings & Recommendations

Finding C1a: Health care in Alaska is big business and represents a significant employment sector.

Finding C1b: Access to health care requires a sufficient supply and adequate distribution of health care providers. Successful achievement of the goal of expanding access to health care in Alaska is directly tied to health care workforce capacity and capability.

Finding C1c: Health care worker shortages in Alaska are widespread and costly.

Finding C1d: A comprehensive approach to health care workforce training includes strategies at every point on the training continuum (K12, post-secondary, graduate and post-graduate, on-the-job, continuing medical education).

Finding C1e: Alaskans have been particularly innovative in meeting their health care workforce needs.

Finding C1f: Many organizations, both public and private, have a stake in health care workforce development, and there are numerous programs and groups currently involved in health care workforce planning. There is evidence of collaboration in these planning and development efforts; however, not all related activities are fully coordinated.

Health care in Alaska is a six billion dollar industry, representing 16% of the state's gross domestic product.[xxv] It is also one of the biggest players in Alaska's labor market. With eight percent of the state's wage and salary jobs it leads all other industries except government, trade, and hospitality. Alaska's top employer is a health care provider – Providence Health & Services – employing over 4,000 people in 2008. Five of the top 20 employers in the state are health care organizations.[xxvi]

Health care is not only one of the largest employment sectors in Alaska, it is consistently the fastest growing. Between 2000 and 2007 the number of wage and salary jobs in the health care industry grew 40%, from 20,700 to 29,000, compared to just 13% for all other industries. Health care employment grew faster in Alaska than the U.S. overall, with 40% job growth compared to 19% in the U.S. from 2000 to 2007. Health care employment growth has outpaced Alaska's population growth rate by five times.[xxvii] The Alaska Department of Labor & Workforce Development projects the health care industry will continue to expand in the next decade, increasing by 25% between 2006 and 2016 and adding twice as many jobs as any other industry.[xxviii]

One other aspect of the health care industry important to the overall economy of the state is that there are health care jobs in virtually every community. There are at minimum paraprofessional health care providers in even the smallest villages. 23% of Alaska's health care workers are employed in rural areas.[xxix]

A functional health care system cannot be sustained without an adequate workforce. One key measure of access to health care is the supply of health care providers as a ratio to population. But having an adequate workforce goes beyond simple measures of supply. The workforce must be competent to provide high quality care that is culturally appropriate, must be literate in the use of health information

technologies, and must be able to adapt to new patient care settings and models that provide integrated, interdisciplinary, patient-centered care. Having an adequate statewide supply of well trained providers is not enough either – workforce distribution is an important factor as well.

Meeting the demand of Alaska's health care industry for an increasing number of health care workers presents a significant challenge. The supply of new workers produced by Alaska's training and education system plus those imported from outside Alaska cannot keep up. Alaskan health care employers had an estimated 3,529 number of vacant positions in 2007. Primary care occupations (family physicians, general internists, nurse practitioners, physician's assistants, and community health aide/practitioners) are experiencing vacancy rates of 15% - 20%. 19% of psychiatrist positions were vacant in 2007. Other occupations for which shortages exist include pharmacists (23.7% vacancy rate), and therapists (physical, occupational, speech, and speech-language pathologists with vacancy rates ranging from 15.6 – 29.3%). Key nursing specialties also experience high vacancies, with a 23.4% vacancy rate for nurse case managers. Behavioral health occupations had a relatively lower vacancy rate at 13.9%, but made up the highest proportion of vacancies – with an estimated 1,033 vacant positions. In a 2007 survey of health care organizations conducted by the Alaska Center for Rural Health (and from which the above noted estimates are derived), 54% of respondents cited "inadequate pool of qualified workers" as the top reason for vacancies.[xxx]

The costs associated with these vacancies are high. 80 Alaska health care organizations surveyed in 2005 reported spending $24 million in the preceding year for vacancies in 12 key health occupations - $11 million on recruitment costs plus $13 million on itinerant temporary workers. They identified three main barriers to recruitment – locating qualified candidates, Alaska's geographic isolation and harsh climate, and the need to satisfy the lifestyle and employment requirements of spouses and other family members. [xxxi]

The approach to replenishing the health care workforce as the numbers of jobs grow and workers are lost through retirement and attrition includes a combination of "growing our own" strategies – providing training and education in and for Alaska, and importing workers from outside Alaska through a variety of recruitment strategies. There is a history of collaboration in Alaska as the health care industry has partnered with the University system and state and federal funding agencies in the development of health care education and training programs in order to improve our ability to "grow our own."

The University of Alaska (UA), the Alaska Legislature and Alaska's health care industry have demonstrated a commitment to increasing in-state health career training and education opportunities in recent years. The number of students in UA health programs increased 68% between 2001 and 2008. In the fall of 2007 UA had 3,501 students enrolled in health programs. UA now has 80 health programs statewide in various fields including allied and behavioral health, emergency services, health management, medical office management, nursing, primary care, public health, and therapies. In partnership with the health care industry and with financial support from health care organizations and the state Legislature, the UA has recently added or expanded a number of programs, including:

- Doubling the nursing program to more than 220 AAS and BS admissions each year, and providing AAS nursing programs in 12 communities;
- Doubling the number of WWAMI medical school seats from 10 to 20;
- Addition of radiologic technology in six locations;
- Development of cooperative programs with outside universities for occupational, speech and language therapies and audiology;
- Expansion of the distance Master's program in social work;

- Provision of rural allied health training via distance delivery;
- Doubling the Master's of Public Health program to 70 distance students; and,
- Opening the Physician's Assistant program (beginning July 2009).[xxxii]

Training and education strategies do not begin at the post secondary level however. They include developing the pipeline of potential future Alaskan workers – reaching them early in their K12 education, making sure they have a solid foundation in math and science, and exposing them to potential careers in the health field. One program that helps young people explore health careers is the Area Health Education Center (AHEC). AHECs are federally and state funded programs meant to create formal relationships between university health programs and community partners to support health career education development. Alaska has an AHEC based out of UAA's School of Nursing, administered by the Alaska Center for Rural Health, and serving four regions of the state through partnerships with the Yukon Kuskokwim Health Corporation, Fairbanks Memorial Hospital, the Alaska Family Practice Residency Program, and Southeast Alaska Regional Health Consortium. In addition to encouraging Alaska's youth to pursue health careers, the AHEC facilitates clinical rotation opportunities and continuing education for health professionals in underserved areas. In addition to the AHEC program, Alaska's WWAMI program and also the Alaska Native Tribal Health Consortium administer a number of health career development programs.

Training and education strategies do not end at the post-secondary level either. They also include post-graduate programs such as graduate medical education (GME – residency programs for medical school graduates) and also non-physician programs such as clinical internships for Ph.D. psychologists. Alaska currently has one GME program, the Alaska Family Medicine Residency Program, and groups are in various stages of planning residency programs for pediatrics, psychiatry and internal medicine. Alaska lacks an internship for our Ph.D. doctoral students in psychology.

One other approach to addressing health care workforce shortages that must be noted – one for which Alaska is a proven leader – is innovation in the development of new types of workers and in the utilization of existing provider types. The extreme health care delivery challenges posed by the remoteness and isolation of many of Alaska's Bush communities led to a unique workforce innovation in the middle of the past century that has become a model for other countries with similar challenges – the Community Health Aide/Practitioner. Alaska's tribal health system has used that model to address behavioral health and oral health needs in more recent years, with the development of the Behavioral Health Aide and the Dental Health Aide Therapist Programs. Another innovation is Alaska's use of mid-level practitioners – nurse practitioners and physician's assistants – who have an expanded scope of practice to allow more independent practice by these providers than in many other states. Mid-level practitioners have played an important role in meeting the primary care needs of rural communities not large enough to support a physician practice in Alaska since the 1970s, and play an important role today in urban Alaska as well.

There are a number of collaborative health care workforce planning and development efforts currently underway. Following are some key examples:

- The Alaska Health Care Workforce Coalition (AHCWC) represents a large industry-led partnership that includes not only representatives of health care provider organizations, but also the three state government agencies that play an important role in health care workforce development – Health & Social Services, Education & Early Development, and Labor & Workforce Development, as well as K12 school districts, and the University of Alaska. This

Coalition is in the process of developing a statewide strategic health care workforce plan for Alaska under the auspices of the Alaska Workforce Investment Board (AWIB). A draft of this plan is currently being circulated for public comment, and will be finalized and submitted to the AWIB for endorsement in February 2010.

- The Alaska Diversified Economic Planning Team, established under Administrative Order #249 by Governor Palin, is in the process of developing a statewide strategic comprehensive economic development plan for the state (the "Legacy Plan"). This team has 16 different workgroups currently in the process of addressing various aspects of economic development. One of the workgroups is addressing health care, as it is not only a major employer and driver of Alaska's economic engine; it is also an important support industry for other sectors of the economy. The Legacy Plan Health Care Workgroup, scheduled to produce a report in 2010, is primarily focusing on health workforce issues.

- Last year the Department of Health & Social Services (DHSS) established a position housed at UAF in the Office of the Associate Vice President for Health Programs and supported with funding from the Alaska Mental Health Trust Authority (AMHTA) charged with the responsibility for coordinating the numerous projects under AMHTA's Workforce Development Initiative with DHSS and UA behavioral health workforce projects.

- The Trust Training Cooperative, housed in the University of Alaska Anchorage (UAA) College of Health and Social Welfare's Center for Human Development, includes numerous partners focused on improving training coordination and availability for smaller and rural organizations servicing AMHTA beneficiaries. The Cooperative recently completed a behavioral health training needs assessment.

In addition to these various partnerships, coalitions and workgroups, there are a few entities that contribute routinely to research and analysis of Alaska's health care workforce.

- The Research and Analysis Section in the Alaska Department of Labor & Workforce Development;
- The Section of Health Planning and Systems Development in the Division of Health Care Services, Alaska Department of Health & Social Services; and
- The Alaska Center for Rural Health housed at UAA.

These examples demonstrate that many private and public entities are invested in health care workforce development, but there is no one entity responsible for coordination of all these activities. A single organization charged with coordination of the many health workforce development activities in the state, and designated to provide the organizational home to support implementation of the statewide strategic plan currently under development by the AHCWC, is needed. This would help minimize the possibility that efforts might be duplicated and wasted, or that gaps in important aspects of workforce development go unaddressed. The designated entity could ensure that a comprehensive approach to meeting Alaska's health care workforce needs is taken, including strategies to address:

- On-going assessment of Alaska's health care workforce size, composition and distribution
- Workforce innovations required for responding to transformation in patient care models
- Training needs along the continuum of K12 education through graduate medical education and including on-the-job training
- Improved recruitment and retention of health care workers
- Sustainability of the health care workforce planning, development and support infrastructure.

Recommendation C1a: The Commission recommends that the Governor and Alaska Legislature maintain health care workforce development as a priority on Alaska's health care reform and economic development agendas.

Recommendation C1b: The Commission recommends that the Governor and Alaska Legislature explore strategies for strengthening the pipeline of potential future Alaska health care workers.

Recommendation C1c: The Commission recommends that the Governor and Alaska Legislature explore strategies for ensuring Alaska's health care workforce continues to be innovative and adaptive, and that it is responsive to emerging patient care models.

Recommendation C1d: The Commission recommends that the Governor designate a single entity with the responsibility for coordinating all health care workforce development planning activities in and for Alaska. Coordination and collaboration of funders, policymakers and stakeholders in workforce planning and development efforts should be encouraged to the greatest extent possible.

Recommendation C1e: The Commission recommends that the 2010 Alaska Health Care Commission continue studying health care workforce needs in coordination with other organizations and coalitions addressing this issue, and identify recommendations for additional improvements.

2. Physician Shortage

Finding C2a: The United States is facing a shortage of physicians as this provider population ages and enters retirement and the production is not expected to keep up with demand. As the physician shortage increases in the U.S. the competition for recruiting physicians to Alaska will become increasingly difficult.

Finding C2b: Alaska has a shortage of primary care physicians[4].

Finding C2c: New physicians face disincentives to entering primary care specialties.

Finding C2d: Providers stay to practice where they train.

Finding C2e: Mid-level medical practitioners (Nurse Practitioners and Physician's Assistants) and medical support staff (nurses, medical assistants, care coordinators, etc.) are essential occupations for addressing primary care physician shortages.

There are many professions that make up the health care workforce and all are vital to a functional health care delivery system. The Commission chose to focus on the physician workforce in their first year, in part because the one specific health care delivery challenge they chose to study this year is the problem of Medicare access to primary care doctors. For their analysis of the physician workforce the Commission benefited from a recent study by the Alaska Physician Supply Task Force completed in 2006.[xxxiii] The Task Force was commissioned by the President of the University of Alaska and the

[4] The Commission includes both osteopathic as well as allopathic medical doctors in their definition of physician. The Commission's definition of primary care physician is slightly different from most standard definitions – family practitioners, pediatricians, and general internists are included, but also psychiatrists, and Ob-Gyns are excluded.

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Commissioner of the Department of Health & Social Services to address questions regarding current and future need for physicians in Alaska, and to consider current and potential strategies for meeting estimated physician need.

The United States is experiencing a shortage of physicians which is expected to worsen as the baby boomer cohort of doctors enter retirement, the nation's population ages and requires more intensive medical services, and programs to educate new physicians have insufficient capacity to keep up with demand. A deficit of 96,000 to 200,000 physicians is projected nationwide by 2020.[xxxiv] In 2006 the Association of American Medical Colleges recommended the number of medical school slots in the country be increased by 30% by the year 2020. As the competition between states increases for a decreasing supply of physicians, it has become increasingly difficult to recruit out-of-state doctors to move to Alaska.[xxxv]

The Physician Supply Task Force determined that Alaska has a shortage of physicians that is expected to worsen over the next 20 years. They estimated that Alaska should have 375 more physicians today, based on an assumption that Alaska should have 110% of the current national average physician-to-population ratio. The ratio of physicians to population in Alaska is 2.05 doctors per 1000 population compared to 2.38 doctors per 1000 population nationwide. Their recommendation was to increase the number of additional physicians practicing in Alaska each year from the current net average annual increase of 38 (78 new minus 40 lost to retirement and attrition) by more than 50%, to 59 net new physicians per year.

The Commission was impressed by the thorough and professional analysis conducted by the Task Force, but challenged a couple of the assumptions they used to derive estimates of current and future shortages in Alaska. One assumption the Task Force made was that the national average physician to population ratio is representative of the level of need. Another was that Alaska should have 10% more than the national average because of the structural inefficiencies in our state's health care system, and because of the additional administrative and supervisory responsibilities associated with support of paraprofessionals (Community Health Aides/Practitioners) and mid-level practitioners. The Commission felt that this assumption did not account for the fact that these other provider types relieve the actual direct patient care burden for those physicians, nor did it account for the expanded scope of practice of mid-level practitioners in Alaska that allows more independent practice on their part.

Because of questions regarding some of the Task Force's assumptions, the Commission was not prepared to agree at this time that Alaska faces a crisis in total physician supply, but conceded there is evidence pointing to a shortage of primary care physicians. The Alaska Center for Rural Health's 2007 Alaska Health Workforce Vacancy Study estimated a 20% statewide vacancy rate for general internists, a 19% vacancy rate for psychiatrists, and a 15.8% vacancy rate for family physicians. The problem Alaska's seniors are experiencing finding a primary care physician who will accept new Medicare patients is another indicator of this problem. These signs coupled with the Commission's strategic focus on developing and strengthening new primary care patient care models led to a determination that Alaska is experiencing a shortage of primary care physicians, and a recommendation that the state's limited public resources spent on physician supply development should be focused on increasing the supply of primary care physicians specifically.

A consideration of strategies to increase the supply of primary care physicians requires an understanding of the disincentives new medical school graduates face to entering primary care specialties. According to the Association of American Medical Colleges, the average educational debt of

indebted graduates of the class of 2008 was $154,607, an increase of 11% over the previous year. 87% of graduating medical students carry outstanding loans, and 79% of graduating medical students have debt of at least $100,000.[xxxvi] The high level of debt most new physicians have to bear poses a significant disincentive to choosing to enter a primary care specialty, as these are the lowest paid fields. Other disincentives beyond relatively low pay exacerbated by high debt burden include the practice environments that tend to require more work hours, more on-call time, and a higher administrative burden for generalists, and also the higher prestige that is often associated with practicing as a specialist as opposed to a generalist. A combination of strategies for improving education, recruitment, and supporting innovative practice models is required to address the need for an increased supply of primary care physicians.[xxxvii]

Alaska is one of just 6 states that do not have their own medical school. Instead, Alaska participates in a collaborative medical education program, WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho), that provides a medical school opportunity to rural states in the northwest. Instead of paying to support an in-state medical school, the Alaska Legislature appropriates funds to pay the University of Washington for the government subsidy portion of the WWAMI medical school, which is approximately $50,000 per student per year. In addition to the government subsidy, Alaska WWAMI students pay tuition of approximately $20,000 per year (equivalent to Washington in-state tuition for UW medical students).

The number of medical student seats Alaska supports in WWAMI is set in state law (AS 14.42.033). Alaska supported 10 seats since the beginning of the program in 1971, but the legislature doubled support to 20 seats beginning with the 2007 school year. Even after this 2-fold increase, Alaska has less than half the national average medical school capacity. The U.S. average number of medical school seats to population is 26.6 per 100,000, compared to 11.9 for Alaska.[xxxviii] The 30-member nation OECD average is 39.6/100,000.[xxxix] The Alaska Physician Supply Task Force recommended that Alaska expand participation in WWAMI to 30 and then eventually 50 seats.

The rate of return of Alaska WWAMI students to medical practice in Alaska is 47%, compared to the national average for all U.S. public medical schools which is 39%. Alaska medical students who participated in WICHE (Alaska's participation in WICHE medical school programs ended in 1995) had an 18% return rate. The actual return on investment for Alaska when the rate of return of all WWAMI students (including those entering Wyoming, Washington, Montana, or Idaho's program) to medical practice in Alaska is 88% of the number of seats Alaska has subsidized.[xl] As far as quality, the U.S. News & World Report ranked WWAMI as the #1 medical school for primary care in 2009 for the 15th consecutive year, and also #1 for both rural medicine and for family medicine for the 17th consecutive year.[xli]

The physician training pipeline ends with graduate medical education. Following completion of medical school, graduates have to complete a residency program in order to be licensed and practice in the United States. Residency programs vary in length. A family medicine residency is three years long. According to national studies physicians tend to stay and enter practice in the community where they complete their final residency training. Alaska was the last state in the nation to establish an in-state residency program, but since 1997 has had the Alaska Family Medicine Residency Program (AFMRP). The program expanded capacity from eight to 12 residency slots a few years ago. In the past 12 years AFMRP has graduated 75 family practice physicians. Of those 75 graduates, 80% have stayed to practice in Alaska, and over half of those who have stayed are practicing in rural Alaska. The AFMRP was designed to train physicians for practice in rural Alaska, so it is achieving its original goal.[xlii]

A number of other residency programs are being considered for Alaska and are at various stages in the planning process. A pediatric residency program is being planned by a collaborative group including Providence, the Alaska Native Medical Center, and a number of private providers. This program would be a branch residency program of the UW Children's Hospital Pediatric Residency Program, with residents practicing in Alaska for four months out of each of the three years in the program. A psychiatric residency program planning process is underway with financial support from the Alaska Mental Health Trust Authority. This program would also be a branch program of UW, which has already developed a similar branch model in Spokane and Boise (these two programs have been successful in terms of retaining residency graduates to practice in their communities). Psychiatric residencies are four years in length, and the Alaska branch program would have the residents spending their first two years in Seattle, and their last two years in Alaska. One other residency program under consideration is for general internal medicine, but an organized planning effort has not quite coalesced at this point due to lack of financial support and leadership.

One barrier to development of residency programs in Alaska is funding. Most residency programs receive a significant portion of their operational funding from Medicare, which since its inception in 1965 considered educational activities in teaching hospitals a reimbursable expense. Because of the substantial growth in costs associated with support of graduate medical education (GME) – which in 2007 cost Medicare $8.8 billion – Congress imposed a cap in the Balanced Budget Act of 1997 on the number of residency positions Medicare could support. The cap was set at the number of residents who were training in a given teaching hospital as of December 31, 1996, and did not include provisions for making adjustments or redistribution based on need. This cap effectively locks Alaska out of the Medicare GME funding pool.[xliii]

Medical education expansion is an important strategy for increasing primary care physician supply, but the time it takes to prepare a college graduate to practice medicine is a minimum of seven years. In addition to increasing capacity for education of new physicians, other strategies to improve recruitment and retention of physicians from outside Alaska must be considered. Support-for-Service programs offer an important recruitment and retention tool for states. These programs provide current or future health practitioners with educational scholarships, educational loans, repayment of educational loans, or direct monetary incentives in return for a contractual obligation with the practitioner to serve a period of service in a needy area.

Loan repayment and financial incentive programs are the most popular form of support-for-service programs, as studies document service obligations established at the beginning of a practitioner's educational process (through a scholarship or loan) are less effective in terms of achieving the desired recruitment outcome as are loan repayment and financial incentive programs. Another benefit of loan repayment and financial incentive programs is that the return is immediate. One study documented a service completion rate of 94% and 93% respectively for loan repayment and financial incentive programs, compared to 63% and 41% respectively for scholarship and loan with service option programs.[xliv]

One last strategy the Commission considered for addressing the shortage of primary care physicians was the use of mid-level practitioners – physician's assistants and nurse practitioners – to help meet Alaska's primary care need. The recent support by the Alaska Legislature for establishing a PA training program at UAA is a significant step, but opportunities for expanding the use of "physician extender" occupations should be further explored.

Recommendation C2a: The Commission recommends that the Governor and Alaska Legislature target the state's limited financial resources invested in physician workforce development to strengthening the supply of primary care physicians.

Recommendation C2b: The Commission recommends that the Governor and Alaska Legislature support development and maintenance of an educational loan repayment and direct financial incentive program in support of recruitment and retention of primary care physicians and mid-level practitioners.[5]

Recommendation C2c: The Commission recommends that the Governor and Alaska Legislature support the continued expansion of the WWAMI program. Future expansion should be supported as resources allow.

Recommendation C2d: The Commission recommends that the Governor and Alaska Legislature support graduate medical education for primary care and behavioral medicine. State financial support should continue for on-going operation of the Alaska Family Medicine Residency Program, and should be appropriated for the planning and development of in-state residency programs for pediatrics, psychiatry, and primary care internal medicine.

Recommendation C2e: The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to address equity in the allocation and distribution of Medicare Graduate Medical Education (GME) residency slots. The exclusion of new programs is not equitable, and there should be heavier weighting for primary care GME and for shortage areas.

Recommendation C2f: The Commission recommends that the Governor and Alaska Legislature explore strategies for improving the primary care delivery model and utilizing "physician extender" occupations as an additional approach to addressing the primary care physician shortage.

[5] The Commission's recommendation that an educational loan repayment and direct incentive program be established for Alaska to assist with addressing physician shortage specifically is not meant to exclude other provider types for which shortages are documented from such a program.

D. Health Information Technology

1. General HIT Findings & Recommendations

Finding D1a: Development and utilization of electronic information management tools is essential to health care system improvement for the purpose of supporting:

- Increased health care efficiency and effectiveness; and
- Improved clinical quality and patient safety.

Health information technology is a broad concept that encompasses the use of electronic data and communication systems for compiling, maintaining and transmitting health information. The term "health information technology" (HIT) is more commonly used today to refer to electronic health records (EHR), health information exchange (HIE), and related data collection, storage, and management applications. These data and information management applications are dependent on many of the same technologies as telemedicine/telehealth, which is the use of telecommunication technology to provide clinical and other health services when participants are at different locations. For the purposes of this report the Commission includes both EHR/HIE and telemedicine/telehealth under an umbrella definition of HIT.

Broad adoption of interoperable EHR/HIE systems is widely regarded to be an essential element of health reform, necessary to support increased efficiency and effectiveness of health care and also to improve quality and patient safety.[xlv] Unfortunately the health care industry is far behind other industries, such as banking and commerce, in the adoption of electronic information management tools,[xlvi] and the United States lags as much as much as a dozen years behind other industrialized nations in the move from paper to electronic health records.[xlvii]

Telemedicine/telehealth has been used to improve access to health care in Alaska for decades[xlviii,xlix], and continued development, deployment and modernization of technologies supporting distance delivery of care is essential to meeting the Commission's goals of improved access at a reasonable cost. Alaska is benefiting from early work in telemedicine/telehealth, as collaborative efforts to deploy and support use of telecommunication strategies for expanding access to health care in the state became the catalyst for projects and eventually whole new organizations now devoted to supporting adoption of EHRs and development of a statewide HIE.

The Commission identified HIT – both EHR/HIE and telemedicine/telehealth - as an essential cornerstone of health care delivery system transformation for Alaska because it is required for successful implementation of virtually all potential specific strategies for health care improvement – from cost and quality transparency, to fraud reduction, to supporting evidence-based clinical practice. But it is important to note that HIT is not a magic bullet that will solve all health care system problems – it is a tool – it is not a goal in itself. The Commission also found that, while there is evidence that HIT adoption leads to improved efficiency and quality of health care, there is insufficient research into the question regarding the financial effects.[l,li]

Recommendation D1a: The Commission recommends that the Governor and Alaska Legislature take an aggressive approach to supporting adoption, utilization, and potential funding of health information technology, including health information exchange, electronic health records and telemedicine/telehealth that promise to increase efficiency and protect privacy.

2. Health Information Exchange and Electronic Health Records

a) Development and Use of HIE/EHR

Finding D2a: Many providers in Alaska are at the early end of adopting electronic health records. Many still use paper records. Barriers to adoption of electronic health information technologies by Alaska's health care providers include:

- Start-up costs for new systems, including purchase of new hardware and software as well as costs associated with implementing new office procedures, training staff, and transitioning existing records from paper to electronic;
- The multitude of products on the market making evaluation and selection of one system time-consuming and costly for individual providers and small practices;
- Systems that are not user-friendly from the provider's perspective, i.e. are difficult, inflexible and time-consuming to use;
- Costs associated with on-going operation and maintenance; and,
- Antiquated and nonstandard eligibility and claims processing systems.

Finding D2b: Federal policies, such as the national incentive program funded under ARRA and pending Medicare payment penalties, are forcing rapid adoption of electronic health records by providers. Some Alaskan providers feel forced to move forward quickly while being concerned that standards are not yet fully in place and systems may not be ready.

Health care providers in Alaska have begun the transition of their medical record systems from paper to electronic format. A statewide survey conducted in 2009 to determine the current usage of EHRs and interest in their adoption among Alaska physician practices found that, of the 378 physicians and 62 clinic managers responding, 50% reported using an EHR and a third reported using ePrescribing.[6;lii] Survey respondents who did not use an EHR reported that the initial cost and practice disruption are the major barriers to adoption. Uncertainty about which EHR system to buy was also a significant barrier.

Before continuing it may be helpful to define a few key firms. The federal government, in their work to standardize HIT, has developed a compendium of terms. [liii] The new standardized definitions include:

- Electronic Health Records (EHRs) - "electronic records of health-related information on an individual that conform to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care organization."
- Electronic Medical Records (EMRs) are distinguished from EHRs as being internal to one health care organization – "electronic records of health related information on an individual that conform to nationally recognized interoperability standards and that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization."
- Personal Health Records (PHRs) are distinguished from EHRs and EMRs as being managed and controlled by the individual patient – "electronic records of health-related information on an individual that conform to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.
- Health Information Exchange (HIE) is "the electronic movement of health-related information among organizations according to nationally recognized standards."

[6] The surveyors noted that the percentage of respondents reporting EHR usage could not be ascribed to the total population of Alaska physicians because of the self-selecting nature of the survey methodology.

- Regional Health Information Organization (RHIO) - "a health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community."

The federal government is actively driving the health care industry toward broad adoption of HIT. In April 2004 President Bush established the Office of the National Coordinator for Health Information Technology (ONC).[liv] The ONC is charged with coordinating and promoting the deployment of interoperable electronic health information systems throughout the nation as well as other related health technology initiatives. This agency has been leading national standards development initiatives and administering related grant programs for the past five years.

In 2009 Congress included more than $20 billion in the American Recovery and Reinvestment Act (ARRA) for the development and adoption of health information technology under the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH sets a goal of 2014 to increase dramatically the number of health care providers who have and effectively use EHRs and HIEs. The goal is to be achieved through an array of financial incentives, education, training and state-led actions.

Under HITECH Medicare will begin providing incentive payments of up to $44,000 for individual providers and $2 million for hospitals starting in 2011 for "meaningful use of electronic health records." Beginning in 2015 providers not using an EHR will be penalized through reductions to their reimbursement rate. CMS and ONC issued regulations on December 30, 2009 setting standards for the Medicaid and Medicare incentive programs, providing a definition of "meaningful use," and setting standards for certification of EHR technology. Under HITECH state governments also play a lead role in planning and implementation of efforts to establish HIE(s) for their state.[lv]

The Alaska Legislature passed SB 133 during the 2009 session, creating a statewide health information exchange system for Alaska and directing the Department of Health & Social Services to enter into a contract and to designate a qualified entity in the state to assist in the planning and implementation of the network. The Division of Health Care Services (DHCS) is leading this effort, and expects to award the HIE contract and designate the State HIE Entity this month (Jan 2010). DHCS is also responsible for development of a new Medicaid Management Information System (MMIS), and is working to ensure that the Statewide HIE Plan is closely coordinated with the State Medicaid HIT plan.[lvi]

Two non-governmental organizations active in the advancement of EHR/HIE in Alaska today are spin-offs from the Alaska Telehealth Advisory Council (ATAC), which was created in 1999 with federal funds earmarked to foster telemedicine in Alaska. ATAC's membership included DHSS, hospitals, tribal health organizations, professional provider groups, the insurance industry, the telecommunications industry, and the University of Alaska. The ATAC sunset in 2007, but while the group was active they developed many initiatives that are continuing to support deployment and use of telehealth applications and services. In 2005 the ATAC fostered the creation of the Alaska EHR Alliance (AEHRA), formed to support implementation of EHRs in physician practices, and ChartLink, formed to support development of a statewide HIE. Chartlink was incorporated as a 501(c)(3) in 2008 as the Alaska eHealth Network (AeHN). AEHRA conducted the EHR physician survey earlier in 2009, and is now in the process of selecting two recommended EHR vendors for Alaska's providers based on the results of that survey, and will negotiate reduced prices for Alaska's providers with those vendors.

EHR/HIE-related health information management systems currently in use by state government in Alaska include:

- MMIS (Medicaid Management Information System): an electronic information management system the federal government requires all states maintain to process Medicaid claims and store and retrieve data needed to manage and audit the Medicaid program. Alaska's MMIS was implemented more than 20 years ago in 1987, and now new technology and federal requirements dictate the construction of a new system. The process to design, build and operate Alaska's new MMIS began in 2006 with release by DHCS of a Request for Proposal (RFP), and the resulting contract was awarded in 2007 to Affiliated Computer Services, Inc. (ACS). The new system currently under development is known as the Alaska Medicaid Health Enterprise. It expected to be operational by the fall of 2011.

- RPMS (Resource and Patient Management System): an information management system administered by the U.S. Indian Health Service that includes clinical, business practice, and administrative information management applications and is in use in most health care facilities within the IHS delivery system. In addition to a number of organizations within the Alaska Tribal Health System, the Alaska Division of Public Health's Public Health Nursing Section uses RPMS as the EHR/HIE for the state's public health centers.

- AKAIMS (the Alaska Automated Information Management System): a state government administered web-based management information system and clinical documentation tool for the state's behavioral health provider grantees. AKAIMS provides an EHR function in addition to supporting state and federal data reporting requirements. Behavioral health providers with their own clinical information systems are able to interface electronically to a data repository to allow compliance with state and federal reporting requirements.

- Several public health monitoring and population health protection systems: Disease tracking, biosurveillance and epidemiological investigations, and immunization monitoring are some of the governmental public health functions supported by information management systems. Systems currently in use by the Division of Public Health in DHSS include AK-STARS (infectious disease reporting system and database), VacTrAK (vaccine registry), the Alaska Cancer Registry, the Alaska Birth Defects Registry, and the Alaska Trauma Registry.

Financing currently supporting EHR/HIE development in Alaska includes:

- $10.4 million awarded by the Federal Communication Commission (FCC) Rural Health Care Pilot Program to the Alaska Native Tribal Health Consortium (on behalf of the private/public partnership now represented by AeHN) at the beginning of 2008 to unify electronic health care networks throughout the state and enable connectivity between rural and urban providers within Alaska and to the Lower 48. The FCC funds are supporting the design and construction of a statewide broadband network to facilitate exchange of health information, and to support telemedicine services, video conferencing, and voice-over-internet applications. The Alaska Legislature provided $500,000 in FY 09 through a capital appropriation to provide required matching funds in support of this project, and the Alaska Federal Health Care Partnership provided an additional $500,000 in matching funds.

- $300,000 from ONC to assess Alaska privacy and security laws, and subsequently an additional $300,000 to develop policies and procedures for the secure and private exchange of health information. Alaska is one of the eight original member states in the Health Information Security and Privacy Collaboration (HISPC), which has been working together to develop inter-organizational privacy agreements. See the Privacy and Security section below for more information on this project.

- $2.5 million in capital funding was appropriated by the Alaska Legislature for the Alaska Primary Care Association in FY 2009 to support development of the Alaska Community Health Integrated Network, a Wide Area Network for Community Health Centers in Alaska to support development and sharing of electronic health records, practice management software, videoconferencing and telehealth applications.

Recommendation D2a: The Commission recommends that the Governor direct the Department of Health & Social Services to explore options for assisting providers (particularly smaller primary care practices and individual primary care providers) with adoption of electronic health record systems.

Recommendation D2b: The Commission recommends that the Governor ensure Alaska's statewide health information exchange supports providers who have not yet adopted their own electronic health record system by facilitating identification and purchase of systems that are interoperable with the state exchange.

Recommendation D2c: The Commission recommends that the Governor ensure that HIT is utilized to protect the public's health. Alaska's health information exchange should connect with electronic public health reporting systems to enable real-time disease reporting and rapid identification of public health threats.

Recommendation D2d: The Commission recommends that the Governor ensure that data available through the statewide health information exchange is utilized to identify opportunities for administrative efficiencies, coordination and optimization of care, and health care quality and safety improvement.

Recommendation D2e: The Commission recommends that the 2010 Alaska Health Care Commission track the development of the Alaska Statewide Health Information Exchange, Alaska's new Medicaid Management Information System (MMIS), and the use of ARRA funds for electronic health record deployment; and the Commission should continue to identify current issues, policy choices and recommendations based on these developments.

b) Privacy and Security

Finding D2c: Alaskans are concerned about the privacy of their personal health information. Progress has been made by the federal government to develop national health information security and privacy protection standards, and Alaskans have participated in these efforts, but more work remains to be done.

For EHR and HIE efforts to be successful consumers and health care providers must trust their information will be kept confidential and secure. An appropriate balance must be struck between protection of individual privacy violations and breaches in system security, and the need to permit appropriate access to information. Policies that are too strict will decrease the value of electronic availability and exchange of information. Policies that are too lax will erode public trust and lead providers to implement restrictions to protect their patients.

Alaska is an original member state of the national Health Information Security and Privacy Collaboration (HISPC), a multi-state collaborative funded by the U.S. Department of Health & Human Services in 2006 to address the privacy and security challenges presented by electronic health information exchange. Governor Murkwoski initially designated the ATAC to be the state's HISPC representative, but a new designee has not been officially named by a Governor since the ATAC sunset in 2007. Alaska ChartLink now incorporated as the Alaska eHealth Network has been filling the role as Alaska's representative to HISPC, providing a coordinated approach to addressing privacy and security issues for Alaska.

In Phase I of the HISPC Privacy and Security Solutions project an assessment of the current privacy and security landscape in Alaska was completed. The assessment included an intensive investigation of current community practices and the legal environment. AeHN facilitated discussions with 250 Alaskan providers and consumers from across the state to identify security and privacy issues related to data sharing, and provided that information to the federal team working on national policy. Since that time AeHN participated representing Alaska on a multi-state collaborative that developed a set of standardized data sharing agreements and policies for the exchange of protected health information between private health entities, and between public health agencies. Other standardized policies and procedures developed under Phase III of HISPC include, a Privacy and Confidentiality Policy, a Policy and Procedure for Addressing Breaches of Confidentiality, an Identification and Authorization Policy, a Provider Participation Agreement, and a Patient Participation Agreement.

Federal efforts to protect privacy and security of electronic health information continues with the implementation of the HITECH Act, which includes a focus on privacy and security and expands current federal privacy and security protections already in place under HIPAA (the Health Insurance Portability and Accountability Act). At the state level, SB 133 requires the HIE State Designated Entity to adopt an opt-out provision which will allow individual Alaskans to request removal from the data sharing system. The next step in HIE development for Alaska may include an update of medical records laws to support privacy and security in the emerging electronic environment.

Recommendation D2f: The Commission recommends that the Governor designate a statewide entity with the responsibility for ensuring broad implementation of health information security and privacy protections. The entity should participate in on-going efforts at the national level to identify security and privacy standards, should oversee application of those standards to Alaska's statewide health information exchange, and should identify a process for Alaskan patients to opt out of participation in the health information exchange.

3. Telehealth/Telemedicine

Finding D3a: Alaskans have been particularly innovative in the use of telecommunications technologies as one way to bridge our vast geography and address health care access challenges.

Finding D3b: Barriers to adoption and use of telemedicine include:[7]

- Insufficient telecommunications connectivity in some rural Alaskan communities;
- Inadequate access to training for providers and their staff;
- Medical licensure restrictions across state borders;
- Misalignment of payment systems between costs and benefits.

Telemedicine – literally "medicine across distance" - is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. The term "telehealth" encompasses a broader definition of remote health care delivery that is not limited to clinical services.[lvii] Alaska has been a leader in the development and utilization of telehealth applications as a mechanism for improving access to care for nearly a century - from a 674 mile dogsled relay to transport desperately needed diphtheria anti-toxin to the residents of Nome in the winter of 1925[8] - to CB radio communication between doctors in regional hospitals and Community Health Aides in village clinics during the 1960s – to remote monitoring of ICU patients in rural community hospitals by critical care specialists in urban medical centers today.

The Alaska Federal Health Care Partnership (AFHCP) was founded in 1995 to support collaborative efforts among federal health care providers, including shared training opportunities, service contracts, and technology. The Partnership includes the Department of Defense (Air Force 3rd Medical Group, Bassett Army Hospital), Veteran's Administration (Alaska Regional Office), US Coast Guard, Indian Health Service, and tribal health organizations. The Partnership has launched a number of telehealth initiatives over the years for beneficiaries of their federal programs, including a home telehealth monitoring and care coordination program, a teleradiology project, and a telebehavioral health initiative.

The AFHCP created the Alaska Federal Health Care Access Network (AFHCAN) in 1998. AFHCAN is federally funded and operated by the Alaska Native Tribal Health Consortium. It provides telehealth solutions to 248 sites throughout Alaska, including tribal health organizations, Army, Air Force, and Coast Guard sites, and state public health nursing centers.[lviii] They also now serve customers in other states and other countries, including Greenland and Panama. AFHCAN started out with the deployment of store-and-forward applications due to limited availability of broadband connectivity in the state, but has expanded to add video conferencing applications with the increasing access to high-speed lines with greater data capacity.

Other telemedicine programs actively involved in improving access to health care in the state today include the Alaska Rural Telehealth Network, Providence's REACH system (for remote evaluation of stroke) and eICU, the Alaska Psychiatric Institute's Telebehavioral Health Care Services Program, and the Southeast Alaska Regional Health Consortium Telebehavioral Health Program.

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[7] The order of the bullets in this finding is not meant to imply priority order of significance.

[8] Coordination of the relay effort was achieved through communications by Morse code transmitted over telegraph lines.

An essential telecommunication service necessary for meeting today's telehealth and also HIE/EHR needs is broadband - advanced communications systems capable of providing high-speed transmission of services such as data, voice, and video over the Internet and other networks.[lix] There are 82 communities in Alaska without broadband service, and an additional 31 communities with unknown Internet connectivity levels.[lx] There are currently a number of federally funded programs supporting expansion and subsidies for broadband service in the state, including:

- The Rural Health Care Program of the FCC's Universal Services Fund (USF), administered by the Universal Service Administration Company, which provides health facilities in rural communities with affordable telecommunication services by subsidizing telecom and Internet access charges related to the use of telemedicine and telehealth. The Health Planning and Systems Development Section in the Division of Health Care Services provides technical assistance to rural health clinics across the state to help with the annual USF application process. 240 health clinics in rural Alaska submitted applications to this program in FY 2009.[lxi]

- The Regulatory Commission of Alaska and the Alaska Department of Commerce, Community and Economic Development have provided federally funded grants for a number of years (since 2003) to telecommunications carriers and cable operators to provide broadband Internet service in rural Alaskan communities. The Rural Alaska Broadband Internet Access Grant Program provides up to 75% of the funding required to expand broadband service into rural communities, and subsidizes rates for these services so that they are comparable to those paid by residents of Anchorage, Fairbanks and Juneau for a period of at least two years after expansion project completion.[lxii]

- The American Recovery and Reinvestment Act of 2009 included $7.5 billion to increase broadband access in underserved areas of the country, and also included associated funding to create a nationwide map of broadband availability. The Denali Commission received a federal stimulus grant under this initiative in November 2009 to map broadband access in Alaska down to the census block level. The project will identify availability of wireless, cable, fiber optic and telephone services along with connection speeds, and is expected to be completed by 2012. A number of Alaskan telecommunication companies have already applied for stimulus funds to continue the deployment of broadband to rural Alaska.

Recommendation D3a: The Commission recommends that the Governor and Alaska legislature work with federal and local partners to ensure all Alaskan communities have access to broadband telecommunications infrastructure that provides the connectivity and bandwidth necessary to optimize use of health information technologies.

Recommendation D3b: The Commission recommends that the Governor direct the Alaska Department of Health & Social Services to investigate innovative reimbursement mechanisms for telemedicine-delivered services; test new payment methodologies through Medicaid, and work with other payers to encourage adoption of successful methodologies.

E. Access to Primary Care for Medicare Patients

Finding E(a): Alaska's Medicare-eligible population is growing.

Finding E(b): Medicare patients in some areas of Alaska experience trouble accessing primary care. The communities experiencing the most trouble with access are those with larger populations, notably Anchorage.

Finding E(c): One contributor to the Medicare access problem is an insufficient supply of primary care physicians willing to accept and retain Medicare patients in larger urban centers.

Finding E(d): Health care providers report Medicare's burdensome administrative requirements, onerous audits, and what they find to be insufficient reimbursement rates as the primary reasons for limiting or denying provision of Medicare services.

Finding E(e): Care for Medicare patients is often more complex and time-intensive than for the general patient population.

Finding E(f): Mid-level practitioners are increasingly being used to solve the Medicare access problem.

Finding E(g): Health care providers report Medicare's physician and mid-level practitioner reimbursement schemes are not rational and not reliable.

Finding E(h): Health care providers commonly report that Medicare's audit process designed to weed out fraud and abuse in the system focuses more on identification of billing errors than intentional fraud, incentivizes audit contractors to pursue and penalize providers for unintentional billing errors, and unnecessarily places an onerous administrative and legal burden on providers. The audit process, which appears to physicians to be based on an assumption of guilt, serves as a disincentive for Alaska providers to provide care for Medicare patients.

Background

Medicare is the federal government's health insurance program for the elderly (age 65 and older) and disabled. Created by Congress in 1965, it is partially funded with payroll taxes, and is administered by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health & Human Services. Medicare benefits include:

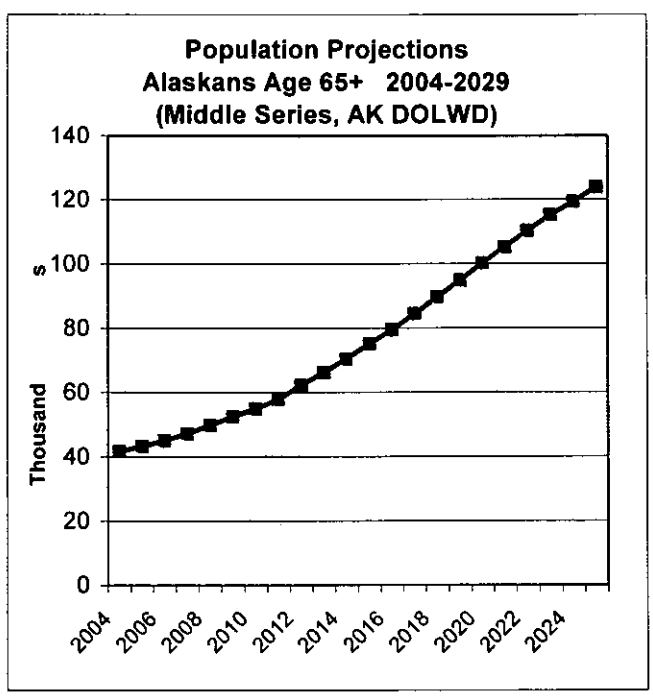
- **Part A (Hospital Insurance)**, covering inpatient hospital stays, some care in skilled nursing facilities, and hospice.
- **Part B (Medical Insurance)**, covering medically necessary services not covered under part A, such as outpatient hospital care, physician services, some preventive services, diagnostic tests, and durable medical equipment.
- **Part C (Medicare Advantage)**, an optional fee-for-service plan that provides Part A and Part B benefits through a private health insurance plan.
- **Part D (Medicare Prescription Drug Plan),** provides prescription drug coverage.

Medicare premiums are highly subsidized by the federal government, and spending for Medicare has grown steadily since its inception with costs doubling every four years between 1966 and 1980. Medicare costs, now at $495 billion, accounted for 19% of all health care expenditures in the U.S. in 2009. One strategy the federal government implements to control soaring costs is limiting the physician payment rate.

The sustainable growth rate (SGR) formula for Medicare was created by Congress in 1997 to limit Medicare growth. The SGR, which is tied to the GDP, triggers reductions in the Medicare physician payment rate when costs rise too steeply – which has been the case each year since the SGR was created. Congress has not had the political will to enforce the reductions however, and has intervened each year to block them. While the statutory payment reductions have not been enforced, the SGR has had the effect of limiting potential payment rate increases. This strategy has not had the intended effect however, as reduced or limited payment rates are offset by increased utilization and total Medicare costs have continued to rise.

Another variable in Medicare physician rate setting are geographic differentials. Alaska has benefited from successful efforts by our congressional delegation to enact legislative provisions to boost the reimbursement rate for Alaskan physicians by increasing Alaska's geographic differential. Effective January 2009 Alaska's Medicare physician reimbursement rate was set permanently in federal law at 29% above the national average.

In 2008 there were 59,435 Alaskan Medicare beneficiaries, approximately 82% of whom were aged 65 or older with the remainder qualifying due to disability. The number of Alaskans aged 65 and older has more than doubled over the past two decades, from 22,095 in 1990 to 49,455 in 2008. That number is projected to nearly triple again by the year 2030 to 134,391.



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The Problem

Many Alaskan Medicare beneficiaries, particularly those in more urban communities, report they have trouble finding a physician to take them as a patient. A study conducted by the Institute for Social and Economic Research (ISER) at UAA in 2008 confirmed there are few primary care physicians in Anchorage who will accept new Medicare patients.[lxiii] The researchers found that only 17% of Anchorage primary care physicians accept new Medicare patients compared to 61% nationally.[lxiv]

Driving this problem is the growing demand for Medicare services due to 1) the aging of Alaska's population, and 2) the need for increasingly complex care to treat and manage chronic conditions. As noted above, Alaska is experiencing significant growth in the Medicare eligible population that is expected to continue over the next two decades. The growing number of Medicare beneficiaries is compounded by the amount of extra time and effort it takes to treat a typical Medicare patient. One study found that for every 100 Medicare patients a primary care physician treats, that physician potentially has to interact with 99 other physicians in 53 different practices as they work to coordinate treatment of multiple and complicated health problems.[lxv]

The problem of growing demand is compounded by an inadequate supply of primary care physicians. Physicians report Medicare's low reimbursement rates, about one-third less than what private insurance pays in Alaska, as a primary reason behind decisions to not accept new Medicare patients or opt out of the Medicare system entirely. Other factors playing into these decisions include Medicare's burdensome administrative requirements, and a federal government audit process that is onerous and punitive. If there were more primary care physicians they would be able to spread the Medicare patient load and physician practices might more easily be able to absorb losses from lower reimbursement and increased paperwork.

Potential Solutions

Recognizing that the ability to drive changes in federal policy is limited, the Commission felt the most effective state-based strategy for addressing the Medicare access problem is to increase the supply of primary care providers, following similar recommendations to those specified in Part III.C of this report. The Commission was particularly interested in the opportunity to develop an internal medicine residency program for Alaska. One of the few primary care practices in Anchorage that was accepting new Medicare patients until recently was the Family Medicine Residency Program, but they had to cap the number of seniors they could accept as the elder portion of their patient population had grown to the point that the residents were not able to get the amount of experience with younger populations they needed. An internal medicine residency program would provide a dual benefit by producing more primary care physicians who specialize in treating adults and who are likely to stay in Alaska to practice, and by also creating a new clinical practice that would accept Medicare patients.

The Commission heard from a couple of groups proposing to expand clinical capacity. One group proposed starting a new for-profit primary care practice that would see Medicare patients exclusively, and would be staffed by a physician-led nurse practitioner team. The Commission had reservations regarding the proposed care model, which would limit a patient's ability to be seen for multiple conditions at the same time. The complex care needs of this population are too great and require a high level of coordination. The Commission also felt that a for-profit practice should be able to make the business case to investment partners if the proposal was viable, and that government investment would

not be appropriate. A second group suggested that expansion of the Anchorage Neighborhood Health Center (ANHC) would support the ability to expand the Medicare patient population seen there, but a specific request was not made of the Commission, and the ANHC recently received a sizeable state capital grant ($10 M) to support the planned expansion. The Commission felt that state government strategies for expanding medical clinic capacity are most appropriately targeted at Federally Qualified Health Centers and Rural Health Clinics – which are non-profit safety net providers such as the ANHC.

The Commission determined that it was also necessary to request assistance again from Alaska's congressional delegation with seeking relief from Medicare's inequitable reimbursement rates, burdensome administrative requirements, and onerous audit conditions. There were questions about how the administrative requirements of Medicare compare to Medicaid and other 3rd party insurance providers, and a suggestion was made to investigate that question in order to support the request.

One new program the Commission considered as a potential solution to the Medicare access problem was PACE (Programs of All-Inclusive Care for the Elderly). PACE is a Medicare and Medicaid program that provides community-based care and services for older adults and people over 55 living with disabilities who would otherwise require nursing home level of care. PACE programs are required to provide a comprehensive set of wrap-around integrated medical and social services managed by an interdisciplinary team of health care professionals. Eligible Alaskans on Medicare choosing to participate in this optional program would be guaranteed access to primary care.

Initially started as a Medicare demonstration project in 1978, PACE proved so successful in improving outcomes for families and patients, health care providers, government and other payers, that it has been replicated in 31 states by 69 PACE organizations that serve nearly 18,000 individuals today. An evaluation by the federal government (then HCFA now CMS) conducted during the 1990s that studied the impacts of PACE on a wide variety of outcomes found that it resulted in long-lasting decreases in nurse visits to the home, inpatient hospital admissions, inpatient hospital days, and nursing home days. In addition, this study found that PACE enrollees lived longer and spent more days in the community than did non-PACE participants in a similar demographic control group.

The estimated number of Alaskans dually-eligible for both Medicare and Medicaid living in the Municipality of Anchorage is 7,539.[lxvi] An estimated 10% may be eligible to participate in a PACE program. Two Anchorage health care organizations, Providence and Southcentral Foundation, have expressed some interest in potentially developing a PACE program in the community.

States may elect PACE as an optional Medicaid benefit through the Medicaid State Plan Amendment process. Approval of a State Plan Amendment by CMS does not obligate the state to implement a PACE program, but provides the option and positions the department and interested providers to move forward with program development.

Because only the frail elderly and disabled are eligible to participate in PACE, and those individuals are likely to be receiving higher levels of specialty care already, eligible participants are not as likely to be among those Medicare patients experiencing problems with access to health care. Developing a PACE program in Alaska would most likely make only a very small impact on the Medicare access problem, but because of the many other benefits a PACE program would offer eligible Alaskans, the Commission determined the state should facilitate development of this program.

Recommendation E(a): The Commission recommends that the Governor and Alaska Legislature improve the supply of primary care providers in order to enable increased access to care for Medicare patients by:

- Supporting a student loan repayment and financial incentive program for primary care providers practicing in Alaska and serving Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved);
- Supporting development of a primary care internal medicine residency program;
- Supporting WWAMI program expansion as resources allow; and,
- Supporting mid-level practitioner development.

Recommendation E(b): The Commission recommends that the Governor and Alaska Legislature explore strategies for removing barriers to the development of designated Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), facilitating development through state application for federal shortage designations for Medicare populations and supporting planning for new and expanded FQHCs/RHCs.

Recommendation E(c): The Commission recommends that the Governor and Alaska Legislature work with Alaska's Congressional delegation to improve Medicare's reimbursement scheme to ensure the sustainability of care to Medicare patients.

Recommendation E(d): The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to redesign the Medicare audit process so that it focuses more on identification and prosecution of fraudulent practices than on billing errors. Reported financial incentives for audit contractors should be eliminated and replaced with performance measures. Concern over billing errors should be addressed through provider training and performance reports, not through audit processes designed to weed out fraud and abuse.

Recommendation E(e): The Commission recommends that the Governor and Alaska Legislature commission an analysis comparing Medicare to Medicaid and private insurance administrative requirements, including recommendations for streamlining public insurance administrative procedures to make them more user-friendly.

Recommendation E(f): The Commission recommends that the Governor facilitate development of PACE programs in Alaska by directing the Department of Health & Social Services to submit a State Plan Amendment to the U.S. Centers for Medicare and Medicaid Services (CMS) to add PACE as a Medicaid service, and to identify and remove barriers to development of PACE programs.

PART IV: Health Care System Transformation Elements

A number of issues and potential strategies were identified by the Commission as important to a comprehensive approach to health care reform for Alaska. Potential elements of health care system transformation identified for future study are described briefly in this part of the report, and a suggested approach for planning related to these issues is provided in Part V.

A. Access to Health Care

1. Health Insurance Coverage

Because federal health care reform efforts underway during 2009 have focused primarily on increasing health insurance coverage, the Commission decided it would not be prudent to evaluate state options for expanding coverage until Congress completes their work.

Future study of access to health care coverage will require analysis and understanding of:

- **National reforms adopted in and for Alaska.** Strategies for increasing health insurance coverage in pending federal legislation include creation of a new government-administered insurance plan ("public option"), creation of health insurance exchanges, creation of non-profit member-operated health insurance cooperatives ("Co-ops"), expansion of Medicaid eligibility, individual and employer mandates requiring purchase of insurance, subsidies for low income individuals to purchase insurance, and insurance market reforms. If federal legislation passes, future state health commission work should include analyzing options and making recommendations for state policy direction needed to implement federal reforms at the state level. At a minimum, the work of this or a future commission to consider health insurance coverage expansion will require study of the impact of national reforms in Alaska.

- **Alaska's private insurance market.** Only 23% of Alaskans have health insurance purchased on the private market. An additional 32% have insurance through their employers' self-insured plan (exempt from state regulation under federal law (ERISA)). The remaining 45% of Alaskans have insurance through a public plan (Medicaid/Medicare), have health care provided by the military or the tribal health system, or are uninsured. Consideration of insurance market reform strategies will require study of the potential impact on Alaska's health care system since less than a quarter of the population is covered by the state-regulated insurance market.[lxvii]

- **The challenge small businesses face in obtaining insurance coverage for their employees.** Most of Alaska's smallest businesses (those with fewer than 10 employees) cannot afford to offer health benefits to their employees. 52% of uninsured Alaskans are employed adults (9% are unemployed adults, and the remainders are children and others not in the work force). Those studying this issue in the future can benefit from the work conducted by the Department of Health & Social Services on health insurance coverage in Alaska during 2005-2007 under a grant from the Robert Wood Johnson Foundation. One of the findings from that study is the importance of understanding the seasonal nature of Alaska's workforce. Other results from that study were obtained from surveys and focus groups conducted with Alaska business owners regarding their ability to obtain insurance for their employees and the barriers they face.

2. Health Care Workforce Development

Alaskans' access to quality health care is dependent on the availability of a well trained health care workforce with sufficient numbers of workers in the right occupations and the right locations to meet the needs of the population. The focus by the Commission during their first year on the physician workforce was just a first small step and only one component in what should be a comprehensive and sustained approach to development and implementation of a health care workforce strategy for Alaska. As noted in Part III, Section C of this report, there are numerous organizations collaborating on various aspects of health care workforce planning and development. Future study and improvement of Alaska's health care workforce cannot occur in isolation but must consider and build on these other efforts, and a comprehensive approach to addressing Alaska's health care workforce needs must include strategies to address:

- On-going assessment of Alaska's health care workforce size, composition and distribution
- Workforce innovations required for responding to transformation in patient care models
- Training needs along the continuum of K12 education through graduate medical education and including on-the-job training
- Improved recruitment and retention of health care workers
- Sustainability of health care workforce planning, development and support infrastructure

3. Physical Health Care Services

Individual services and systems of care within the health care delivery system need to be better understood and considered as part of future work to improve the system. During this year the Commission heard specific concerns about access to dental services, and the condition of Alaska's Trauma System. Those two areas could be a starting point for delving deeper into analysis of Alaska's health care system. Additional areas might include pharmacy, vision care, and preventive services.

4. Behavioral Health & Long Term Care

The Commission noted that any effort to transform Alaska's health care system should consider the system from the consumer's perspective. From the individual health care consumer's perspective their behavioral health and long term care needs cannot be separated from their physical health needs. For that reason alone future health care planning and policy development efforts need to consider these other systems and services, and another important factor necessitating their inclusion is that behavioral health and long term care are significant cost drivers in the increasing cost of health care.

The Commission did not attempt in their first year to address issues related specifically to the funding and delivery of behavioral health and long term care in Alaska. In part because there are other groups working on planning for behavioral health and long term care improvement, such as the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Alaska Commission on Aging, and the Department of Health & Social Services, while there is no other entity charged with examining the broader health care delivery system. Future work must not leave these sectors out however. Recent plans, such as the Comprehensive Integrated Mental Health Plan and the State Plan for Long Term Care Services, should be reviewed.

If this or a future Commission wishes to foster innovation in transforming Alaska's health care system to better support a healthier Alaskan population they will need to coordinate with the behavioral health and long term care planning entities to ensure they are taking an integrated and holistic approach while not duplicating efforts.

B. Cost & Quality (Value)

The trend in state and federal health care reform efforts has been moving away from more simplistic cost control measures, such as caps on fees, towards a focus on improved value, thus most strategies to address the cost of care cannot be separated from strategies to improve quality.

1. Understanding the Cost of Care in Alaska

Information presented in Part II of this report indicates costs are higher in Alaska compared to other states, but a thorough understanding of the underlying reasons why costs vary is required prior to making specific policy recommendations to address the problem. Is it due to an insufficient supply of providers and insufficient competition between providers? Is there higher utilization of medical services in our state, and if so is it due to waste in the system or due to a higher prevalence of complex health conditions? How does fragmentation of the health care delivery system affect overall costs? Are payers unable or unwilling to negotiate the lowest possible price for services?

An important aspect of understanding variations in cost and underlying cost drivers is understanding how cost shifting occurs when one payer or set of payers underpays a health care provider (pays less than the costs the provider incurs to deliver the service). Prices charged are typically higher than the cost of care (and beyond profit margin) to make up for capped reimbursement by some providers, low fees negotiated with contract payers, and uncompensated care provided for uninsured and underinsured individuals who are not able to pay. Further analysis of cost drivers and cost shifting is needed to support development and implementation of successful strategies to control cost and improve value.

2. Primary Care Innovation

One of the Commission's central strategies for improving health care cost and quality is innovation in the patient care model at the primary care level. A lot of work must be done to implement the Commission's recommendation (#A2a) in support of primary care innovation. A collaborative effort with the primary care provider community and the Alaska Department of Health & Social Services needs to be undertaken to define the care model in more specificity beyond the identified characteristics, performance standards and measures must be developed, required internal organization supports for providers must be identified (such as information technology, knowledge management strategies for evidence-based practice, and development of effective teams), as well as requirements for a supportive payment and regulatory environment.

3. Value-Driven Purchasing

The fee-for-service approach to purchasing health care drives up the overall cost of care by incentivizing the provision of more services, and more costly services, while offering no incentives for improved quality or efficiency. "Value-driven purchasing" (VDP) identifies and implements purchasing practices intended to improve the value of health care services by holding providers accountable for both the quality and cost of services delivered to patients. VDP strategies include establishing standardized quality measures and reporting requirements, reporting of health care price and quality information, and use of direct incentives or disincentives to providers and consumers to promote improved quality of care and health outcomes as well as greater value for dollars spent. There are a number of strategies that could be studied to start Alaska on the road to value-driven purchasing.

a) Leverage State Purchasing Power

State government in Alaska represents a substantial payer for health care services. The state spent over $1.5 billion last year in Medicaid expenditures, payment of state employee and retiree claims (not counting benefit credits paid to union health trusts), payment of state employee Workers' Compensation medical claims, and purchase of health care services for incarcerated offenders in the state correctional system. Collaboration between these state programs to develop shared value-driven purchasing strategies could provide significant market-share leverage for improving health care quality and cost in this state. This is an area that warrants additional study and potential recommendations.

b) Provider/Payer Cost Sharing Demonstration Projects

Because of the way the fee-for-service payment system is structured, health care providers may face situations where implementing measures that will reduce overall costs in the system and save money for the payer will actually increase the cost the provider incurs while reducing their revenue. This may be particularly true of hospitals, when investing in a costly new technology will improve patient outcomes and reduce hospital bed days. Future work on this issue could involve working with Alaska's hospitals to determine the extent to which these types of situations might delay innovation (and thereby delay improved patient outcomes and overall system costs), and consider the advisability of cost sharing demonstration projects.

c) Cost and Quality Transparency

Consumers need to know the price and quality of their health care options in order to make informed decisions and support their ability to participate more fully in their care. Empowering consumers with information not only supports improved decision-making on their part, but drives the entire system to provide better care for less money. An infrastructure to support transparency of health care cost and quality for Alaskan consumers, compiling and analyzing data on pricing and quality measures for physician services and hospital care and producing public information through an accessible and understandable reporting mechanism, does not currently exist.

Creating a system to provide transparency is not as simple as it may sound however. Pricing of individual services might be misleading without a more comprehensive picture of the total cost of care for a given condition and the expected outcomes of various care options. And transparency to support a market-based approach is not the only solution to the health care cost and quality problem. Health care is different than other goods and services, and all the conditions required for a competitive market do not exist in the health care market. Consumers do not fully control all of their health care dollars, and they cannot participate fully in all aspects of clinical decision-making about their care. In addition, many

health care decisions are made for consumers in urgent or emergent situations when the consumer is severely ill, injured or under too much emotional stress to participate in their care decisions.

The potential benefits of and barriers to developing an information system to support consumer choice need to be fully understood as part of a strategic approach to making the system more transparent in order to improve quality and control costs.

d) Evidence-Based Medicine

The Dartmouth Atlas of Health Care[lxviii] and numerous other studies have consistently demonstrated wide variations in practice patterns and use of health care resources across geographic regions of the United States – the tests and treatment a patient with a given health condition receives varies based on the location in the country where the care is received. The waste in the health care system due to misused medical resources is estimated to represent as much as 30% of health care spending. Moreover, research has documented those regions of the country where there is overuse of health care resources and resulting higher spending actually have lower quality of care and worse health outcomes.[lxix lxx lxxi]

Decreasing the variability in health care services and spending requires the application of evidence-based medicine, which seeks to improve the decision-making of individual health care providers as they make diagnosis and treatment decisions about individual patients, to engage the patient in making informed decisions about their care, and to improve the policies of payers and health care delivery organizations. Evidence-based medicine is defined as a set of principles and methods intended to ensure that to the greatest extent possible, population-based policies and individual medical decisions are consistent with evidence of effectiveness and benefit." [lxxii] The core idea behind evidence-based medicine is that the right care must be provided to the right patient in the right place at the right time and at the right price. And that all the determinations about what constitute these "right" decisions are based on the best available scientific evidence.

Improving evidence-based medical decision making may be the key to increasing value in health care – decreasing cost and increasing quality. There are a number of roles public policy can play in supporting and driving the use of evidence-based medicine. One state government example comes from Washington state, which has enacted a set of statutory provisions authorizing the state's public payers (Medicaid, Workers' Compensation, state government employee benefit plans, and the corrections department) to use evidence-based methods to improving quality of care, reduce wasteful use of health care resources, and determine what benefits should be covered.[lxxiii] Continuing work to improve value must include identification of the best approaches to expanding the application of evidence-based medicine in Alaska

e) Payment Reform[lxxiv]

The current fee-for-service payment system rewards health care providers for volume, not value. The financial incentives in this system lie entirely in the provision of more health care services and the sale of more health care commodities regardless of the quality of care provided, and may actually serve as a disincentive to creating health. Movement away from fee-for-service to new payment methodologies will require capacity for electronic information management, and therefore development and implementation of health information technology.

Reform of payment methodologies to reward quality can evolve in an incremental approach that can be initially pilot tested and gradually implemented to prevent harm to health care providers and their

business interests, and in a way that supports providers as they transform the health care system over time. Research is required to guide implementation of new payment methods, and careful evaluation is required to assess cost-effectiveness, impact on quality of care and patient outcomes, and identification of unintended consequences. Following are three value-driven payment strategies this or a future Commission might choose to analyze and for which they might develop policy recommendations.

- ***Pay-for-Performance***
  A pay-for-performance program provides a bonus payment for health care providers meeting certain standards of quality on a predetermined set of clinical measures. One approach would provide incentives for improvement over baseline performance as well. One challenge to developing a pay-for-performance program in Alaska will be the small size of many of Alaska's hospitals and the lack of any large primary care group practices, as sufficient patient volume to provide statistically valid measurement of quality is required.

- ***Patient-Centered Primary Care Enhanced Service Payment***
  The Commission in this report recommends the state of Alaska aggressively pursue development of innovative models of patient-centered primary care. Implementation of this recommendation will require further work to develop a detailed definition including the criteria a practice will have to meet in order to be deemed as meeting the new standard of care. The level and source of funding as well as the reimbursement mechanism for enhanced payment to support these new patient care models will need to be identified as well. As Medicaid is the state's largest payer, the Department of Health & Social Services is the logical entity to begin this next level of planning in support of the development of a Medicaid pilot program. DHSS might look to partner with other state agency health care purchasers and also private health insurance companies operating in Alaska to expand the reach of such a program.
- ***Bundled Payment Systems***
  Payment bundling provides a global fee for a specified set of services. Development of this payment system could be evolved over time, starting with bundling of a limited set of hospital services related to certain acute care episodes (related to certain illness diagnoses for a specified period of time – for example, coronary artery bypass surgery and extending 30 days beyond discharge); and expanding over time to include physician inpatient care and post-acute care. A particular challenge to implementing this strategy in Alaska is the lack of integrated care networks here. Hospitals would initially have to contract with physicians and other service providers required to deliver the suite of services potentially needed to treat the bundled diagnoses or procedures. Other challenges involve the lack of sophistication of information and accounting systems of many of Alaska's smaller hospitals, the need to identify standards to ensure cost reduction does not negatively impact quality, mechanisms for avoiding "cherry-picking" of patients with the potential for fewer complications, and ways to reduce exposure to risk for providers.

f) Reporting and Non-Payment for "Never Events" and other Health Care Acquired Conditions
"Never events", as suggested by the term, are occurrences of medical errors that should never happen. The National Quality Forum maintains a list of 28 Serious Reportable Adverse Events considered "never events." Examples include surgery performed on the wrong body part, surgery performed on the wrong patient, leaving a foreign object in a surgical patient, patient death or disability due to use of a contaminated device, and patient death or disability due to a medication error.

CMS enacted a policy on July 31, 2008 to deny Medicare payment for medical services provided by a hospital for care required as the result of a never event. The new CMS policy also authorized State Medicaid Directors to enact this same policy in their state Medicaid program. A number of private insurance companies also have non-payment for never event policies.

Health care acquired infections, such as MRSA and C.Diff, are not included on the "never event" list; however the U.S. Centers for Disease Control and Prevention estimate that, in hospitals alone, these infections account for 1.7 million infections and result in 99,000 deaths annually. Many more are estimated to occur in other health care settings such as day-surgery clinics.

Required public reporting of these conditions can serve as an incentive for health care providers to increase efforts to prevent these problems, and also provide the public health system with information needed to assist health care providers with prevention techniques. Statutorily mandated health care acquired conditions reporting has been considered by the Alaska legislature in the past, and a plan for developing a health care acquired conditions reporting system is currently under development by the Alaska Division of Public Health in the Department of Health & Social Services.

Future work on this issue could include an assessment of the incidence of medical errors in Alaska, the extent to which never event payment policies have been adopted in Alaska, and if there are opportunities for expanded and improved use of this policy as well as other strategies for reducing the occurrence of medical errors and improving patient safety.

4. Fraud & Abuse Control

The National Health Care Anti-Fraud Association, a public-private partnership of insurance company and government health care payers, estimates that a minimum of 3% of national health care expenditures is lost to fraud and abuse. Health care fraud - intentional misrepresentation or deception for the purpose of receiving higher reimbursement – can take many forms. One of the more common forms is for criminals to obtain patient information and pose as fictitious doctors, billing public and private insurance plans for service that was never rendered. The increased cost to payers for these fraudulent claims translates into increased premiums for private insurance holders and increased taxes to support Medicaid and Medicare.

It is difficult to determine the actual extent and impact of fraud and abuse in the health care sector – one cannot survey the criminals to determine how much they are making – but future work on this issue could include analysis of the current systems in place for fraud and abuse detection, investigation and prosecution for Alaska's Medicaid program and utilized by the insurance industry here. This analysis could include a look at current capacity, including funding and staffing levels, current practices, and also criminal penalties in state statute.

5. Tort Reform

Costs associated with medical liability (medical malpractice insurance premium costs, malpractice awards, and the practice of defensive medicine) are believed to be one driver of increasing health care costs, and reform of related civil justice laws has been one cost control strategy suggested in health care reform debates at the federal and at state levels. Estimates of potential savings from medical malpractice reform vary, but two very recent studies predict measurable savings. The Congressional Budget Office, in an October 2009 study for Senator Hatch, pegs the potential cost savings at 0.5% of

total national health care spending. The National Bureau of Economic Research estimates, in a September 2009 study, that three different types of medical tort reform could reduce premiums for employer-sponsored health insurance plans by 1 to 2% each.

This is one strategy that has been addressed at least partially in Alaska. In 2005 the Alaska Legislature passed the Alaska Medical Injury Compensation Reform Act, limiting noneconomic damage awards for personal injury resulting from health care services to $250,000 (limit increases to $400,000 for wrongful death or injury resulting in permanent physical impairment that is more than 70% disabling). Alaska's court system also plays a role – discouraging frivolous lawsuits through Alaska Civil Rule 82, which requires the losing party to tort litigation to pay attorney fees and court costs to the prevailing party.

Future work related to this issue could include evaluation of the impact of the medical liability reform law passed in 2005 and study of additional strategies, such as regulation of medical malpractice insurance providers and development of programs to encourage alternatives to litigation.

6. Process Innovation Strategies

One other factor driving higher cost and reduced quality is operational inefficiency in the delivery of health care services. Inefficiencies associated with both direct medical services and those associated with administrative and logistical support services can benefit from systematic efforts to streamline work processes and drive out waste. [lxxv] Health care managers have been successfully applying process-innovation strategies that are popular in the manufacturing industry to improve efficiency and quality of their services. Examples of problems tackled range from reducing the number of mistakes in invoices, to reducing the number of patients requiring intravenous antibiotics, to shortening the length of stay in chronic obstructive pulmonary disease patients. [lxxvi]

Two popular process-innovation strategies in use in health care systems today are Lean Thinking and Six Sigma. Lean Thinking (also known as Toyota Production System (TPS), or simply "Lean") came out of the Japanese auto industry. Lean provides an integrated set of tools, principles, and practices focused on waste reduction and synchronizing work flow, utilizing an extended process flowchart as a tool for identifying non-value-added steps and bottlenecks. Six Sigma was originally introduced by Motorola as a method for driving company-wide quality improvement. It provides an organizational structure of project leaders and project owners, and a problem-solving strategy similar to medical practice – information gathering followed by careful diagnosis, application of "treatment," and follow-up to determine efficacy.

Future work to improve efficiency in health care service delivery processes in Alaska could include analysis of the extent to which manufacturing industry process innovation strategies are being applied by Alaska's major health care providers. Options and opportunities for fostering the transformation in the culture of Alaska's health care businesses to focus on continuous improvement could be identified. Also methods for spreading the adoption of process innovation strategies, for example by supporting forums for sharing best practices and providing technical assistance, could be considered.

C. Prevention

1. Public Health: Population-Based Health Promotion & Disease/Injury Prevention

Many diseases and injuries are preventable. Simple, non-medical, individual approaches to prevention such as hand washing, eating healthy foods, exercising, not smoking, drinking alcohol in moderation if at all, and wearing bicycle helmets and life jackets go a long way towards avoiding illness and injury. Individuals acting alone cannot create all of the conditions necessary to ensure good health however.[lxxvii]

Since antiquity societal leaders recognized the importance of communal action to protect and promote the health of community members. Some of the rules described in the Old Testament were intended to prevent illness in the community from contaminated food or to prevent the spread of communicable disease. Today governments act to ensure safe food and water, maintain sanitation systems, provide vaccinations, deliver maternal and child health services, enact public polices such as seat belt laws, and operate programs such as tobacco control in order to optimize the health of the population under their jurisdiction.

Public health is defined as "what society does collectively to assure the conditions for people to be healthy."[lxxviii] There are two main characteristics of public health – 1) it is concerned with prevention rather than cure, and 2) it is concerned with population-level rather than individual-level health issues. Public health protects and improves communities by preventing epidemics and the spread of disease, promoting healthy lifestyles for children and families, protecting against hazards in homes, work sites, communities and the environment, assuring high quality health care services, and preparing for and responding to emergencies.

The significant improvements in health status in the United States during the 20th century – such as the increase in life expectancy from 45 years in 1900 to over 75 years in 2000 – are primarily due to public health interventions. Only five years of this 30 year increase in the average lifespan of Americans is attributable to the aggregate effects of improvements in medical care.[lxxix] 25 years of this gain are due to advances in public health.[lxxx] Attainment of the Commission's vision to transform Alaska's health care system so it focuses on creating health and not simply treating illness and injury requires an understanding of and support for Alaska's public health system.

A report by the Institute of Medicine published in 2002 found that the nation's governmental public health infrastructure had been neglected, and an overhaul of its components (e.g., workforce, laboratories, public health law) was needed to ensure quality of services and optimal performance. Governmental public health agencies are the backbone of the public health system but do not work alone. Other organizations and sectors of society – including the health care delivery system, communities, business, the media, and academia are important partners in the public health system.[lxxxi]

In Alaska the state legislature is charged under the constitution to "provide for the promotion and protection of public health" (Constitution of the State of Alaska, Article VII, Section 4). The legislature has paid attention to the needs of Alaska's public health infrastructure over the years. For example, by funding construction of two new technologically modern public health laboratories during the past 10 years, and by passing comprehensive reform of the state's public health laws as they relate to public health functions (AS 18.15) in 2005. But a review of Alaska's public health system has not been conducted in over a decade, and the capacity of the system to meet the need for population-based health promotion and disease and injury prevention is not well understood.

Future work by the Commission could include analyzing the adequacy of Alaska's public health infrastructure, and developing policy recommendations to ensure the state's public health system is sufficiently supported to deliver population-based disease and injury prevention and health promotion services.

2. Safe Water and Sanitation Systems

Safe water and waste water systems are essential to the prevention of disease. At the turn of the last century infectious diseases such as typhoid and cholera were the leading cause of death in the United States. Today many of those diseases have been virtually eliminated - in large part due to modern sanitation systems.

The association between safe drinking water and gastrointestinal illness has long been recognized, but a recent study conducted in Alaska by the CDC Arctic Investigation Program found a link between in-home water service and higher rates of respiratory and skin infections as well. The CDC team noted as "particularly disturbing" their finding that villages in one region with low in-home water service (less than 10% of homes served) experienced a respiratory infection hospitalization rate that was five-times higher than that of the general U.S. population, and a pneumonia hospitalization rate among infants that was 11-times higher.[lxxxii] This study demonstrates the importance of having safe water that is not only available in the local community for drinking, but is also readily and easily available in the home for hygiene use.

Nearly every home in the U.S. – 99.4% according to the 2000 U.S. Census – now has running water and flush toilets. Alaska ranks last in the nation, with 93.7% of Alaska homes having these basic services. In rural Alaska however, only 77% of homes have modern sanitation facilities.[lxxxiii]

Support for improved sanitation systems in rural Alaska has been underway for some time, beginning with efforts of the Indian Health Service in the 1960s. In 1972 the state of Alaska enacted the Village Safe Water Act and began contributing state resources for construction of water projects. In 1994 the Rural and Native Sanitation Development Program, jointly funded by the state and federal government, was implemented. When this program began only 37% of rural Alaska households had adequate sanitation facilities. Today the Alaska Department of Environmental Conservation administers the Village Safe Water Program in partnership with the Alaska Native Tribal Health Consortium, providing state and federal funds totaling approximately $60 million annually as well as technical assistance to Alaska's smallest communities to design and construct water and wastewater systems.

Future work on the part of the Commission could include developing an understanding of the state's plan for bringing sustainable and appropriate safe water and wastewater systems to every Alaskan community, and developing policy recommendations to ensure the state's adherence to that plan.

3. Employee Health Risk Management

Health care spending on individuals with one chronic condition is more than twice that for people without such conditions, and spending is nearly 15 times greater on individuals with five chronic conditions. Employers and their insurance plans are increasingly working to change enrollees' health behaviors as a means of achieving cost savings.

Health Risk Management Programs offer incentives such as lower premiums or contributions to HSAs for employees who agree to participate in the program. These programs generally require a health risk assessment and health improvement goals supported by lifestyle management tools, health coaches, and disease management plans.

Health Risk Management Programs have demonstrated effectiveness in reducing the rate of increase in health insurance premiums over time. The City and Borough of Juneau has a long standing program (since 1989), and over the years their premium rate increases have consistently been below the regional average. Safeway has flat-lined employee health benefit cost increases for four years straight since implementation of such a program. Providence Alaska, which is self-insured, launched a program in November of this year based on findings that the program will reduce costs.

While this strategy has primarily been about cost control, it demonstrates how a focus on prevention can work to make individual Alaskans healthier while achieving the added benefit of lowered costs.

PART V: 2010-2014 Strategic Plan for Transforming Alaska's Health Care System

A. 5-Year Planning Framework

The Commission's recommended five-year strategic planning framework is comprised of six essential elements:

I. **Develop a Vision of Alaska's Transformed Health Care System**
Accomplished in 2009 – Documented in Part I of this Report.

II. **Accurately Describe Alaska's Current Health Care System**
Begun in 2009 – Documented in Part II and Appendix A of this Report.
Next Steps:
1. Identify gaps in knowledge (e.g., why are prices for health care services higher in Alaska?)
2. Fill in the gaps and complete the picture
3. Analyze impact of national health care reform on Alaska

III. **Build the Foundation for a Transformed Health Care System**
- **Statewide Leadership**
- **Workforce Development**
- **Health Information Technology**

Begun in 2009 – Documented in Part III of this Report.
Next Steps:
1. Track implementation of 2009 recommendations
2. Implement 2009 recommendations requiring Commission action
3. Continue analysis and identification of solutions for further recommendations

IV. **Design Elements Required for Transformation of Alaska's Health Care System**
Begun in 2009 – Documented in Part III and IV of this Report.
Next Steps:
1. Continue working on design elements for primary care innovation and healthy lifestyles
2. Prioritize additional potential strategies (identified in Part IV) for analysis and recommendations

V. **Measure Progress of Health Care Transformation**
First Steps:
1. Work with system stakeholders to identify and develop consensus on indicators to measure progress (see potential indicator set below).
2. Develop data collection and analysis capacity for indicators that are not currently measurable.
3. Report progress on an annual basis to Governor, Legislature, and the general public.

VI. **Communicate with the Public & Engage Stakeholders**
Begun in 2009 – Commission Public Communication Plan included in Appendix D of this Report.
Next Steps: Implement Commission Public Communication Plan

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Potential Health Care System Transformation Measures

1. Increase Access
    - Percent of Alaskans insured
    - Percent of Alaskans who have a specific source of on-going care
    - *Measure of insurance affordability*
    - *Indicator of workforce supply*
2. Control Costs
    - Annual growth rate in total health system expenditures in Alaska
    - Annual growth rate in Alaska's Medicaid expenditures
    - Impact on Alaska's state budget: new spending, net savings, new revenues
    - *Measure of provider revenues based on value*
3. Safe, High-Quality Care
    - Percent of population receiving key preventive services or screenings
    - Percent of Alaskans with chronic conditions controlled
    - Percent reduction in gap between benchmark and actual levels of quality
    - Percent reduction in gap between benchmark and actual levels of safety
4. Focus on Prevention
    - Percent of Alaskan communities with safe water and wastewater systems
    - Percent of Alaskans reporting health risks
        - Percent of Alaskans who smoke cigarettes
        - Percent of Alaskans who are obese
        - Percent of Alaskans who are binge drinkers
    - Percent of Alaskans with moderate to severe depression
    - Death rate among Alaskans due to injury (intentional and unintentional)

B. Suggested Action Plan for 2009 Recommendations

Recommendation	Responsible Party and Action	Timeline and Resources
A1a: The Commission recommends that the Governor and Alaska Legislature investigate and support additional strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.	**Governor:** 2010 - Direct DHSS to investigate and develop recommendations for effective strategies to encourage and support healthy lifestyles of Alaskans. **Legislature:** 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs variable depending on availability of funding and approach to implementation
A1b: The Commission recommends that the 2010 Alaska Health Care Commission continue evaluating the question of what works to support behavior change, and identify additional recommendations for future improvement.	**Commission:** Include healthy lifestyles strategies analysis and recommendation development on 2010 work plan; Coordinate with DHSS investigation of same question.	**Jan 2010 – Dec 2010** **Cost:** $0 (assumes funding of Recommendation B2a)
A2a: The Commission recommends that the Governor and Alaska Legislature aggressively pursue development of patient-centric care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects. Development of pilot projects should include definition of the patient-centric model, identification of performance standards and measures, and payment models that are outcome-based.	**Governor:** Direct DHSS to: 1) collaborate w/the AHCC to define patient-centric care models and identify performance standards and measures; 2) pursue grant opportunities to obtain funding for piloting medical home models of care; and, 3) identify statutory and regulatory barriers to development of such care models. **Legislature:** Consider future requests for removal of statutory barriers and financial support for pilot projects and new payment methodologies.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; (assumes funding of Recommendation B2a) Future costs variable depending on availability of funding and need for pilot project funding.
B1a: The Commission recommends that the Governor and Alaska Legislature invest in the state health policy infrastructure required to study, understand, and make recommendations to respond to the implications of national health care reform for Alaska.	**Governor:** Direct DHSS to develop proposal for development of health policy analysis capacity.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
B2a: The Commission recommends that the Alaska Legislature establish an Alaska Health Care Commission in statute, similar in size to the Commission established under Administrative Order #246, to provide a focal point for sustained and comprehensive planning and policy recommendations for health care delivery and financing reform, and to ensure transparency and accountability for the public in the process.	**Legislature:** Pass legislation to establish a Health Care Commission in statute, and fund associated fiscal note. **Governor:** Sign passed legislation into law	**Jan 2010 – Apr 2010** **Cost:** $500,000 annual operating budget (based on DHSS fiscal notes for pending legislation)

C1a: The Commission recommends that the Governor and Alaska Legislature maintain health care workforce development as a priority on Alaska's health care reform and economic development agendas.	**Governor:** Direct state agencies to ensure future health care and economic development plans consider health workforce needs and strategies. **Legislature:** Direct legislative committees to ensure health care and economic development agendas consider workforce needs and strategies.	**Jan 2010 – Dec 2014** **Cost:** $0
C1b: The Commission recommends that the Governor and Alaska Legislature explore strategies for strengthening the pipeline of potential future Alaska health care workers.	**Governor:** 2010 – Direct DEED, DHSS, and DoLWD to collaborate together and with stakeholders on the investigation and development of recommendations for strengthening the health workforce pipeline. **Legislature:** 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.	**Jan 2010 – Dec 2014** **Cost:** $0
C1c: The Commission recommends that the Governor and Alaska Legislature explore strategies for ensuring Alaska's health care workforce continues to be innovative and adaptive, and that it is responsive to emerging patient care models.	**Governor:** 2010 – Direct DHSS to consider innovative approaches to health workforce development. **Legislature:** 2011-2014 – Consider future requests for legislation and financing of health workforce innovations.	**Jan 2010 – Dec 2014** **Cost:** $0
C1d: The Commission recommends that the Governor designate a single entity with the responsibility for coordinating all health care workforce development planning activities in and for Alaska. Coordination and collaboration of funders, policymakers and stakeholders in workforce planning and development efforts should be encouraged to the greatest extent possible.	**Governor:** 2010 – Direct DHSS to collaborate with system stakeholders to develop a recommendation for the most appropriate entity to be charged with the responsibility for health care workforce development planning coordination.	**Jan 2010 – Dec 2014** **Cost:** Estimated $0 - $250,000 depending on capacity and needs of designated entity
C1e: The Commission recommends that the 2010 Alaska Health Care Commission continue studying health care workforce needs in coordination with other organizations and coalitions addressing this issue, and identify recommendations for additional improvements.	**Commission:** Include health workforce planning coordination, analysis, and recommendation development on 2010 work plan	**Jan 2010 – Dec 2010** **Cost:** $0 (assumes funding of Recommendation B2a)
C2a: The Commission recommends that the Governor and Alaska Legislature target the state's limited financial resources invested in physician workforce development to strengthening the supply of primary care physicians.	**Legislature:** Limit future appropriations intended to increase the supply of practicing physicians in the state to utilization for primary care physicians only (Family Physicians, Pediatricians, General Internists, and Psychiatrists).	**Jan 2010 – Dec 2014** **Cost:** $0

C2b: The Commission recommends that the Governor and Alaska Legislature support development and maintenance of an educational loan repayment and direct financial incentive program in support of recruitment and retention of primary care physicians and mid-level practitioners.	**Legislature:** Pass legislation to establish educational loan repayment and financial incentive program to support recruitment and retention of primary care providers. **Governor:** Sign passed legislation into law	**Jan 2010 – Apr 2010** **Cost:** Estimated $1.5 - $7.5M annually
C2c: The Commission recommends that the Governor and Alaska Legislature support the continued expansion of the WWAMI program. Future expansion should be supported as resources allow.	**Legislature:** Pass legislation to continue WWAMI expansion as state general fund resources allow. **Governor:** Sign passed legislation into law	**Jan 2010 – Apr 2010** **Cost:** $600,000 (estimated annual cost of 4-seat expansion in 4th year)
C2d: The Commission recommends that the Governor and Alaska Legislature support graduate medical education for primary care and behavioral medicine. State financial support should continue for on-going operation of the Alaska Family Medicine Residency Program, and should be appropriated for the planning and development of in-state residency programs for pediatrics, psychiatry, and primary care internal medicine.	**Governor:** 2010 – Direct UA to collaborate with system stakeholders to develop proposals for development of pediatric, psychiatric and primary care internal medicine residency programs for Alaska. **Legislature:** 2011-2014 – Consider future requests for state participation in support of residency program development and operation.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs variable depending on availability of funding and approach to implementation
C2e: The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to address equity in the allocation and distribution of Medicare Graduate Medical Education (GME) residency slots. The exclusion of new programs is not equitable, and there should be heavier weighting for primary care GME and for shortage areas.	**Governor:** Send letter to congressional delegation. **Legislature:** Send letter to congressional delegation.	**Jan 2010 – Apr 2010** **Cost:** $0
C2f: The Commission recommends that the Governor and Alaska Legislature explore strategies for improving the primary care delivery model and utilizing "physician extender" occupations as an additional approach to addressing the primary care physician shortage.	**Governor:** Direct DHSS to work with health workforce development stakeholders to make planning for physician extender and primary care team worker occupations a high priority. **Legislature:** Consider future requests for health workforce development targeted at primary care.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs variable depending on availability of funding and approach to implementation
D1a: The Commission recommends that the Governor and Alaska Legislature take an aggressive approach to supporting adoption, utilization, and potential funding of health information technology, including health information exchange, electronic health records and telemedicine/telehealth that promise to increase efficiency and protect privacy.	**Governor:** Follow development of the state HIE and consider future requests for support of HIT needs. **Legislature:** Consider future requests for HIT development.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined

D2a: The Commission recommends that the Governor direct the Department of Health & Social Services to explore options for assisting providers (particularly smaller primary care practices and individual primary care providers) with adoption of electronic health record systems.	**Governor:** Direct DHSS to work with the state HIE contractor and AK EHR Alliance on exploration of options for assisting small primary care practices with adoption of EHRs.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
D2b: The Commission recommends that the Governor ensure Alaska's statewide health information exchange supports providers who have not yet adopted their own electronic health record system by facilitating identification and purchase of systems that are interoperable with the state exchange.	**Governor:** Direct DHSS to work with the state HIE contractor and AK EHR Alliance on facilitating identification of EHR systems that are interoperable with the state HIE.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
D2c: The Commission recommends that the Governor ensure that HIT is utilized to protect the public's health. Alaska's health information exchange should connect with electronic public health reporting systems to enable real-time disease reporting and rapid identification of public health threats.	**Governor:** Direct DHSS to work with the state HIE contractor and the Division of Public Health on integration of electronic real-time disease reporting systems in the statewide exchange.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
D2d: The Commission recommends that the Governor ensure that data available through the statewide health information exchange is utilized to identify opportunities for administrative efficiencies, coordination and optimization of care, and health care quality and safety improvement.	**Governor:** Direct DHSS to work with state HIE contractor to identify potential uses of data from the exchange to support health care quality, safety, and efficiency improvement opportunities.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
D2e: The Commission recommends that the 2010 Alaska Health Care Commission track the development of the Alaska Statewide Health Information Exchange, Alaska's new Medicaid Management Information System (MMIS), and the use of ARRA funds for electronic health record deployment; and the Commission should continue to identify current issues, policy choices and recommendations based on these developments.	**Commission:** Include HIE, MMIS and ARRA EHR status review, analysis and recommendation development on 2010 work plan **DHSS:** Provide quarterly report to the AHCC on status of HIE, MMIS, and ARRA EHR implementation	**Jan 2010 – Dec 2010** **Cost:** $0 (assumes funding of Recommendation B2a)
D2f: The Commission recommends that the Governor designate a statewide entity with the responsibility for ensuring broad implementation of health information security and privacy protections. The entity should participate in on-going efforts at the national level to identify security and privacy standards, should oversee application of those standards to Alaska's statewide health information exchange, and should identify a process for Alaskan patients to opt out of participation in the health information exchange.	**Governor:** Direct DHSS to collaborate with the state HIE contractor and system stakeholders to develop a recommendation for the most appropriate entity to be charged with the responsibility for implementation of health information security and privacy protections.	**Jan 2010 – Dec 2010** **Cost:** $0

D3a: The Commission recommends that the Governor and Alaska legislature work with federal and local partners to ensure all Alaskan communities have access to broadband telecommunications infrastructure that provides the connectivity and bandwidth necessary to optimize use of health information technologies.	**Governor & Legislature: Jan 2010 – Dec 2011:** Follow Denali Commission's 2-year broadband mapping initiative. **Jan 2012 – Dec 2014:** Work with local, federal and private sector partners to address gaps in service where identified.	**Jan 2010 – Dec 2014** **Cost:** $0; Future costs to be determined
D3b: The Commission recommends that the Governor direct the Alaska Department of Health & Social Services to investigate innovative reimbursement mechanisms for telemedicine-delivered services; test new payment methodologies through Medicaid, and work with other payers to encourage adoption of successful methodologies.	**Governor:** Direct DHSS to investigate and develop a project proposal for pilot testing innovative reimbursement mechanisms for telemedicine-delivered services through Medicaid.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
E(a): The Commission recommends that the Governor and Alaska Legislature improve the supply of primary care providers in order to enable increased access to care for Medicare patients by: o Supporting a student loan repayment and financial incentive program for primary care providers practicing in Alaska and serving Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved); o Supporting development of a primary care internal medicine residency program; o Supporting WWAMI program expansion as resources allow; and o Supporting mid-level practitioner development.	**Same as for Recommendations C2a – C2f**	**Same as for Recommendations C2a – C2f**
E(b): The Commission recommends that the Governor and Alaska Legislature explore strategies for removing barriers to the development of designated Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), facilitating development through state application for federal shortage designations for Medicare populations and supporting planning for new and expanded FQHCs/RHCs.	**Governor:** 2010 - Direct DHSS to investigate and develop recommendations for facilitating support of FQHCs and RHCs. **Legislature:** 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs variable depending on availability of funding and approach to implementation
E(c): The Commission recommends that the Governor and Alaska Legislature work with Alaska's Congressional delegation to improve Medicare's reimbursement scheme to ensure the sustainability of care to Medicare patients.	**Governor:** Send letter to congressional delegation to initiate discussion. **Legislature:** Send letter to congressional delegation to initiate discussion.	**Jan 2010 – Dec 2010** **Cost:** $0

E(d): The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to redesign the Medicare audit process so that it focuses more on identification and prosecution of fraudulent practices than on billing errors. Reported financial incentives for audit contractors should be eliminated and replaced with performance measures. Concern over billing errors should be addressed through provider training and performance reports, not through audit processes designed to weed out fraud and abuse.	**Governor:** Send letter to congressional delegation to initiate discussion. **Legislature:** Send letter to congressional delegation to initiate discussion.	**Jan 2010 – Apr 2010** **Cost:** $0
E(e): The Commission recommends that the Governor and Alaska Legislature commission an analysis comparing Medicare to Medicaid and private insurance administrative requirements, including recommendations for streamlining public insurance administrative procedures to make them more user-friendly.	**Governor:** Direct DHSS to investigate and develop a recommendation for a process to compare public and private insurance administrative requirements.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
E(f): The Commission recommends that the Governor facilitate development of PACE programs in Alaska by directing the Department of Health & Social Services to submit a State Plan Amendment to the U.S. Centers for Medicare and Medicaid Services (CMS) to add PACE as a Medicaid service, and to identify and remove barriers to development of PACE programs.	**Governor:** Direct DHSS to develop and submit SPA to CMS adding PACE as an Alaska Medicaid benefit, and to develop capacity to negotiate rates with providers interested in developing a PACE program.	**Jan 2010 – Dec 2010** **Cost:** $200,000 (estimated by DHSS; for actuarial consultant and Office of Rate Review staff)

C. 2010 Work Plan for the Alaska Health Care Commission

Following is a suggested approach to continuing the work of the Alaska Health Care Commission through 2010. This plan will need to be adapted and more details added based on the level of financial and staff resources allocated to this work once financing is determined.

- **Analyze Variations in Pricing and Resulting Cost Shifting in Alaska's Health Care Delivery System**
  - Contract with consultants who have expertise in health economics and health care business management.

- **Analyze Impact of National Health Care Reform** - If national reform legislation passes:
  - Identify state government roles and responsibilities for implementation
  - Analyze and determine potential impact on Alaska's health care system
  - Develop recommendations for Governor and Legislature for maximizing potential benefits and minimizing potential harms

- **Track Implementation of the Commission's 2009 Recommendations**
  - Monitor status of relevant bills during legislative session
  - Consult with Governor's Office on interest and approach to implementing recommendations requiring Governor's action
  - Commission staff to report quarterly to the Commission on status of implementation

- **Implement 2009 Recommendations Requiring Commission Action**
  - Recommendation A1b: Continue studying and develop additional recommendations to support healthy lifestyles
  - Recommendation A2a: Collaborate with DHSS and primary care provider community on definition of patient-centric care model and development of performance standards and measures.
  - Recommendation C1e:
    - Coordinate with the DHSS/AMHTA/UA Behavioral Health Workforce Partnership, Alaska Health Care Workforce Development Coalition and the Legacy Plan Health Care Workgroup
    - Continue analysis of health care workforce issues and develop additional recommendations
  - Recommendation D1b:
    - Coordinate with DHSS to receive a quarterly report on the development of the new statewide health information exchange, the new Medicaid Management Information System, and the use of ARRA funding for electronic health record deployment
    - Continue analysis of health information technology issues and strategies and develop additional recommendations

- **Prioritize, Analyze and Develop Recommendations on Potential Access, Value (Cost Containment and Quality Improvement), and Prevention Strategies described in Part IV of 2009 Report**

- **Implement the Commission's Public Communication Plan**

- **Develop an Evaluation Plan for Tracking the Performance of Alaska's Health Care System**
  - Work with health care system stakeholders to finalize performance metrics that will provide a snapshot of the efficiency, effectiveness, and safety of Alaska's health care delivery system.
  - Identify system for compiling, analyzing, and reporting performance metrics data.

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APPENDIX A

HEALTH CARE IN ALASKA

I. How Health Care in Alaska is Provided

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Prepared for the Alaska Health Care Commission
by the
Section of Health Planning & Systems Development
Division of Health Care Services
Alaska Department of Health & Social Services

APPENDIX A: HEALTH CARE IN ALASKA

I. HOW HEALTH CARE IN ALASKA IS PROVIDED

A. HEALTH CARE DELIVERY SYSTEMS: PRIVATE, TRIBAL, MILITARY AND VETERANS ADMINISTRATION

INTRODUCTION

People in Alaska obtain care for health needs through three different systems: the private sector, the military and Veterans' Administration health system, and the Alaska Tribal Health System. The "private sector" can be defined as any services provided by non-military/VA or non-tribal providers. It includes hospitals, physicians, dentists, mental health and substance abuse professionals, and various kinds of clinics. It also includes a wide array of support services such as pharmacies, imaging centers, renal dialysis centers, medical supplies and equipment sales and service, medical transportation services, nursing homes, rehabilitation centers, residential psychiatric treatment facilities, and home care and hospice.

The tribal and governmental systems represent a larger portion of both facilities and service providers in Alaska than in other states, since one fifth of the population (about 135,000) is eligible for services in the tribal system, and 14% percent (about 90,000) are covered by the military system. (In the U.S. as a whole the proportions are 2% tribal and 4% military.)[1]

In Alaska, services that are provided by federal or state governments directly (rather than through reimbursement or an insurance program) are mostly Veterans Administration and military services for active duty and former service people in the Army, Air Force, and the Coast Guard. State and local government services are limited primarily to state psychiatric hospital, Pioneer Homes, public health services,[2] and some locally owned and operated clinics. Governments also play a major role in reimbursing private and tribal providers for the costs of providing care (rather than providing care directly) through Medicare, Medicaid and other programs. Governments also contract with or provide grants to private, tribal and for-profit organizations to provide services.

Alaska's health services have evolved in response to many factors including geography, population needs and traditions, and historical events. Many of Alaska's hospitals are former tuberculosis control hospitals built by the U.S. Public Health Service to treat the epidemic of the early 20th century. Then Alaska's location gave it a critical military and communication defense role for the country during World War II and during the Cold War of the 1950s and 1960s. The major role of the federally recognized tribes in planning and implementing a coordinated system

[1] U.S. Bureau of the Census, 2000 Census.

[2] Services include immunizations, well child care, services related to infections diseases, sexually transitted disease screening, treatment and partner management, newborn hearing screening, family planning, and home visits for follow-up on referrals of high risk families with children.

of care for Alaska Natives, through an agreement with the Indian Health Service called "compacting," has supported and determined the development of care in rural areas of the state.

Health care is a major contributor to the state's economy. Health care accounted for eight percent of Alaska's employment in 2006, with 29,000 workers, and payroll of about $1.2 billion. Most of the jobs were in the private and tribal sectors – 93%. Fully one third of Alaska's health care employees worked in physicians', dentists' and other health practitioners' offices, with 40% in hospitals, and 9% in nursing home and other residential care. About 9% worked in outpatient care centers such as ambulatory surgery centers, dialysis centers, imaging facilities, and other diagnostic and treatment facilties, 6% worked in home health care, and 2% in other ambulatory care settings. Seven of the twenty five largest health care employers were tribal organizations – they accounted for 6,000 employees of 16,640 in those twenty five firms. Thus employment in the non-tribal private sector was likely about 23,000 in 2007, or at least 6% of the state's total employment.[3]

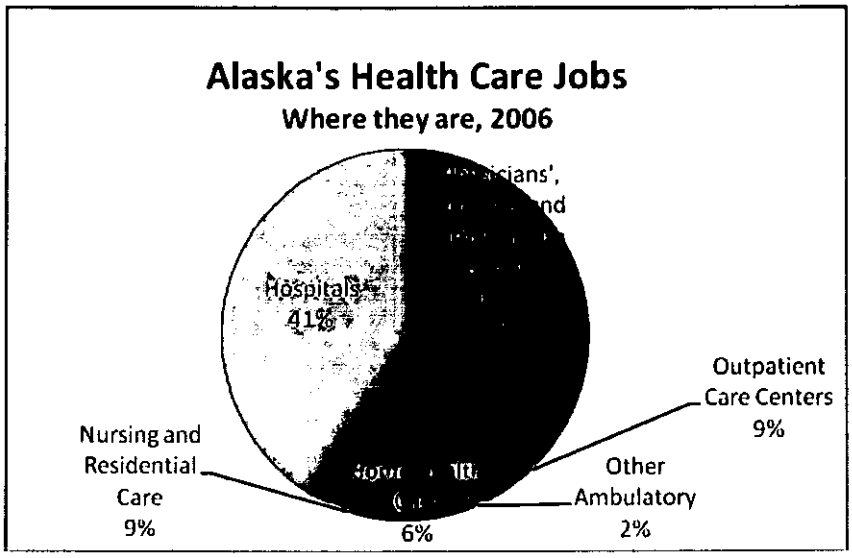

Figure 1: Alaska's Health Care Jobs, 2006

Thinking of health care services as a "continuum" of care from prevention through treatment, rehabilitiation, and maintenance of optimum health can help one comprehend the many different services, facilities and programs. A simplified graphical presentation shows relationships of some of the key components in Figure 2.

Figure 2: Continuum of Care

Least Intensive $		$$	**Most Intensive** $$$
Home/Community Based	Community & Regional Services &Facilities		Facility Based &/or High Tech
Prevention Early Intervention Case Management	Outpatient (Less Intensive) Day treatment	Intensive outpatient (Expanded O/P Services) Examples: day surgery, dialysis, cancer treatment	In-patient Medical Treatment (Hospital) Residential
Long Term Care: Home-based maintenance	Home health skilled care	Assisted living	Nursing Home

[3] Fried, N. "Alaska's Health Care Industry," Alaska Economic Trends, Anchorage, February 2008.

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1. PRIVATE HEALTH CARE SECTOR

The private health care sector includes an array of services from highly specialized diagnosis and treatment to primary care, prevention, and supporting goods and services. Firms range from self-employed professionals, contractors and small businesses to national corporations. Even the not-for-profit health services include very large entities like Providence Alaska Health Systems, the largest employer in Alaska with about 4,000 employees in 2006,[4] to small community-based community health centers like Bethel Family Health Services with 9 employees. Seattle, Washington is still the nearest source for some highly specialized services such as heart and other organ transplants and severe trauma treatment.

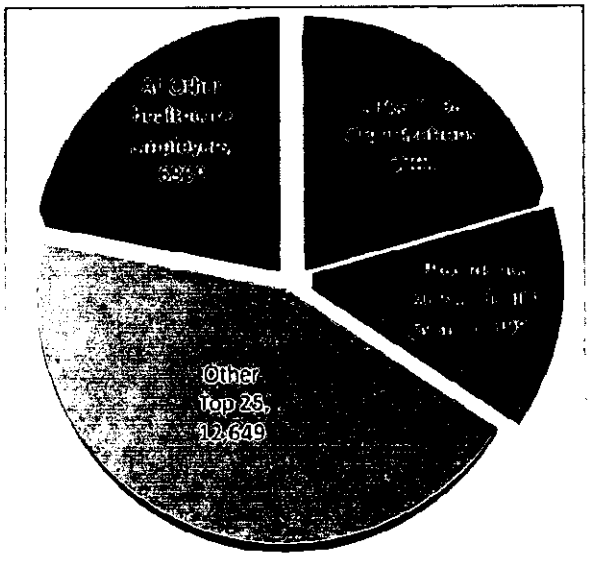

Figure 3: Distribution of Health Care Employment 2006

Only two of Alaska's hospitals are for-profit entities, Alaska Regional Hospital and North Star psychiatric hospital. However many of the free-standing diagnostic, treatment and ambulatory services facilties are for-profit entities. Private sector physicians, dentists, psychologists and other practitioners are either self-employed or have incorporated to pay themselves and staff salaries. Drug stores, medical supply companies, and many other support services are for-profit firms.

Nearly one-third (approximately 10,000) of all health industry jobs in 2007 were in private hospitals. Hospitals are major employers because "they're labor intensive and provide around–the–clock care; three shifts of workers cycle through the hospitals each day.[5]" The Alaska Department of Labor identifies 82 percent of Alaska's non-military employment in hospitals to be in the privately owned and managed facilities rather than local public or tribal facilities.

The private not-for-profit organizations include community-based Community Health Centers and mental health service agencies that receive grants from federal and state government programs. Although these organizations must meet guidelines of public programs, most are not government-run organizations – their boards of directors, employment policies, salary rates, goals and programs are governed by their own bylaws and policies.

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[4] Fried, N., "The Trends 100," Alaska Economic Trends, Anchorage, July 2009. P. 6.
[5] Ibid., p. 9.

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In Alaska, no "managed care organizations" exist in the private sector, and formal provider networks are lacking. However informal referral patterns, and "panels" of preferred providers associated with a variety of insurance programs, result in some structured relationships, and some facilities and groups are affiliated or jointly managed.

2. ALASKA TRIBAL HEALTH SYSTEM

The Alaska Tribal Health System (ATHS) is a voluntary affiliation of nearly 40 tribes and tribal organizations providing health services to American Indians/Alaska Natives (AI/AN) in Alaska. The ATHS is a diverse and multifaceted health care system that has developed over the last 30 years since passage of the 1975 Indian Self-Determination and Education Assistance Act (ISDEA). Each of the tribal health organizations within the ATHS is owned and operated independently, while remaining interconnected via the system's sophisticated patterns of referrals and their primary and common mission of improving the health status of Alaska's American Indian/Alaska Native (AI/AN) population.

Alaska has 228 federally recognized tribes, accounting for about 135,000 people. At present, Alaska Native villages are situated mostly along the coast and rivers of Alaska. The dispersal of the communities across a huge, mostly roadless territory accounts in large part for the creation of the innovative statewide health system.

As part of its trust responsibility to Native people, the federal government is required to provide a basic level of health care services to the AI/AN population. The trust responsibility deems these services "pre-paid" with aboriginal lands and authority that tribes ceded to the U.S. government in treaties. In 1975, Congress created a process for transferring Bureau of Indian Affairs and Indian Health Service health programs to tribal governments through the Indian Self-Determination and Education Assistance Act (ISDEA, Public Law 93-638). In doing so, Congress noted the past inadequacies of Native American health care, and reaffirmed its intention to involve tribes in health care programs through tribal self-governance.[6]

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[6]From Jumping Through Hoops: Traditional Healers And The Indian Health Care Improvement Act, 4 DePaul Journal of Health Care Law 843-860, 844-847 (Summer 1999) , accessed on http://academic.udayton.edu/health/02organ/Indian03.htm August 10, 2009:
"In passing the Act, Congress noted the government's "unique legal relationship with, and resulting responsibility to" Indians, necessitated the creation of a comprehensive health care system. The IHCIA set forth the following goals for the IHS:

(1) to assure Native Americans access to high-quality comprehensive health services in accordance with need;
(2) to assist tribes in developing the capacity to staff and manage their own health programs and to provide opportunities for tribes to assume operational authority for IHS programs in their communities; and
(3) to be the primary federal advocate for Native Americans with respect to health care matters and to assist them in accessing programs to which they are entitled. Subsequent amendments in 1992 extended the purpose of the IHCIA to raising the health status of Native Americans over a specified period of time to the level of the general United States population. Additionally, the IHCIA sought a high level of participation by Indian tribes in the planning and management of IHS programs, services, and demonstration projects under subsequent self-determination amendments.

The Alaska Native Medical Center (ANMC), a 156 bed facility in Anchorage, serves as the referral center for specialty care. The other tribally administered hospitals (former US Public Health Service hospitals) are located in the six rural communities of Sitka, Barrow, Bethel, Dillingham, Kotzebue and Nome. There are 36 tribal health centers and 176 tribal community health aide clinics. In many rural areas of the state tribal health organizations are the only health care providers available, and serve everyone in the area regardless of race or IHS-beneficiary status.

The federal Indian Health Service (transferred from the Bureau of Indian Affairs to the US Public Health Service in 1955) manages an Alaska Area Native Health Service office (one of eleven Area Offices) that works in conjunction with nine tribally operated service units to provide comprehensive health services to about 135,000 Alaska Native people. Services funded in-part by IHS are delivered by tribal health organizations, or under contract with non tribal service providers. The federal government through the IHS holds title to six tribally operated hospitals[7] and three tribally operated health centers in Alaska (on St Paul Island, Annette Island and Tanana Village) and is responsible for their maintenance.

Together, the tribal organizations that compose the ATHS operate an $800 million (FY2006) health care sector, and employ more than 7,000 full and part-time staff statewide. Beneficiaries are not charged for most services received within the ATHS. Financing for the entirety of the ATHS's programs is split between a variety of sources, including federal and state grants and contracts for specific services; Medicaid, Medicare, and private insurance revenue; rural sanitation funding; and other smaller sources of funding. While the Indian Health Service represents the largest funding source, it accounts for only 60% of total revenue.

The Alaska Tribal Health Compact, which authorizes tribes and tribal health organizations to operate health and health-related programs, was formed October 1,1994. The Alaska Native Tribal Health Consortium (ANTHC) was organized as a statewide non-profit health service organization owned by Alaska Natives and managed by all tribes in Alaska. Other "compact" organizations under P.L. 93-638 include the tribal health corporations that serve regions and specific communities. ANTHC manages all statewide health services formerly provided by the Indian Health Service. ANTHC has responsibility for essential statewide services, including the Alaska Native Medical Center,which it manages in conjunction with the Southcentral Foundation (the regional tribal health organization serving Anchorage and the surrounding communities).

The Compact is the umbrella agreement (also identified as P.L. 93-638, Title-V Self-Governance Compact) that sets forth the terms and conditions of the government-to-government relationship between Alaska Native tribes and/or tribal organizations, and the United States government through the Indian Health Service.[8] The 23 tribes and tribal organizations that belong to the Compact include:

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[7] The Alaska Native Medical Center in Anchorage, Samuel Simmons in Barrow, Kanakanak in Dillingham, Maniilaq Health Center in Kotzebue, Mt. Edgecumbe in Sitka, and Yukon-Kuskowim Delta Hospital in Bethel. Norton Sound Hospital in Nome is the only tribally managed hospital that is not Federally-owned.

[8] http://www.anhb.org/index.cfm?section=Advocacy

(footnote continued)

- Alaska Native Tribal Health Consortium
- Aleutian//Pribilof Islands Association Inc.
- Annette Island and SU--Metlakatla Indian Community
- Arctic Slope Native Association
- Bristol Bay Area Health Corporation
- Chugachmiut
- Copper River Native Association
- Council of Athabascan Tribal Governments
- Eastern Aleutian Tribes Inc.
- Ketchikan Indian Community
- Kenaitze Indian Tribe
- Knik Tribal Council
- Kodiak Area Native Association
- Maniilaq Association
- Mt. Sanford Tribal Consortium
- Native Village of Eklutna
- Norton Sound Health Corporation
- Seldovia Village Tribe
- Southcentral Foundation
- SouthEast Alaska Regional Health Consortium
- Tanana Chiefs Conference Inc.
- Yakutat Tlingit Tribe
- Yukon-Kuskokwim Health Corporation

In addition, there are 17 tribes and tribal organizations that contract with the Indian Health Services to provide health services under P.L. 93-638, Title I.

ANTHC Maps are available on www.anthc.gov
in formats that can be printed to large sheets for more legible readability:[9]

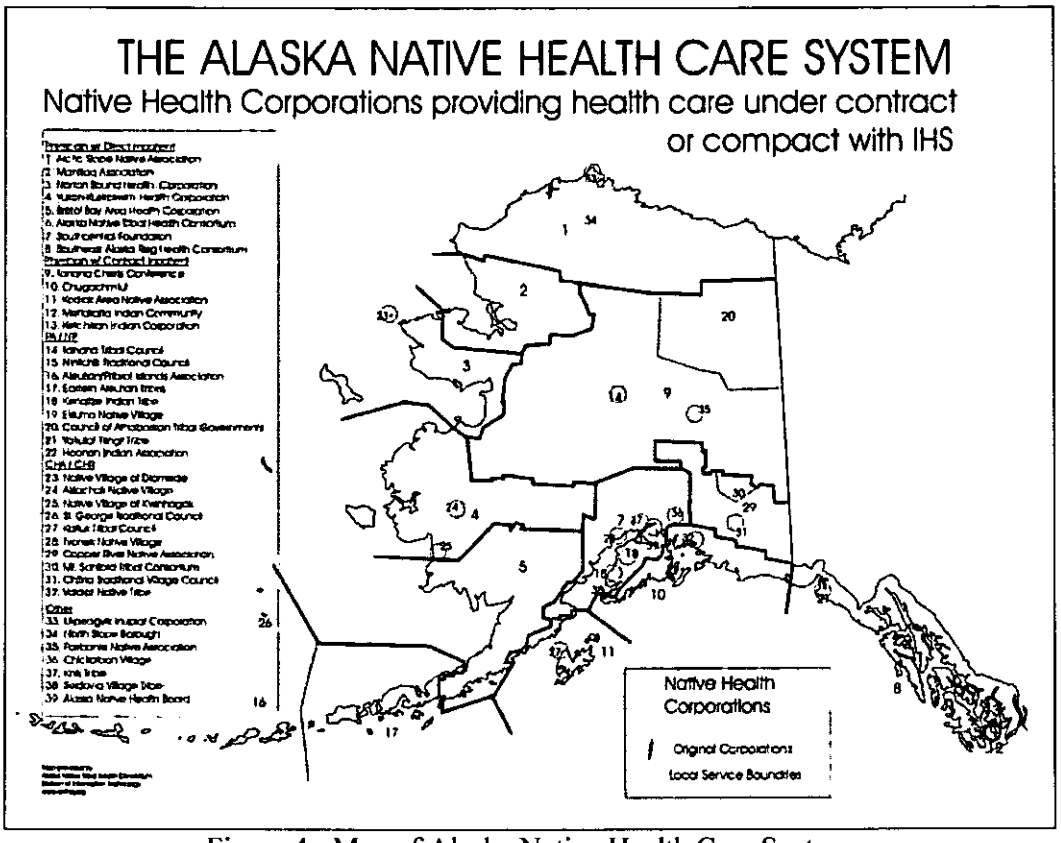

Figure 4: Map of Alaska Native Health Care System

3. U.S. MILITARY AND THE VETERANS AFFAIRS SYSTEMS

U.S. Department of Defense

About 50,000 active duty military and dependent Alaskans are eligible for health care services provided by the Department of Defense. Military retirees and veterans (numbering 76,000[10]) have access to certain services. The U.S. Air Force has responsibility for all military, dependents' and veterans' health care in the southern part of the state, and the U.S. Army is responsible for serving these populations in the northern part of the state. A major health center serves each of these areas: Elmendorf AFB Hospital serves the Southern Region,[11] and Bassett

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[9] Maps of the Tribal system as well as resource materials about its components are available on the website http://www.anthc.org/ref/maps/ .

[10] US Department of Veterans Affairs, http://www1.va.gov/opa/fact/statesum/akss.asp accessed 8/13/2009

[11] Southern Region: The 3rd Medical Group, Elmendorf AFB, Alaska is responsible for military services including Air Force, Army, Navy, Marine, Coast Guard, Army/Air National Guard and reserve services units and family members of active duty service personnel.. The health care services provided by the 3rd Medical Group include:

a. Primary Care- Pediatrics, Family Practice, Flight Medicine, Internal Medicine and Dental.

(footnote continued)

Army Community Hospital serves the Northern Region.[12] The Veterans' Administration runs an outpatient medical center in Anchorage, and clinics in Fairbanks, Wasilla and Kenai.[13] When a patient requires highly specialized care, he or she may be referred to a private sector hospital or, more often, to military medical centers out of state. The military has medical centers to serve local military installations in Alaska as well as to provide for surge capacity in times of emergencies. Alaska's military forces have the capability of airlifting complete surgical and hospital facilities to any part of the world or to provide services in times of national emergencies.

The Department of Defense (DOD) TRICARE program (formerly CHAMPUS) is a regionally managed health coverage program for active duty and retired members of the uniformed services, their families and survivors. TRICARE is not an insurance plan, but a health care entitlement program, funded by the U.S. Department of Defense (DoD) for active duty, Guard and Reserve and retired members of the military, and their eligible family members and survivors. TRICARE for Life now provides health care coverage to TRICARE beneficiaries 65 years of age or older. Beneficiaries need to pay the premium for participation in Medicare Part B (physician and other non-inpatient care). TRICARE provides services at military treatment facilities, and supplements that with access to civilian health care networks where necessary (much like the IHS Contract Health Care program).

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b. Specialty Care- Women's Health Clinic (OB/GYN), Physical and Occupational Therapy, Optometry/Ophthalmology, Ear/Nose/Throat, Surgery, and Nutritional Medicine
c. Ancillary- Pharmacy, Radiology, Laboratory
d. Inpatient services including Intensive Care Unit and Labor & Delivery
e. Emergency Care- Emergency Room (ER)
f. Supplementary Services-Family Advocacy Program/Social Work/Mental Health/Health Promotions and Life Skills.

[12] Northern Region: Bassett Army Community Hospital, Fort Wainwright, Alaska is attached to the Alaska Command, and reports to Chief of All Army Medical Services at Walter Reed Army Hospital. It serves Fort Wainwright, Eielson Air Force Base, Fort Greely and it associated units. Remote army sites are provided with health services through Troop Medical Clinics at Fort Richardson, Fort Greely and Eielson Air Force Medical Clinic. The health care services provided by are:

a. Primary Care
b. Women's Health Care
c. Orthopedics
d. Audiology
e. Health Promotion
f. Medical Laboratory and X-Ray
g. Mental Health Care
h. Dental Care
i. Pharmacy

[13] Sources:

- 3rd Medical Group Elmendorf AFB website: www.elmendorf.af.mil/units/3rd Medical Group
- Alaska VA Healthcare System and Regional Office: www.visn20.med.va.gov/Alaska. and, www.va.gov/hac/forbeneficiaries/champva.asp
- MEDDAC – Fort Wainwright, Alaska website: www.wainwright.army.mil/sites/local

Alaska Veterans Administration (VA) Healthcare System

The Alaska VA Healthcare System and Regional Office offer primary, specialty, and mental health outpatient care. Services are provided at the Anchorage VA Medical Center, on Elmendorf Air Force Base (through a joint venture with the USAF), and through fee-based arrangements with community hospitals in Fairbanks, Wasilla and Kenai.[14] The VA Medical Center in Anchorage also features a comprehensive Homeless Veteran Service consisting of a Domiciliary Residential Rehabilitation Treatment Program, Veterans Industries, Psychosocial Residential Rehabilitation Treatment Program, VA Supported Housing Program and outreach. These health care services are provided and coordinated through the Anchorage VA Medical Center. In addition to this center of care, the Veterans Administration has established a system of Community Based Outpatient Clinics located at Fort Wainwright, Kenai, and Wasilla.

A pilot project announced in September 2009 is intended to enable veterans to get care through community health centers or other local clinics with Veteran's Administration reimbursement so that less travel for care should be involved.

Coast Guard Clinics

The US Coast Guard history of service in Alaska dates back to the Revenue Cutter Service. Coast Guard personnel and their families are stationed throughout Alaska, including remote sites such as Port Clarence, St. Paul, Attu, Dutch Harbor, and Shoal Cove. Coast Guard clinics in Kodiak, Juneau, Sitka, and Ketchikan support the health care needs of the nearly 5,000 Coast Guard members and their families in Alaska.[15]

Alaska Federal Health Care Partnership

Alaska Federal Health Care Partnership (AFHCP) is a voluntary partnership of the organizations serving the federal health care beneficiaries in Alaska. AFHCP combines the healthcare resources of the Alaska Native Medical Center, Alaska Native Tribal Health Consortium, Department of Defense, Department of Homeland Security, Department of Veterans Affairs, U.S. Coast Guard, and the Indian Health Service. The combined beneficiary population of these organizations is over 250,000 with some beneficiaries having dual, or even triple, eligibility within the health and wellness provider systems. The Partnership represents over 250 health care facilities across the state-- from isolated village clinics staffed by health aides in the most remote parts of Alaska, to the Alaska Native Medical Center, the military hospitals in Anchorage and Fairbanks, and the extensive VA clinical services in the Anchorage area.[16]

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[14] About eighty health care providers are paid for by the Veterans Administration at the Elmendorf AFB Hospital, for providing emergency room care, intensive care and staffing for a medical services unit. The Veterans Administration also provides social workers to this hospital.

[15] http://www.afhcp.org/coast%20guard.html

[16] Alaska Federal Health Care Partnership website http://www.afhcp.org/index.html accessed 8/13/2009

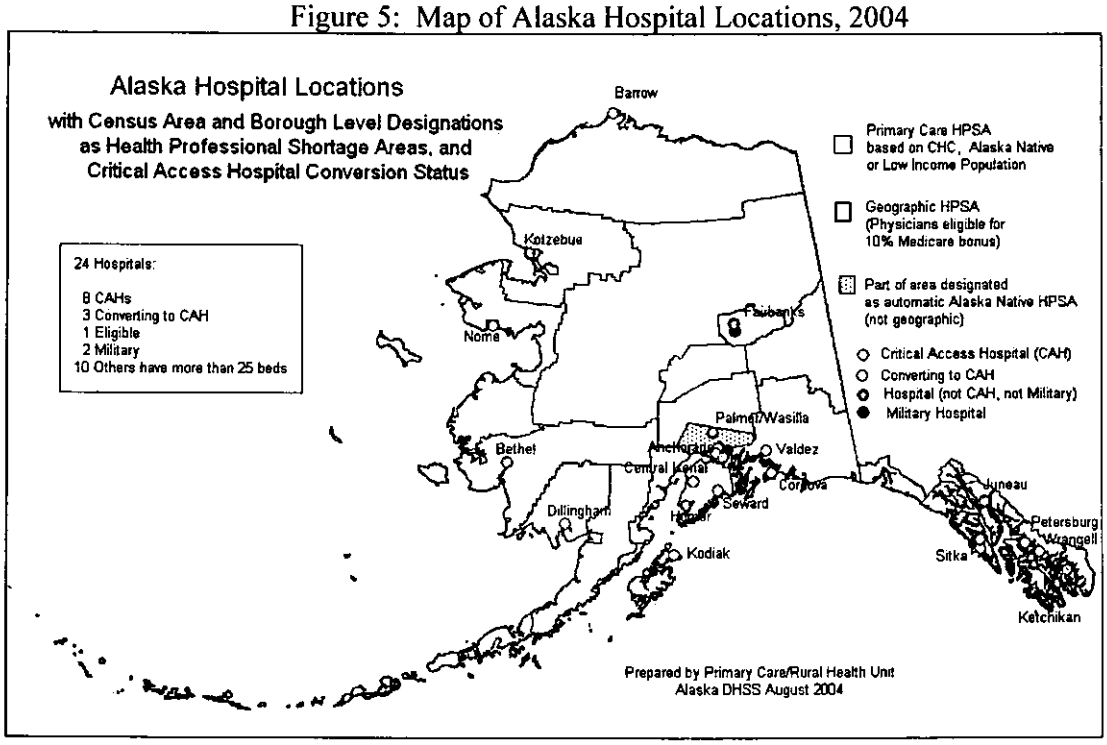
B. FACILITIES

I. MEDICAL FACILITIES

1. HOSPITALS

There are 27 hospitals in Alaska: 24 that provide general acute care (including two military and seven tribally operated hospitals), and three specialized hospitals (one long term acute care and two psychiatric hospitals).[17] The greatest concentration of hospitals is in the Anchorage/Mat-Su region.[18] The relatively large hospitals in Anchorage and Fairbanks serve as referral facilities for providers from rural areas of the state. Hospitals in Seattle also serve as key referral destinations for residents of Alaska in need of "high tech" and specialty services.

Figure 5: Map of Alaska Hospital Locations, 2004



Statewide, there are 1,562 beds in Alaska hospitals, not including those operated by the military. Of those beds, 154 are psychiatric in the two specialized hospitals, 60 are "long term acute care,"

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[17] A general acute care hospital must provide surgical, anesthesia, perinatal, medical, nursing, pharmaceutical, dietetic, laundry, medical records, radiological, laboratory, and emergency care services. Such a hospital must also provide speech, occupational, or physical therapy services. A rural primary care hospital or a critical access hospital must provide the services of a general acute care hospital except that the provision of surgical, anesthesia, perinatal, speech, occupational therapy, or physical therapy services is optional. A long-term acute care hospital must provide medical, nursing, pharmaceutical, dietetic, occupational therapy, physical therapy, laundry, medical records, radiological, social work, respiratory, and laboratory services. (7 AAC 12.105)

[18] http://www.hss.state.ak.us/dph/Healthplanning/publications/healthcare/default.htm (Alaska Health Care Data Book, figure 4.170)

5055

and 1348 are acute care beds (of which 146 are identified as swing beds that can be used for acute or long term care).

TABLE 1: ALASKA HOSPITALS, 2008

Region/Hospital	*Location*	*Licensed Beds***	*Governance*
Anchorage Matanuska-Susitna Region			
Providence Alaska Medical Center	Anchorage	326	Private Non-Profit
Alaska Regional Hospital	Anchorage	250	Private For-Profit
Alaska Native Medical Center	Anchorage	150	Tribal Health Corporation; Federal ownership
Air Force Medical Center – Elmendorf	Anchorage	105	Federal Military
Mat-Su Regional Medical Center	Palmer	74	Private Non-profit
St. Elias Long Term Acute Care Hospital	Anchorage	60	Private Non-Profit
Alaska Psychiatric Institute	Anchorage	80	Public State
North Star Hospital	Anchorage	74	Private For-Profit
Interior Region			
Fairbanks Memorial Hospital	Fairbanks	152	Private Non-Profit
Bassett Community Army Hospital	Ft. Wainwright	55	Federal Military
Southeast Region			
Bartlett Regional Hospital	Juneau	71	Public Municipal
Ketchikan General Hospital*	Ketchikan	25	Public Municipal
Petersburg Medical Center*	Petersburg	12	Public Municipal
Mt Edgecumbe Hospital	Sitka	27	Tribal Health Corporation; Federal ownership
Sitka Community Hospital *	Sitka	12	Public Municipal
Wrangell Medical Center*	Wrangell	8	Public Municipal
Gulf Coast Region			
South Peninsula Hospital*	Homer	22	Public Municipal
Providence Kodiak Island Medical Center*	Kodiak	25	Public Municipal
Providence Seward Medical Center*	Seward	6	Public Municipal
Central Peninsula Community Hospital	Soldotna	49	Public Municipal
Providence Valdez Community Hospital *	Valdez	11	Public Municipal
Cordova Community Medical Center*	Cordova	13	Public Municipal
Southwest Region			
Yukon-Kuskokwim Delta Regional Hospital	Bethel	50	Tribal Health Corporation; Federal ownership
Kanakanak Hospital*	Dillingham	16	Tribal Health Corporation; Federal ownership
Northern Region			
Norton Sound Regional Hospital*	Nome	18	Tribal Health Corporation
Simmonds Memorial Hospital*	Barrow	14	Tribal Health Corporation; Federal ownership
Manillaq Medical Center*	Kotzebue	18	Tribal Health Corporation; Federal ownership

*Critical Access Hospital

** Total beds include licensed and/or certified acute care and swing beds. Many hospitals are operating with fewer beds than the number licensed.

Data Source: Health Facilities List, Licensing and Certification Section, Division of Public Health 2009

The scope of services provided by Alaska's urban hospitals has been changing dramatically. Bed counts have remained quite stable in the last decade, but hospital "campuses" have grown to accommodate an array of emerging technologies and day treatment services that were formerly available only as inpatient services or out-of-state. Examples of services that have been introduced by hospital systems in the last five years include: cardiac catherization, cardiac electrophysiology ablation, cardiac rehabilitation, chemotherapy and cancer services, renal dialysis, pediatric medicine, birthing centers, outpatient surgery, sleep disorder testing, sports medicine rehabilitation, and expanded hospice and home care. The addition or expansion of these services to Alaska's urban hospitals has provided an incentive to physicians and businesses that support these services to establish residence and to provide care in Alaska, often partnering with the hospital care system. This has allowed Alaskans to receive care in-state.

Alaska's hospitals in communities with populations smaller than 30,000 – that is, outside of Anchorage, Mat-Su, Fairbanks and Juneau – are recognized to be critical "economic engines" of their communities, providing jobs directly, and providing assurance of emergency services and access to care for residents of their service areas, and for employers who want to attract workers. The Balanced Budget Act of 1997 (Public Law 105-33) established the Medicare Rural Hospital Flexibility Program, a national program designed to assist states and rural communities in improving access to health care services in rural areas through the development of limited service hospitals and rural health networks. Thirteen Alaska hospitals (see table above) are now certified by Medicare as Critical Access Hospitals (CAH) enabling them to obtain cost-based reimbursement rates from the Federal Medicare program.

Critical Access Hospital Certification

A Critical Access Hospital (CAH) is an acute care facility that provides emergency, outpatient, and limited inpatient services and may be linked to full service hospitals and other types of providers in a rural health network. CAHs generally provide inpatient care for up to 96 hours, unless discharge or transfer is precluded due to inclement weather or other emergency conditions. CAHs may maintain up to 25 beds to furnish both acute and skilled nursing level care, provided that no more than 15 of these beds are used for acute care at any one time. A CAH may operate nursing home beds or provider-based services like home health. CAHs are reimbursed on a "reasonable cost" basis for services provided to Medicare beneficiaries.

Trauma Center Designation

Alaska's highest level Trauma Center (Level II) is the Alaska Native Medical Center (ANMC). Level II Trauma Centers provide comprehensive trauma care, serving as the lead trauma facility for a geographical area. Emergency physicians and nurses are available in-house to provide direct patient care and initiate resuscitation and stabilization. Prompt availability of general surgeons and certain specialty surgeons is required. A Level II Trauma Center also provides educational outreach and prevention programs, and assumes responsibility for trauma system leadership in the absence of a Level I Trauma Center. Under ACS criteria, Level I centers must conduct trauma research and teach trauma care physicians. Cities in Alaska do not have the patient loads or academic medical centers to support this level of care and the nearest Level I

Trauma Center is located in Seattle. There are four Level IV-designated Trauma Centers in Alaska: Norton Sound Regional Hospital (Nome), Yukon-Kuskokwim Delta Regional Hospital (Bethel), Mt. Edgecumbe Hospital (Sitka), and Sitka Community Hospital (Sitka).

2. Outpatient Facilities

Recent changes in technology and medical practice have allowed patients to receive some services as outpatients rather than being hospitalized. Outpatient services can be performed in a hospital setting or in a freestanding facility. Currently the State of Alaska licenses ambulatory surgery centers, and birthing centers, as authorized by Alaska Statute 47.32. (It also licenses hospitals that may offer ambulatory surgery and ESRD services.)[19] In addition, Alaska has Medicare certified end stage renal disease facilities.

An ambulatory surgical facility provides surgery and anesthesia service, in some cases including pain management and diagnostic services, in an outpatient setting. Ambulatory Surgery Centers (ASC) (which may be called outpatient surgery centers or same-day surgery centers when part of a hospital) perform procedures that are more intensive than those done in the average doctor's office, but not so intensive as to require a hospital stay.

In order for a facility to be licensed as an ASC, services must comply with the state's standards for surgical and anesthesia services in general acute care hospitals. There are also requirements, similar to hospital medical staff regulations,[20] for physicians working in these licensed facilities. Currently there are nine licensed Ambulatory Surgery Centers in the state.

Freestanding Birthing Centers are facilities which are not a hospital or in a hospital, where births are planned to occur away from the mother's residence following normal, uncomplicated pregnancy. The state has eight licensed Birthing Centers: one each in Juneau, Soldotna and Fairbanks, and three in Anchorage and two Wasilla.

Alaska also has Medicare certified facilities for treatment of end stage renal disease, commonly referred to as dialysis centers. Dialysis is used to provide an artificial replacement for lost kidney function. It may be used for acutely ill patients who have suddenly but temporarily lost their kidney function and require services for only a short time period; but is used mostly for patients who have permanently lost their kidney function and require dialysis for a long, indefinite period of time. The state currently has seven Medicare certified End State Renal Disease facilities.[21]

Other diagnostic and testing services now being established in some instances as freestanding businesses are imaging (including Magnetic Resonance Imaging and CT Scan), sleep studies,

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[19] Per AS 47.32.010

[20] Purpose and accountability include that "the provisions of AS 47.05.300 - 47.05.390, regarding criminal history, criminal history checks, criminal history use standards, and a centralized registry, apply to entities listed in (b) of this section, as provided in AS 47.05.300 ."

[21] Licensing and Certification Section, Division of Public Health 2009

and laboratories. Such entities are being called "Independent Diagnostic Testing Facilities" (IDTF)when they are not engaged in patient treatment, but perform diagnostic tests by certified non-physician personnel under physician supervision. These facilities are independent of a hospital or physician's office. The state does not license IDTFs but does monitor the credentials of staff performing tests and the proper functioning of diagnostic equipment used by the facility.

3. Community Health Centers (CHCs) and Special Clinic Certifications

Community Health Centers (CHCs, sometimes referred to as "330 Clinics") are non-profit, community-based organizations that provide health care to low income and medically underserved areas and populations. The CHC program was established under section 330 of the Public Health Services Act, and federal grant funding is provided through the US Department of Health and Human Services, Health Resources and Services Administration (HRSA).[22]

Similar to many outpatient medical clinics, CHCs are required to provide typical primary care services[23] including:

- Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology provided by physicians, physician's assistants, nurse practitioners, nurse midwives, and health aides.
- Diagnostic laboratory and radiological services.
- Preventive services (prenatal services; screening for breast and cervical cancer; well-child services; immunizations; screenings for communicable diseases, environmental contaminants, and chronic health conditions; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; family planning services; and preventive dental services.)
- Emergency medical services.
- Pharmaceutical services.

Additionally, community health centers are expected to provide:

- Referrals to providers of health related services including substance abuse and mental health services.
- Patient case management services including counseling, referral, and follow-up services.
- Patient education regarding health conditions and the availability and use of health services.

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[22] For criteria for designation of Medically Underserved Areas/Populations and and health professional shortage areas, see http://bhpr.hrsa.gov/shortage/index.htm, www.hss.state.ak.us/dhcs/healthplanning or http://www.hss.state.ak.us/dph/healthplanning/primarycare/MUA.htm

[23] Primary care is the provision of professional, comprehensive health services that include health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health problems, and the overall management of an individual's or family's health care services. It entails first-contact care of persons with undifferentiated illnesses, comprehensive care that is not disease or organ specific, care that is longitudinal in nature and care that includes the coordination of other health services.

CHCs differ from privately run physician offices and clinics in several ways. They are required to include a majority of consumer representatives on their Boards of Directors. Their funding is contingent upon demonstration in their funding proposals and utilization reports that they attend to the health status of the entire community in addition to the clinic's patient population. This often means that CHCs participate in prevention program opportunities to address such conditions as diabetes, hypertension, or chronic obesity. Further, chronic care management, medical homes, and the benchmarking of patient outcomes have been the foci of health center activities.

US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care periodically makes US Public Health Service, Section 330 funds available to CHCs to expand their scope of services. Oral health and mental health services are two of the services that have been the focus of additional funding available to CHCs. Many Alaska CHCs have taken advantage of these funding opportunities, and increasingly CHCs are co-locating or otherwise integrating the provision of general dentistry and behavioral health services into their primary care clinics.

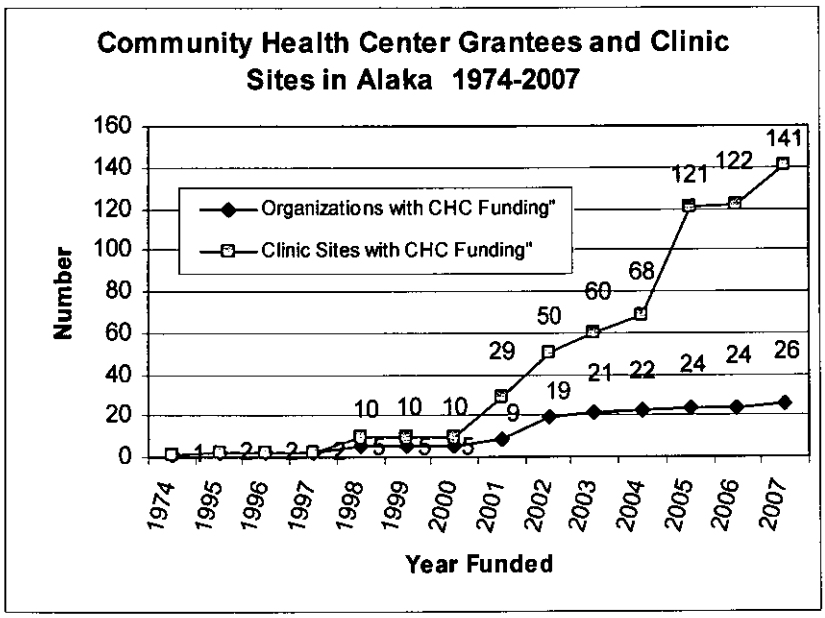


Figure 6: Growth in Number of Community Health Center Grantees and Clinics, 1974 - 2007

Between 1995 and 2009 the number of Community Health Centers in Alaska that were funded in part through Section 330 of the Public Health Service Act grew from two provider agencies – the Anchorage Neighborhood Health Center and Interior Neighborhood Health Center (Fairbanks) who were operating four sites in 1995, to 26 agencies operating 145 healthcare delivery sites.[24]

Community Health Centers are by definition "Federally Qualified Health Centers," or "FQHCs," which are further defined by section 1861 of the Social Security Act. [25] Tribally managed clinics are also FQHCs.

[24] Based on the sites listed as reporting to the Bureau of Primary Health Care's Uniform Data System. ftp://ftp.hrsa.gov/bphc/pdf/uds/2007/07Rollup_StateAK_08Jul2008.pdf

[25] Section 1861 of the Social Security Act "(4) The term "Federally qualified health center" means an entity which—

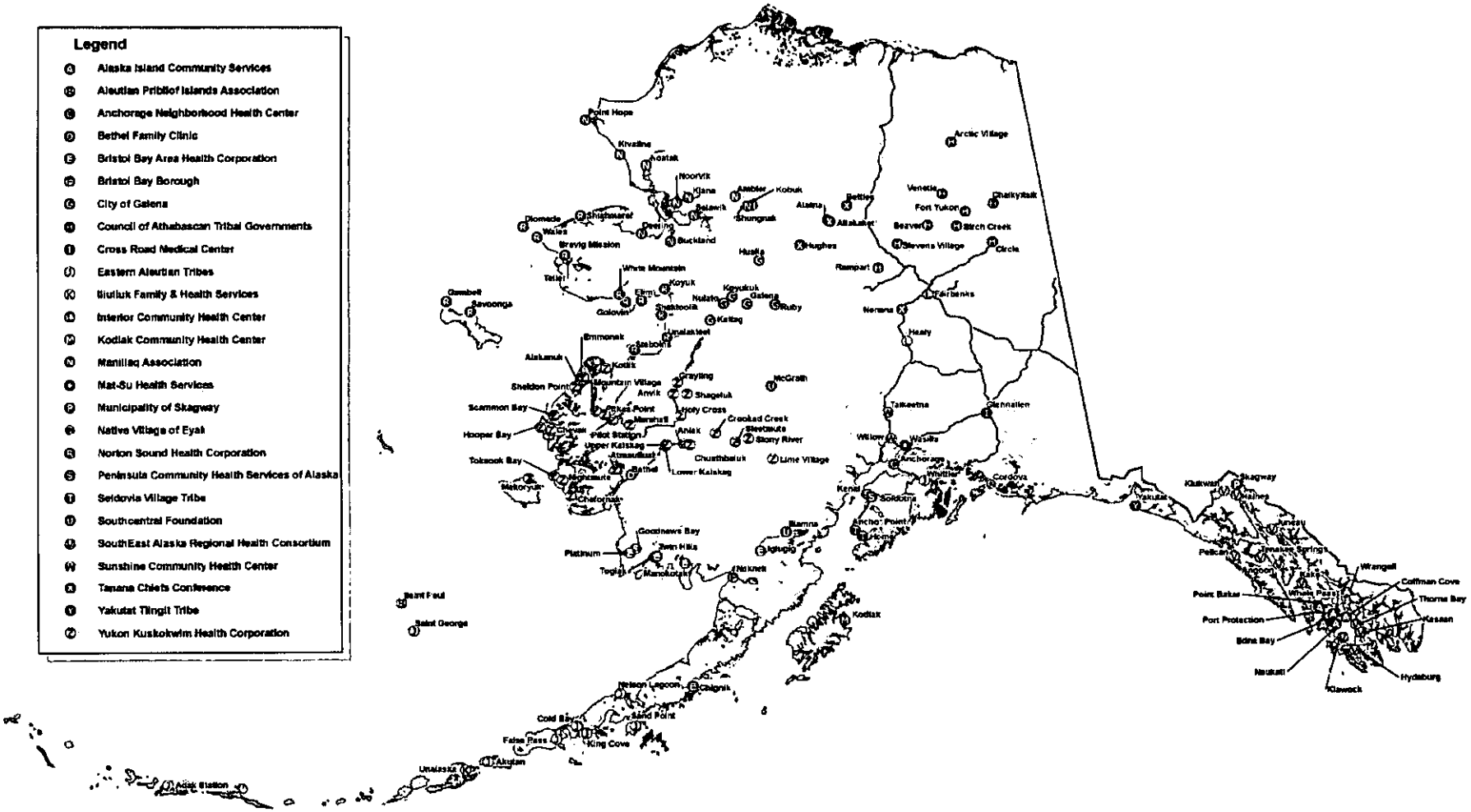
(A)(i) is receiving a grant under section 330 (other than subsection (h)) of the Public Health Service Act, or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 (other than subsection (h)) of such Act;

(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;

(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990; or

(D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act[423]."

Figure 7: Map of the Alaska Community Health Centers, Prepared by Alaska Primary Care Association (David Wilson), Jan. 2009



Frontier Extended Stay Clinics

In remote frontier areas of the country weather and distance can prevent patients who experience severe injury or illness from obtaining immediate transport to an acute care hospital. For residents in some of these communities providers offer observation services traditionally associated with acute care inpatient hospitals until the patient can be transferred or is no longer in need of transport. A Medicare demonstration project is under development in Alaska in which "Frontier Extended Stay Clinics" (FESCs) would be able to be reimbursed more adequately for the extended services provided to Medicare and Medicaid patients, as Medicare certified providers of these services.

Rural Health Clinics

A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs must provide outpatient primary care and laboratory services, and are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner.

RHCs can be for-profit or non-profit entities, and can be either publicly or privately owned and operated. Medicare visits are reimbursed based on allowable costs, and Medicaid visits are reimbursed under the cost-based method or an alternative Prospective Payment System (PPS). This may result in an increase in reimbursement over typical Medicare and Medicaid fee-for-service reimbursement rates.[26]

Rural Health Clinic certification was established under the Rural Health Clinics Act, passed by Congress and signed into law in 1977. The goal of this Act was twofold. First, it encouraged the utilization of physician assistants (PAs) and nurse practitioners (NPs) by providing reimbursement for services to Medicare and Medicaid patients by these health professionals, even in the absence of a full-time physician.[27] Second, it created a cost-based reimbursement

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[26] Downloaded 08-17-09: http://www.raconline.org/info_guides/clinics/rhcfaq.php#whatis

[27] A physician assistant (PA) is a licensed health professional who practices medicine under the supervision of a physician. A physician assistant provides a broad range of health care services that were traditionally performed by a doctor. As part of the physician/PA team, a physician assistant exercises considerable autonomy in diagnosing and treating illnesses. What a physician assistant does varies with training, experience, and state laws. In general, PA's can provide approximately 80 percent of the services typically provided by a family physician. They perform physical exams, diagnose illnesses, develop and carry out treatment plans, order and interpret lab tests, suture wounds, assist in surgery, provide preventive health care counseling, and in 39 states, can write prescriptions. A PA can do whatever is delegated to him/her by the supervising physician and allowed by law. The scope of the PA's practice corresponds to the supervising physician's practice. For example, the PA working with a surgeon would be skilled in surgical techniques in the operating room, perform pre- and post-operative care, and be able to perform special tests and procedures.

Nurse Practitioner: The American Academy of Nurse Practitioners defines Nurse Practitioners as licensed independent practitioners who practice in ambulatory, acute and long term care as primary and/or specialty care providers. They provide nursing and medical services to individuals, families, and groups according to their area of practice/specialty. In addition to diagnosing and managing acute episodic and chronic illness, they also emphasize
(footnote continued)

mechanism for services when provided at clinics located in "underserved" rural areas.[28] Because of subsequent changes in the Medicare law authorizing Medicare Part B coverage for PAs and NPs in all practice settings (not just RHCs), the original incentive for utilizing PAs and NPs was diminished. However, because a RHC gets reimbursed the same amount from Medicare and Medicaid regardless of whether the patient is seen by a mid-level provider (MLP) such as a PA, NP, Certified Nurse Midwife (CMN), or physician, the clinic continues to have a strong incentive to utilize these practitioners whenever it is clinically appropriate.

In Alaska where a majority of rural primary health care programs have been run with funding from the Indian Health Services (IHS) and Section 330 Community Health Center grants (USDHHS Health Resources and Services Administration), the RHC program has not provided the same financial advantages that it has in other states. Tribally managed clinics have more favorable reimbursement rates than Rural Health Clinics for their Medicare and Medicaid patients. Also, many of the tribal clinics are already within the Community Health Center program.

There are currently three Medicare-certified Rural Health Clinics in Alaska: the Edgar Nollner Health Center in Galena, the Hoonah Midlevel Practice Clinic, and the Yakutat Community Health Center.

4. Physician, Dentist and Other Professional Offices

Many physicians and dentists in Alaska are practicing in solo practice offices, but many share professional office space with others or form group practice offices. Some are primary care physician offices, others include one or more specialties. Physicians and dentists, as well as other specialty service providers, are concentrated in Alaska's largest communities, likely due to the amenities available, support staff availability, referral resources, and access to other resources. As noted above, about a third of health care jobs are in health practitioners' offices, according to the industry survey data of the Alaska Department of Labor.[29] Thus in terms of practice settings, professional offices are the most common place of work.

Urgent care centers

Some physicians operate their office as an urgent care center or clinic. They have been established in Anchorage, Fairbanks, Juneau, Kenai, and the Matanuska-Susitna Valley. These can be operated by a single physician or group of practitioners, or the center can be affiliated with a hospital based health care system. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care, on an unscheduled or walk-in basis, but who's condition is not serious enough to warrant a visit to a hospital emergency department. Often urgent care clinics are not open on a continuous basis, unlike a hospital emergency room,

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health promotion and disease prevention, incorporating teaching and counseling of individuals, families, and groups as a major part of their practice.

[28] "Underserved" means that an area has too few providers to meet the needs of the population. For official designation as an "underserved" area, the area needs to be found to be a "health professional shortage area," or HPSA, as defined in Federal regulations. The Alaska Primary Care Office in AKDHSS handles designation applications to the USDHHS health Services and Resources Administration, HRSA.

[29] Fried, N. "Alaska's Health Care Industry," *Alaska Economic Trends*, February 2008.

but provide extended hours compared to a primary care physicians office. They often provide basic laboratory and imaging services, and referral is made to the appropriate health care provider for follow-up care and treatment. Urgent care centers have the same licensing requirements as that of a primary care physician's office or practice.

5. Mid-Level Provider Clinics

Mid-level providers (MLPs) include Nurse Practitioners, Certified Nurse Midwives, and Physician's Assistants.[30] Clinics staffed by MLPs include a handful of private clinics established by these providers. Several community clinics (such as Gustavus and Hoonah) run by communities or tribal organizations have hired mid-level providers as full-time or part-time staff, since the community does not have a population base sufficient to support a physician practice. Another example of mid-level clinic models in use in Alaska is the workplace clinic model used on the North Slope, where oil companies provide contracted physician's assistant services for their employees.

6. Publicly provided clinical medical services

Services provided by state and local health departments include the Municipality of Anchorage and State Public Health Nursing and emergency preparedness immunization programs' services, Early and Periodic Diagnosis and Testing (EPSDT), home visits to high risk newborns and families (upon referral), newborn hearing screening, infectious disease follow-up including follow-up of contacts, Sexually Transmittted Diseases screening and partner management, foodborne outbreak follow-up, and other services.

Alaska Health Fairs and various periodic volunteer programs including the "Northern Edge" training program (sponsored and carried out by the military) bring additional screening, health education, and in some instances treatment services, to selected communities each year. Also, for several years, Anchorage Project Access has organized voluntary donations of services by physicians, especially specialists, and has matched patients with physicians. The Anchorage Neighborhood Health Center (providing primary care services as a Community Health Center) has referred a number of its patients requiring more highly specialized care than the CHC can provide.

7. Comment on Health Care Safety Net

"Health Care Safety Net" is a term used to refer to health care providers who are required by law to see patients regardless of ability to pay. The"health care safety net" includes a wide variety of providers delivering care to low-income and other vulnerable populations, including the uninsured and those covered by Medicaid. Major safety net providers include public hospitals and community health centers as well as teaching and community hospitals, private physicians, and other providers who deliver a substantial amount of care to these populations.

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[30] Definition of NPs and PAs in previous footnote.

8. Health Facilites and the "Certificate of Need" Requirement

The Certificate of Need (CON) program as established in statute AS 18.07 is intended to promote the rational planning of health care facilities and health care services, improve citizen access to and choice of health care facility services, review the availability of qualified human resources available to staff facilities and provide services, contain the costs to the state for health care facility services paid for by public funds, and avoid the proliferation of unneeded health care facilities and services in the state through the application of approved standards, review of the needs and activities of an area, and considering input from residents.[31]

The certificate of need requirements of AS 18.07 apply to the following health care facilities licensed under AS 47.32:[32]

- an acute care hospital;
- a critical access hospital;
- an ambulatory surgical center;
- an intermediate care facility for the mentally retarded;
- a nursing facility;
- a psychiatric hospital;
- a residential psychiatric treatment center.

The CON requirements also apply to certain health care facilities that are not licensed under AS 47.32: independent diagnostic testing facilities and kidney dialysis centers. For facilities other than nursing homes and residential psychiatric treatment centers, the process is required if costs will exceed $1.3 million (as of 2009, threshold raised $50,000 each fiscal year).

II. LONG TERM CARE SERVICES AND FACILITIES

Long term care is distinct from acute care, which focuses on curing an illness or restoring an individual to a previous state of better health. Long term care encompasses a broad range of assistance, services, and supports to meet health and personal care needs over an extended period of time, from nursing home care to home based assistance.

The primary goal of long term care services is to enable senior citizens and disabled individuals to remain in their homes or communities and includes not only health care but services necessary to maintain quality of life including such things as housing and transportation.

Long term care is provided in a range of settings known as a "continuum of care" depending on an individual's needs and preference (Figure 8).[33] Most long term care is non-skilled personal care assistance, commonly referred to as custodial care, such as help performing everyday Activities of Daily Living (ADL) such as bathing and dressing, in the individual's home. Another level of care in the patient's home is home health care provided by skilled and licensed

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[31] As articulated in public notice for regulations 8/12/2009

[32] Certificate of Need Program website http://www.hss.state.ak.us/dph/healthplanning/cert_of_need/

[33] Definitions for ***Continuum of Care Matrix,*** http://www.hss.state.ak.us/dph/healthplanning/movingforward/matrices/RDdefs.htm

medical professionals. Alaska currently has 16 licensed Home Health Care agencies which provide skilled medical care to patients in their homes. Of these 16 agencies, nine are hospital based.

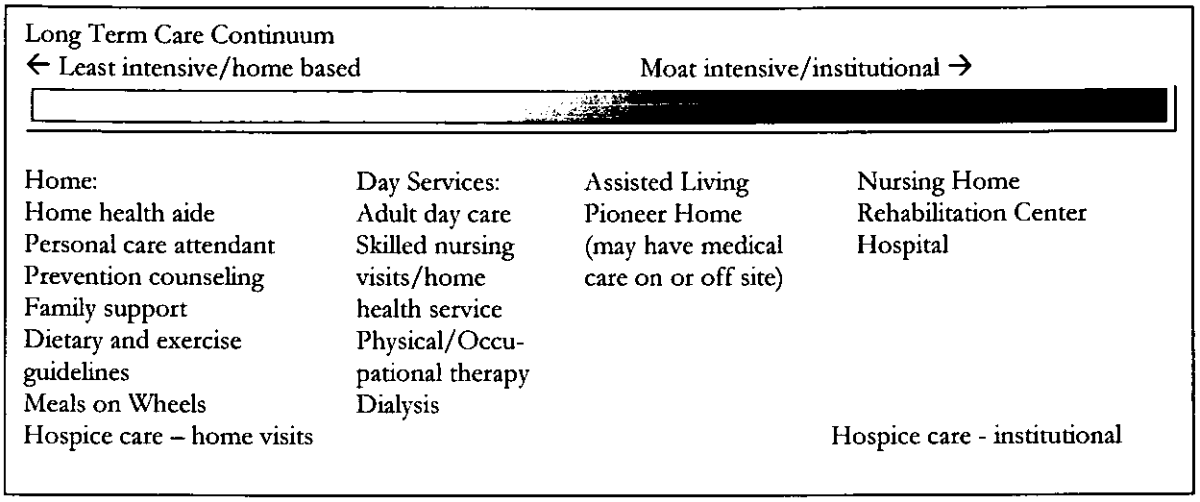

Figure 8: Long Term Care Continuum of Care

When a patient is terminally ill, regardless of age, hospice care can be a choice for the patient and their family. Hospice care provides support by both medical professionals and trained volunteers focusing on the palliation, or relief of symptoms, of a terminally ill patient. This support can be physical, emotional, spiritual, or social. The State currently has 12 licensed Hospice agencies.

Senior housing provides living arrangements designed for handicapped accessibility and convenient access to services. When a senior citizen or disabled individual is no longer able to remain in his or her own home, or with supportive family members, other types of residential care may be available to allow the person to remain in the community. Group homes with assistive services are called "assisted living" facilities. Alaska Pioneer Homes are state-run assisted living homes. Assisted living beds (other than Pioneer Homes) average 2200 annually according to State Certification and Licensing, in about 260 homes.[34] The six Pioneer Homes have 508 beds. Skilled Nursing Facilities (SNFs) or nursing homes provide intensive services for those needing a higher level of care. They offer both short and long-term placements for senior who require significant nursing interventions each day. Alaska has 15 nursing homes with 716 beds.[35]

Assuming that age-specific migration and mortality patterns will remain similar to the current (2000-2005) patterns, it is projected that the population aged 65 and older will nearly triple by

[34] 2009 count is 269 licensed senior assisted living facilities with 2,346 beds.
[35] Current Facilities List, by email from Certification and Licensing, July 31, 2009

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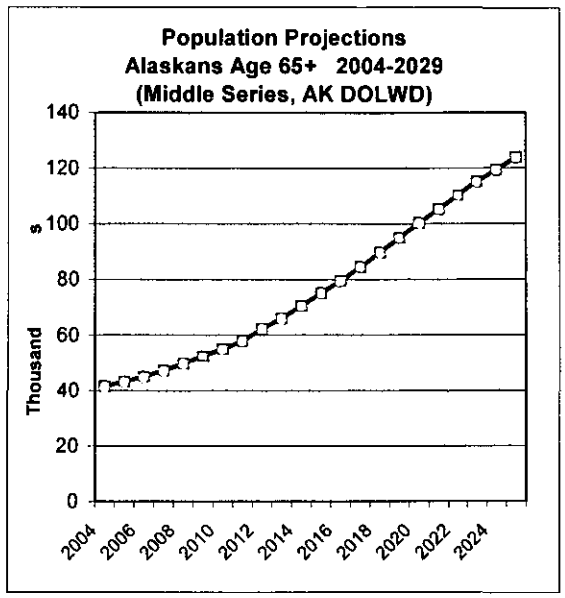
2025, from about 43,000 people in 2005 to about 124,000 in 2025.[36] Those who are 85 and over have the highest rates of use of long term care.

The Commission on Aging along with the Department of Health and Social Services, through their 2008-2011 Plan identifies the goal of Alaska seniors staying in their communities, and having access to an integrated array of health and social supports along the continuum of care.[37] These goals identify the concern for individuals to be able to maintain quality life through the least invasive and expensive services required in the continuum of care.

Figure 9: Population Projections Alaskans Age 65+, 2004-2029



The goal of keeping people in their homes and communities is also expressed through planning for services for individuals with developmental disabilities, to provide home and community based services where possible, for housing and support for employment.

Table 2: Number of Agencies Providing Long Term Care Services

Selected Agencies Providing Long Term Care Services	Number	Types of Employees	Beds (if applicable)
Home Health	16	PCA, Home Health Aide, RN	n.a.
Hospice	12	RN, LPN, Volunteers, LSW, others	n.a.
Senior Center	45*		n.a.
Pioneer Home	6		550
Assisted Living	269		2,346
Nursing Homes	15	RN, LPN, aides, physician supervision	716

*45 senior centers receive state or tribal funding; several others are known to exist with community funding.

[36] Alaska Population Projections, Alaska Department of Labor, 2007

[37] http://www.hss.state.ak.us/acoa/StatePlan.htm

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III. BEHAVIORAL HEALTH FACILITIES

Facilities that offer care to people with mental illness and substance abuse problems range from community clinics (least intensive services) to hospitals for acute psychiatric care (North Star with 74 beds and Alaska Psychiatric Institute with 80 beds). Additional hospitals in Juneau, Fairbanks and regional hubs provide evaluation, stabilization, and short-term treatment and referral. Thirteen (13) non-profit organizations receive grants to provide residential substance abuse treatment.[38] Detoxification beds are available in Anchorage, Juneau, and Fairbanks.

Alaska has six Residential Psychiatric Treatment Centers in Anchorage for youth (total 183 beds), and a total of 438 residential psychiatric beds for youth (2009), distributed as follows:

- Northwest: 14
- Southwest: 13
- Anchorage/Mat-Su: 165
- Southeast: 114
- Interior: 117
- Kenai/Kodiak: 15

In addition, there are approximately 320 beds in "Treatment Resource Homes" with behavioral health services for youth. Most are located in the Anchorage Municipality and Matanuska-Susitna Borough.

Agencies across the state receive grant funds from the Department of Health and Social Services and the Alaska Mental Health Trust Authority[39] to assist residents with behavioral health needs and help to prevent suicide, substance abuse, and other problems. Approximately 65 organizations are receiving grants from the Department of Health and Social Services Division of Behavioral Health in FY 2010 to provide behavioral health treatment and recovery services.(See Behavioral Health Grantees List).

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[38] These are:

Sitka Counseling and Prevention
Rainforest Recovery
Southeast Alaska Regional Health Corporation
Salvation Army Clitheroe
Southcentral Foundation
Akeela, Inc.
Volunteers of America - ARCH
Alaska Rehabilitation Services - Nugen's Ranch
Bristol Bay Area Health Corporation
Central Peninsula Hospital - Serenity House
Tanana Chiefs Conference
Fairbanks Native Association
Yukon Kuskokwim Health Corporation

[39] The Alaska Mental Health Trust Authority is a state corporation that administers the Alaska Mental Health Trust, a perpetual trust managed on behalf of Trust beneficiaries. The Trust operates much like a private foundation, using its resources to ensure that Alaska has a comprehensive integrated mental health program to serve Trust beneficiaries. Detailed elements of the program are included in the Alaska Statutes. (AS 47.30)

By default, the Department of Corrections (DOC) has become the single largest provider of mental health care in Alaska. A 2006 study found that approximately 42 percent (1,524 of 3,628 as of June 30, 2006) of the people incarcerated in Alaska correctional facilities were Trust beneficiaries, with mental illness, substance-related disorders and/or mental disabilities.[40] Also many youth within the Division of Juvenile Justice system have a co-occurring disorder (substance related disorder accompanied by a mental health disorder). A current alternative to incarceration for adults with severe mental illness is diversion into Anchorage or Palmer Coordinated Resources Projects (therapeutic courts). Therapeutic court programs are also operating in Bethel and Fairbanks.

The DHSS Behavioral Health Integration Project, supported by the Co-occurring State Incentive Grant (COSIG) from SAMHSA, has developed the state's capacity to serve clients with co-occurring disorders. Integration of behavioral health and primary care has been advanced by some Section 330 Community Health Centers that have received special funding from HRSA to include services for mental health and substance abuse.

The Department of Health and Social Services coordinates with the Alaska Mental Health Trust Authority and associated boards to develop the Comprehensive Integrated Mental Health Plan to address the needs of Alaskans with mental and emotional illness, alcoholism and substance use disorders, brain injury, developmental disabilities, and Alzheimer's disease and related dementia. The Department and the Trust convene the interested parties to review and plan for population needs, facilities, workforce, and multiple program initiatives.

IV. EMERGENCY MEDICAL SERVICES

Seven Regional EMS Programs (three non-profit EMS councils, three programs based in regional health corporations, and one program residing in a borough-wide fire department) work with the community-based emergency medical services to be sure that emergency medical services personnel (EMTs) are available to respond to the emergency medical needs of Alaska's citizens and visitors, and to be sure that the personnel and their ambulances and air transport are properly equipped. The State Division of Public Health and Alaska Council on EMS have duties to certify EMTs and work with the EMS programs on their training, reporting and assurance of adequate equipment. "Medevacs" (air rescues) play a major role in Alaska.

[40] Hornby Zeller Associates, Inc. (December, 2007). *A Study of Trust Beneficiaries in the Alaska Department of Corrections*, p. ii. This does not include individuals in custody in community residential centers or in the contracted facility in Arizona.

C. Health Care Providers

Health care professionals include a variety of specialists and primary care providers in medicine, dentistry, mental health and substance abuse services, and support services. In recent years, concerns about current and potential shortages of health care professionals have led to several studies of supply and demand, recruitment, and retention of physicians and other health care providers in Alaska.[41]

Primary Care and Specialty Medical Providers

Primary care services in Alaska are provided by a spectrum of providers, including over 800 primary care physicians, many of about 700 licensed mid-level providers (physician assistants and nurse practitioners), and about 550 Community Health Aides and Community Health Practitioners (see description below). The state licensing database (relying on address listed by the license applicant) shows that most physicians are located in larger communities, those with at least 1,000 people. Some of the physicians and mid-level practitioners practice in Community Health Centers and Rural Health Clinics (RHCs).

Several of the smallest hospitals have hired physicians directly to ensure staffing, and most larger hospitals as well as the tribally managed facilities have hired physician staff members, to serve as emergency room physicians, "hospitalists," or generalists who work in outpatient, inpatient and itinerant services.

Three quarters of primary care physicians (including family practice doctors, internists, pediatricians and obstetrician-gynecologists) are in the Anchorage-Wasilla, Fairbanks and Juneau areas. Recruitment and retention are difficult in remote areas. Turnover of health personnel is an ongoing problem.

The National Health Service Corps "scholars" program (with six placements in Alaska in 2009) and loan repayment program (with ten placements in Alaska in 2009), and the Indian Health Service loan repayment program, provide financial support in exchange for service for physicians and mid-level providers committed to work in health professional shortage areas.[42] A federal grant approved in September 2009 for a state-federal loan repayment program will expand the loan repayment opportunities for at least two years.

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[41] Securing an Adequate Number of Physicians for Alaska's Needs, Alaska Physician Supply Task Force Report, August 2006 http://www.hss.state.ak.us/commissioner/Healthplanning/publications/assets/PSTF-06.pdf;
SORRAS I: Status of Recruitment Resources and Strategies (2004),
http://www.hss.state.ak.us/dph/healthplanning/publications/assets/SORRASreport.pdf;
SORRAS II: Status of Recruitment Resources and Strategies 2005–2006,
http://nursing.uaa.alaska.edu/acrh/projects/sorras_report05-06.htm ; and
Alaska Center for Rural Health, 2007 Alaska Health Workforce Vacancy Study,
http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce_7-24-07_body-final.pdf

[42] For explanation and criteria for shortage designations, see Alaska Primary Care Office webpage http://www.hss.state.ak.us/dph/healthplanning/primarycare/PC_home.htm and USDHHS Health Resources and Services Administration, Shortage Designation Branch, http://bhpr.hrsa.gov/shortage/

Specialists are more likely to be in the largest urban areas where they can rely on access for their patients to the tertiary care hospitals (those with more advanced services), the support staff and other support services that can support their practices. Ninety one percent of psychiatrists practice in the Anchorage-Wasilla, Fairbanks and Juneau areas, and 89% of other specialists are located in these urban areas.

Table 3: Licensed Physician, Mid-level and Dental Workforce, by Type, by Region. 2009

Region/Census Area	Medical Doctor	Osteo-path	Physician Assistant	Nurse Practitioner	Dentist	Hygienist
Statewide	1461	122	320	490	486	444
Anchorage/Mat-Su	967	76	179	315	279	287
Gulf Coast	112	15	29	48	53	50
Interior	163	17	55	52	70	50
Northern	19	5	14	9	10	5
Southeast	162	6	22	47	55	48
Southwest	38	3	21	19	19	4
Statewide	100%	100%	100%	100%	100%	100%
Anchorage/Mat-Su	66%	62%	56%	64%	57%	65%
Gulf Coast	8%	12%	9%	10%	11%	11%
Interior	11%	14%	17%	11%	14%	11%
Northern	1%	4%	4%	2%	2%	1%
Southeast	11%	5%	7%	10%	11%	11%
Southwest	3%	2%	7%	4%	4%	1%

*Generalists and Specialists (34 are licensed as specialists, without a "generalist" license)

Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2009).

Table 4: Alaska Physicians with Active Licenses, by Region and by Specialty, 2009

Specialty Group:	Anchorage -Mat-Su	Gulf Coast	Interior	North	South-east	South-west	Grand Total
FAMILY PRACTICE	207	57	41	21	67	27	420
INTERNAL MEDICINE	142	12	32	1	19	2	208
PEDIATRICS	91	2	13		13	5	124
OBSTETRICS AND GYNECOLOGY	59	3	9		2		73
GENERAL PRACTICE			1				1
PRIMARY CARE Total:	499	74	96	22	101	34	826
SURGERY	117	17	21		17		172
EMERGENCY MEDICINE	63	9	15		13	2	102
ANESTHESIOLOGY	68	4	12		6		90
PSYCHIATRY	64	5	8		11		88
RADIOLOGY	37	7	8	1	7		60
PATHOLOGY	24	2	3		1		30
OPHTHALMOLOGY	21	2	4		2		29
OTOLARYNGOLOGY	22	1	4		2		29
NEUROLOGY	14	2	2		1		19
UROLOGY	15	1	1		1		18
PHYSICAL MEDICINE/REHABILITATION	13				1		14
CARDIOVASCULAR DISEASE	13						13
DERMATOLOGY	8	1	2				11
MEDICAL ONCOLOGY	5						5
PREVENTIVE MEDICINE	4				1		5
RADIATION ONCOLOGY	4		1				5
AEROSPACE MEDICINE	1	1	1			1	4
ALLERGY AND IMMUNOLOGY	3				1		4
GASTROENTEROLOGY	4						4
NEONATAL-PERINATAL MEDICINE	3						3
OCCUPATIONAL MEDICINE	3						3
RHEUMATOLOGY	3						3
ANATOMIC AND CLINICAL PATHOLOGY	1				1		2
ENDOCRINOLOGY, DIABETES, AND METABOLISM	2						2
INFECTIOUS DISEASE	2						2
NEPHROLOGY	2						2
PEDIATRIC CARDIOLOGY	2						2
INTERVENTIONAL CARDIOLOGY	1						1
PEDIATRIC HEMATOLOGY-ONCOLOGY	1						1
PSYCHIATRY AND NEUROLOGY			1				1
PULMONARY DISEASE			1				1
SPORTS MEDICINE	1						1
Grand Total	**1020**	**126**	**180**	**23**	**166**	**37**	**1552**
Population (2008 Population Estimates)	367509	75876	104421	23612	69202	39100	679720
Physicians per 1000 population	2.78	1.66	1.72	0.97	2.40	0.95	2.28

Source: July 2009 Occupational Licensing Database. Active (AA status) resident physicians.

Nurses: RNs and LPNs are licensed; Certified Nurse Aides and Personal Care Attendants are not licensed. It should be noted that many nurses cycle into and out of Alaska from out-of-state employment services that help to fill needs for either specialist or generalist nurses, when local supply is insufficient to meet local needs. Data on numbers of such seasonal and/or temporary nurses is not available.

Region/Census Area	RN (Registered Nurse)	Practical Nurse
Statewide	6334	735
Anchorage/Mat-Su	4089	412
Gulf Coast	629	67
Interior	731	150
Northern	90	24
Southeast	660	70
Southwest	135	12
Statewide	100%	100%
Anchorage/Mat-Su	65%	56%
Gulf Coast	10%	9%
Interior	12%	20%
Northern	1%	3%
Southeast	10%	10%
Southwest	2%	2%

Table 5: Licensed Nurses

Physical and Occupational Therapists, active and resident in Alaska, August 2009:

Region/Census Area	Physical Therapists	Occupational Therapists
Statewide	421	186
Anchorage/Mat-Su	269	123
Gulf Coast	49	24
Interior	51	18
Northern	1	1
Southeast	43	20
Southwest	8	0
Statewide	100%	100%
Anchorage/Mat-Su	64%	66%
Gulf Coast	12%	13%
Interior	12%	10%
Northern	0%	1%
Southeast	10%	11%
Southwest	2%	0%

Table 6: Licensed Therapists, 2009

Pharmacists: 471 pharmacists and 1246 pharmacy technicians are licensed in 2009 in Alaska. The vacancy study by Alaska Center for Rural Health suggests that thre is a serious shortage of these professionals.

Region/Census Area	Pharmacist	Pharmacy Tech
Statewide	471	1,246
Anchorage/Mat-Su	294	778
Gulf Coast	51	125
Interior	59	160
Northern	3	35
Southeast	55	130
Southwest	9	18
Statewide	100%	100%
Anchorage/Mat-Su	62%	62%
Gulf Coast	11%	10%
Interior	13%	13%
Northern	1%	3%
Southeast	12%	10%
Southwest	2%	1%

Table 7: Licensed Pharmacists and Techs, 2009

Behavioral Health Providers

Many rural Alaska communities have either only part-time workers helping with behavioral health needs or no mental health services other than the occasional itinerant provider. The *2009 Alaska Health Workforce Vacancy Study*[43] showed that the vacancy rates for all behavioral health occupations were about 10%, with psychiatrist and clinical psychologist vacancy rates about 16% statewide.

To help bridge the gaps in services, the Alaska Native Tribal Health Consortium has been developing a training certification program for behavioral health aides (BHAs). Currently there are 117 village-based behavioral health aide positions throughout the state, being funded by multiple sources. (Not all of these positions use the title BHA but they all operate within the BHA scope of practice). Where possible, BHA services are integrated into primary care settings.

Behavioral health professionals with current active licenses in Alaska (in August 2009) include 88 psychiatrists; 132 clinical psychologists (PhD); 417 licensed professional counselors; 77 marriage and family therapists; 488 social workers (bachelor's and master's level); and 40 psychological associates. Approximately 480 certified chemical dependency counselors, counselor technicians, and traditional counselors provide services throughout the state; many also have state behavioral health professional licenses. The levels and requirements for certification for the many categories of provider are summarized on the website of the Alaska Commission for Behavioral Health Certification.[44]

[43] http://nursing.uaa.alaska.edu/acrh/

[44] Alaska Commission for Behavioral Health Certification
http://www.nattc.org/getCertified/certification.asp?oldID=sakacbhc

Sixty four of the State's 88 active licensed psychiatrists (73%) are located in Anchorage-Mat-Su area. Seventy percent of psychologists are in this area. Many are in private practice, others work partially or wholly as contractors or employees within the tribal system, the military or not-for-profit service agencies. Several Alaska-based and out of state psychiatrists itinerate to regional medical centers to provide psychiatric assessments and to oversee treatment for residents. Telemedicine has become a tool for increasing access to psychiatric services with links to remote sites across the state, through the tele-behavioral health program based at the Alaska Psychiatric Institute, the telebehavioral health network based at the Alaska Native Health Consortium, and through the Department of Corrections' links to prisons from Anchorage.

Table 8: Active Alaska Resident Licensed Providers in Behavioral Health (August 2009)

Region	Psychia -trist	Clinical Psycholo gist	Licensed Professional Counselor	Marriage & Family Counselor	Clinical Social Worker (BA, MSW, LCSW)	Psych Associate
Statewide	88	132	417	77	488	40
Anchorage -Mat-Su	64	92	230	51	259	30
Gulf Coast	5	10	30	6	41	3
Interior	9	16	64	9	71	6
North	0	1	10	0	13	0
Southeast	10	12	65	6	68	1
Southwest	0	1	18	5	36	0
Statewide	100%	100%	100%	100%	100%	100%
Anchorage -Mat-Su	73%	70%	55%	66%	53%	73%
Gulf Coast	6%	8%	7%	8%	8%	8%
Interior	10%	12%	15%	12%	15%	16%
North	0%	1%	2%	0%	3%	0%
Southeast	11%	9%	16%	8%	14%	3%
Southwest	0%	1%	4%	6%	7%	0%

ALLIED HEALTH PROVIDERS

Allied health professions are clinical health care professions distinct from medicine, dentistry, and nursing, but generally supporting those services in helping to meet patients' needs. Although they are an integral part of the overall delivery of care and assist in making the health care system function, there is relatively little information tracking these workers, except for the categories of workers for whom licensure is required by state law. Their salaries and other costs are generally rolled into administrative or program costs. The Alaska Center for Rural Health at University of Alaska Anchorage conducted a study called the Alaska Health Care Workforce

Vacancy Study which identified allied health providers employed, positions available and vacancies.[45] Also, the Occupational Database files posted by the Alaska Department of Labor provide regular reports of employment by quarter, and total workers employed in each occupation each year, by standardized occupational code. Selected allied health occupations are listed in the following table, showing the average quarterly employment in Alaska for 2007 calendar year.

Table 9: Allied Health Employment (Average per Quarter, 2007)

Occupation	Average quarterly employment
Dental Assistant	1079
Dental Hygienist	584
Dental Lab Tech	59
EMT/ETT & Paramedic (308 licensed paramedics '09)	356
Medical & Clinical Lab Technician	297
Medical & Clinical Lab Technologist	238
Medical Records Technician	433
"Other" health technician (SOC code 292099)	401
Optician (74 licensed as dispensing opticians '09)	140
Optometrist (98 licensed, '09)	30
Pharmacy Technician (1126 licensed '09)	544
Psychiatric Technician	253
Physical Therapy Assistant	52
Radiologic Technician	428
Respiratory Therapist	165
Sonographer	39
Surgical Tech	94

Source : Alaska Department of Labor and Workforce Development, Occupational Database, http://laborstats.alaska.gov/?PAGEID=67&SUBID=212, accessed 8/10/2009

IV. PARAPROFESSIONALS (CHA/P, DHA, BHA)

The Community Health Aide (CHA) Program was developed in the 1950s in response to a number of health concerns including the tuberculosis epidemic, high infant mortality, and high rate of injuries in rural Alaska. In 1968, the CHA Program received formal recognition and congressional funding. The long history of cooperation and coordination between the federal and state governments and the tribal health organizations has facilitated improved health status in rural Alaska.

[45] http://nursing.uaa.alaska.edu/ACRH/projects/archives/ahw_vacancy.htm

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The CHA Program now consists of a network of approximately 550 Community Health Aides/Practitioners (CHA/Ps) in over 170 rural Alaska villages. CHA/Ps work within the guidelines of the 2006 *Alaska Community Health Aide/Practitioner Manual,* which outlines assessment and treatment protocols. There is an established referral relationship, which includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians, and dentists make visits to villages to see clients in collaboration with the CHA/Ps.

The Alaska Area Native Health Service has the responsibility for provision of medical and health related services to Indian Health Service beneficiaries residing in Alaska. These services are provided by tribal organizations within the Alaska Tribal Health System. The village based CHA/Ps are a vital link in the delivery system.

Community Health Aides are selected by their communities to receive training. Training centers are located in Anchorage, Bethel, Nome, and Sitka. There are four sessions of CHA training; each lasts three to four weeks. Between sessions, the CHAs work in their clinics completing a skills list and practicum. Completion of the four session training curriculum and successful completion of a clinical skills preceptorship and examination, qualify the CHA as a Community Health Practitioner (CHP). CHA/Ps at any level of training may obtain certification by the Community Health Aide Program Certification Board.

The Community Health Aide Program model is currently being used as a template to develop programs in the areas of dental care, behavioral health, and elder care.[46]

VI. COMPLEMENTARY AND ALTERNATIVE HEALTH PRACTITIONERS

The National Library of Medicine (Medical Subject Headings (MeSH) Section, 2002) classifies alternative medicine under the term complementary therapies. This is defined as therapeutic practices which are not currently considered an integral part of conventional allopathic medical practice. Therapies are termed as *Complementary* when used in addition to conventional treatments and as *Alternative* when used instead of conventional treatment.

The Office of Alternative Medicine, National Institutes of Health (Bethesda, Maryland, April 1995) defined "complementary and alternative medicine (CAM) as a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well being. Alternative therapies include, but are not limited to folk medicine, herbal medicine, diet fads, homeopathy, faith healing, new age healing, chiropractic, acupuncture, naturopathy,

[46] http://www.akchap.org/GeneralInfo.cfm

massage, and music therapy. In Alaska, licensed alternative or complementary providers are chiropractors, acupuncturists and naturopaths.[47]

Table 10: Licensed Complementary/Alternative Providers, 2009

Region/Census Area	Licenced Complementary/Alternative Providers		
	Chiropractors	Acupuncturists	Naturopaths
Statewide	220	74	37
Anchorage/Mat-Su	141	48	22
Gulf Coast	25	10	3
Interior	23	7	8
Northern	3	0	0
Southeast	24	9	4
Southwest	4	0	0
Statewide	100%	100%	100%
Anchorage/Mat-Su	64%	65%	59%
Gulf Coast	11%	14%	8%
Interior	10%	9%	22%
Northern	1%	0%	0%
Southeast	11%	12%	11%
Southwest	2%	0%	0%

Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2009).

[47] http://www.pitt.edu/~cbw/altm.html

Table 11: Summary of Major Health Occupational Groups' Employment Levels, 2007

Occupational Database: Alaska Health Care Employment	**Calendar Year 2007 Employment**	
("Covered employment" -- does not include self-employed or military)	Total People Employed in the Jobs during 2007	Average Quarterly Employment 2007
Allied Health	13,952	9,422
Nursing	10,088	7,581
Home Health Aides	3,497	2,191
Behavioral Health Professionals	3,480	2,394
Dental	2,805	1,806
Other professionals	2,737	1,941
Administration	1,719	1,304
Physicians	1,070	804
Lab techs	819	552
Pharmacists, Podiatrists & Speech/Language Pathologists	723	533
Mid-Levels (Physician Assistants, Nurse Practitioners)	595	382
EMTs (emergency medical technicians)	553	356
Radiologic Techs	547	428
Chiropractors	62	45
Grand Total	*42,647*	*29,737*

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

The worksheet contains the count of workers by occupation for the calendar year. These files are continuously updated and posted to the Web periodically. Six months must pass before data for a particular quarter is considered complete.

The Occupational Database (ODB) contains occupation and place of work information for each wage and salary worker covered by unemployment insurance employed in Alaska. This data series differs from others published by Research and Analysis in that it provides information on each unique worker/employer combination rather than an average monthly employment count or a count of the number of jobs at a particular point in time.

Worker Count Data Limitation: The count of workers is comprised of each unique worker/employer combination. Workers holding jobs with multiple employers are counted more than once.

The worker count is presented for each calendar quarter and summarized for the calendar year. The calendar year totals represent the unique worker/employer count. An employee working all four quarters for the same employer is counted only once.

Occupation codes are based on the Standard Occupational Classification (SOC) system as published by the Office of Management and Budget in October 2000.

Self-employed are NOT included in the figures above. Note that 45 chiropractors were employed on average each quarter in "covered" employment – however there are 218 licensed chiropractors in Alaska with active licenses, so it is likely many are self-employed, not in employment covered by unemployment insurance.

D. HEALTH INFORMATION TECHNOLOGY

HEALTH INFORMATION TECHNOLOGIES IN ALASKA

Health Information Technology (HIT) is expected to be a means to achieve more affordable, safe, and accessible health care. Digital applications available for use by health-care providers and organizations include personal health records (PHRs), electronic health records (EHRs), electronic medical records (EMRs), computerized physician order entry (CPOE) systems, and health information exchange (HIE) systems. All are governed by privacy and confidentiality regulations. Each of these refers to a different set of services:

- Personal health records are records the patient can have in his/her possession, to share with any health care provider seen, and have updated with each visit. Digital PHRs may be kept on a digital memory stick for the patient to carry. They may be self-contained or a copy of a record maintained by a provider.
- Electronic health records and electronic medical records are the mechanisms for replacing paper records with digital ones, that can be easier for doctors or other providers to "search" for medical history, prescriptions and lab results, and that can be stored locally or in a remote location for electronic retrieval or for "exchange" with another provider. Although they are often used interchangeably, there is a difference between EHR and EMR. The EHR is a comprehensive, longitudinal, record of the patient's medical history or complete medical record. EMR refers to the individual pieces of the EHR such as laboratory results, electrocardiograms, prescriptions, history and physical exams, post operative reports, radiology reports, etc.
- Computerized physician order entry (CPOE) is a process of electronic entry of medical practitioner instructions for the treatment of patients (particularly hospitalized patients) under his or her care. These orders are communicated over a computer network to the medical/nursing staff or clinical departments (pharmacy, laboratory or radiology) responsible for fulfilling the order. CPOE has the potential to decrease delays in order completion, reduce errors related to handwriting or transcription, allows order entry at the point-of-care or off-site, provides an opportunity to double check for duplicate or incorrect doses or tests, and simplifies inventory and posting of charges
- Health information exchange systems provide for electronic transfer of patient record information for various possible purposes: to store records in a central place for programs that have multiple service sites; for sending referrals or requested, approved reports between providers. Such information can be limited or comprehensive according to the permissions granted to a potential recipient based on need to know and the patient's requests and approvals.

Digital telehealth systems, such as teleradiology, laboratory reports, telebehavioral health, telepharmacy, and distance learning systems utilizing videoconferencing equipment are also emerging as ways intended to be cost-effective means to improve health care quality and outcomes.

ELECTRONIC HEALTH RECORD USE IN ALASKA

The Alaska EHR Alliance completed a state-wide survey of physicians (378 respondents) and clinic managers (62 respondents) to assess the status of EHR use in Alaska. 29 communities were represented in the survey.[48] This survey found that there are currently at least 55 different EHR systems currently being used in healthcare practices across the state. Of those 55 different EHR systems, no single entity holds a significant portion of the EHR market in Alaska with the two leading products being Centricity (11%) and eClinicalWorks (8%). Most (74%) of EHRs in use include a practice management system. Half of the EHRs are connected to labs and one third are connected to one or more pharmacy. One third of the EHRs in the survey did not connect to any other entity.

E-PRESCRIBING

Adoption of e-prescribing has been identified as being critically important to the advancement of e-Health. E-prescribing is recognized as a gateway technology that could speed the development of EHRs and widespread use of other HIT initiatives. Beginning January 1, 2009, CMS will provide an incentive to "successful e-prescribers." The Medicare e-Prescribing incentive is a new program authorized under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. The program begins January 1, 2009, and provides incentives for eligible professionals who are "successful e-prescribers." Efforts to maximize implementation of e-prescribing systems statewide could result in increase systemic use of other e-health components such as personal health records and electronic health records in both the private and public sectors of health care.

Additionally, there is a disincentive for health-care providers who do not become "successful e-prescribers" by 2012. Under rules adopted by the USDHHS Center for Medicare and Medicaid Services (CMS), eligible professionals who are not "successful e-prescribers" by 2012 will be subject to a differential payment (penalty) for Medicare services beginning in 2012. The differential payment would result in the physician getting 99 percent of the total allowed charges of the eligible professional's physician fee schedule payments in 2012, 98.5 percent in 2013, and 98 percent in 2014.

HEALTH INFORMATION EXCHANGE SYSTEM DEVELOPMENT

The current "system" of health information exchange for Alaskan healthcare providers is a conglomeration of disparate systems with a variety of capabilities and structural platforms that may or may not be interoperable with each other. An integrated Health Information Exchange HIE system is needed to bring the disparate systems together into one functional product that will improve access to critical health information by healthcare providers and the citizens of Alaska in an interoperable, secure, safe, and efficient manner.

Senate Bill 133 (SB 133), passed in the 2009 legislative session, is intended to modernize Alaska's health-care IT infrastructure by providing for development of a secure electronic Health Information Exchange (HIE) system that will bridge connections between disparate EHR

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[48] Status of EHR Use In Alaska, 05/11/ 2009:
http://www.aehra.org/images/downloads/summary_of_ehr_survey_findings_52009.pdf retrieved 08/11/2009

systems. A standards-based HIE will allow individual Alaskans to manage their own personal health records and to authorize their personal health-care providers to exchange electronic medical records in a timely, secure manner. The intended outcome of a fully implemented Alaska Health Information Exchange Network is to improve the patients' access to care, reduce unnecessary testing and procedures, improve patient safety, reduce health agency administrative costs, and enhance rapid response to public health emergencies.

The Alaska Department of Health & Social Services is the process of soliciting proposals for the statewide HIE Entity as authorized by SB 133.

TELEHEALTH

The Alaska Federal Health Care Access Network (AFHCAN) is a telehealth system composed of 248 sites across the state. A total of 44 federal beneficiary organizations participate in the network, including Native and tribal groups, veteran and military providers, and the state of Alaska. AFHCAN initially focused on developing store-and-forward telehealth solution, but has recently expanded into broadband video conferencing telehealth solutions. Store-and-forward solutions were initially developed in response to the limited availability of broadband connectivity in Alaska. Now, however, broadband connectivity supports the larger data payloads and image sets that are often part of an electronic consultation. It has become clear that store-and-forward telehealth offers significant advantages in a distributed multi-organizational health-care environment due to the flexibility it affords providers to respond to cases at their convenience.

Every year, the Alaska Native Medical Center (ANMC) responds to approximately 3,000 telehealth cases and handles 66 percent of these consultations in the same day. Perhaps more impressive is that 50 percent of these cases are responded to within 60 minutes. While store-and-forward was specifically designed to enhance primary care access, approximately 25 percent of all cases today are specialty consultation requests. Video conferencing capacity is also increasing at a rate of three to four times every 12–18 months, with a large deployment of endpoints (funded through the Alaska Federal Health Care Partnership) planned at ANMC in 2009–10 consistent with the growth of video teleconferencing capability at most of the regional health corporations throughout Alaska.

Department of Corrections psychiatric services unit has used video conferencing since [2000], for Anchorage-based psychiatrist and psychologist to provide follow-up and counseling to prisoners in facilities around the state.

The Alaska Psychiatric Institute (API) Tele-Behavioral Health care Services (TBHS) program was originally envisioned under the auspices of the Alaska Telehealth Advisory Council to serve rural communities in south-central and northern Alaska. The API TBHS multidisciplinary team of mental health clinicians provides behavioral health-care services to rural communities throughout Alaska by way of advanced video-teleconferencing technology. The program has continued to grow in the specific number of sites that may access psychiatry because of continuing integration with other information technology, video teleconferencing, and health-care provider networks across Alaska, including the Alaska Native Tribal Health Consortium,

Alaska Federal Health Care Access Network (AFHCAN), the Alaska Rural Telehealth Network (ARTN), and GCI Connect M.D., a medical network that is comprised of over 200 facilities including clinics, hospitals, and medical corporations in the Pacific Northwest and Alaska.[49]

The Alaska Rural Telehealth Network (ARTN) is operational in 11 communities across Alaska, including Soldotna, Cordova, Petersburg, Wrangell, Valdez, Kodiak, Seward, Sitka, Glennallen, Unalaska, and Homer. All sites have digital X-ray capability and most have digital mammography. A Picture Archive and Communications System (PACS) has been implemented system-wide. The PACS is a computer network dedicated to the storage, retrieval, distribution, and presentation of various types of images including ultrasound, mammography, X-ray, computerized tomography (CT), and positron emission tomography (PET). It allows facilities to have their images read from an off-site location (i.e. a Radiologist not located in their facility), which is commonly referred to as teleradiology. The PACS also replaces the need for facilities to maintain hardcopy images on-site by digitally archiving the diagnostic images on the central storage facility – a server located at the Wide Area Network (WAN) core in Anchorage.

[49] GCI ConnectM.D., Medical Network Overview: http://www.connectmd.com/mednet.htm retrieved 04/05/2009.

II. HOW HEALTH CARE IN ALASKA IS FUNDED

A. Introduction

Health care in Alaska is funded by individuals, businesses, and local, state and federal government sources. Individuals pay out-of-pocket costs and contributions to insurance premiums amounting to one fifth of total expenditures. Businesses contribute almost another fifth of the total through purchase of insurance premiums, support for self-insurance programs, and worker's compensation medical benefits. Together the individual and business contributions, "private" sources, account for 38 percent of the total – just under $2 billion of the $5.3 billion total expenditures for health care in Alaska in 2005.

The most comprehensive recent Alaska-focused analysis of funding of health care (not including public health activities or facility construction) by ISER (UAA Institute of Social and Economic Research), identified Federal Government programs as the largest purchaser of these services, accounting for another 38 percent of the total -- $2 billion of the total of $5.3 billion. Local and state government expenditures for covering employee health benefits, for Medicaid and for other programs, make up the remaining 24 percent of the total.

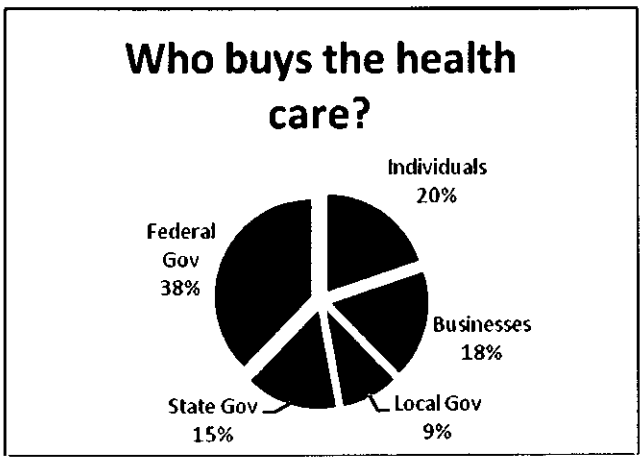

Figure 10: Health Care Purchasers in Alaska, 2005

Table 12: Health-Care Spending in Alaska, FY 2005

Who provides the coverage?	Who Buys the Health Care? (Millions of dollars)					
	Individuals	Businesses	Local Government	State Government	Federal Government	Total*
Individuals	$1,028					$1,028
Employers		$922	$454	$252	$411	$2,039
Government Health Programs			$38	$535	$1,654	$2,227
Total Spending	$1,028	$922	$492	$787	$1,950	$5,294

Source: *Alaska's $5 Billion Health Care Bill – Who Pays?* March 2006 UA Research Summary No. 6. Institute of Social and Economic Research, University of Alaska, Anchorage

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Nearly a quarter of the Federal share is accounted for by military health services ($221,000), insurance premiums and self-insured costs. Half of the Federal share is attributable to Medicare and Medicaid claims paid, and another quarter covers Indian Health Service, veteran's benefits, community health centers and payments for services in elementary and secondary schools. ISER's previous study (1991) provides a base for comparison of rate of increase. In the fifteen year period, employer costs quadrupled, while government program expenditures tripled, and individual's contributions almost tripled.

B. Funding Sources: Expenditures, Services and Facilities Supported, and Covered Populations

A summary of "health care coverage" based on responses to the US Census Bureau's annual Current Population Survey (CPS) shows the following types of reported coverage by insurance programs and public programs (Table 13).

Table 13: Health Insurance Coverage of Alaskans, 2006-2008 Average

Health Insurance Coverage Type Average for data years 2006-2008	**Alaska**		**United States**
	Count	**Percent of Total**	**Percent of Total**
Covered by Any Source	547,203	81.8%	84.5%
Employer	388,381	58.0 %	59.0%
Individual (self-purchased)	42,891	6.4 %	9.0%
Medicaid & Denali KidCare	78,636	11.8 %	13.4%
Medicare	57,384	8.6 %	13.9%
Military/VA	88,944	13.2 %	3.7%
Uninsured all year	121,713	18.2%	15.5%
Total	668,917	(percentages add up to more than 100% because of overlapping coverage types)	

Source: Current Population Survey (CPS), 2007-2009 surveys, 2009 data released September 2009

It is important to note that if otherwise-uninsured American Indians and Alaska Natives are redefined as "covered," then the estimate becomes 14% "uninsured" in Alaska (15% in the US) By CPS definition, "uninsured" includes people of Alaska Native and American Indian Race who may have access to IHS-funded services. In Alaska this is 19% of the uninsured. 63% of

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Alaska Natives are covered by private insurance (36%) or public programs (27%), 36% have no health insurance.[50]

Being "underinsured" (lacking insurance coverage or personal resources to pay for specific services, or being required to pay deductibles or co-payments that exceed personal resources) is a major problem to many individuals even though they have some coverage. It is also an issue for their health care providers. How many people are "underinsured" is not known. Data are available from surveys asking people about their perceptions, for example, did you decide not to see a doctor or other health care provider because of cost? Data from hospitals about levels of charity care, "self-pay" patients, and "left against medical advice" may be informative.

a. **Private Insurance** – including all employment-based except military, and individually purchased policies -- $2.281 billion (43% of total)
   - Private insurance is generally interpreted to mean both the insurance products sold to employers and employees, and to individuals, whether the employment is for a private for profit or not-for-profit firm. Individuals who pay for private insurance are likely to pay for a policy premium, and then also to pay co-payments, deductibles, and out-of-pocket costs of any services not covered by the insurance policy. The ISER estimates[51] found that about 42 percent of individuals' costs were for such out-of-pocket expenses .
   - Expenditures for "self-insured" programs include employers' contributions to such programs. In Alaska, about two thirds of all employers' (non-military) contributions are to such self-insured plans, while only one third is for "insurance premiums" in the private sector, for the insurance products regulated by the State's Division of Insurance.
   - Covered lives: the most recent Alaska Division of Insurance survey of health insurers reported 86,645 individuals were covered under comprehensive health insurance plans at year-end 2008. These numbers are reported by the insurers. The estimate suggests that as many as 340,00 individuals are covered through employer-based "self-insured" plans. (See table of Coverage Type above.)
   - Rolling up the expenditures managed by private insurance and "self insured" (private and public) entities, and the premium payments by individuals, the ISER report estimates $1.685 billion in expenditures for what we generally consider "employment based health insurance." This accounts for about 32% of health care expenditures in FY2005.

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[50] Tribal contract health care facilities are legally required to serve their tribal members. Other qualified American Indians/Alaska Natives may be eligible to receive care as determined by the organization. This policy makes it difficult or impossible for an American Indian or Alaska Native who leaves his tribal home for education or employment to receive the health care services to which he is legally entitled. This lack of "portability" as well as limitations in some of the services that can be provided is the basis for the Census Bureau determination not to count IHS beneficiary status as "heath insurance coverage."

[51] *Alaska's $5 Billion Health Care Bill – Who Pays?* March 2006 UA Research Summary No. 6. Institute of Social and Economic Research, University of Alaska, Anchorage

b. Public insurance and coverage

i. Medicare -- $0.419 billion (Federal)

Medicare provides coverage for health care for about 54,000 individuals in Alaska including 44,000 senior citizens (age 65 and over) and about 10,000 disabled individuals and people with end stage renal disease. Allowable costs include "Part A" (primarily inpatient) services, "Part B" (primarily outpatient/physician/clinic services) for those participating and paying a monthly enrollment fee, and certain prescription drugs under "Part D" for those who have selected that option. With the aging of the baby boomers, a cohort of about 5,000 new "seniors" will join the ranks of the senior population over the next five years, while about 1,800 deaths per year will deplete the population 65 years and over, so the net increase may be over 3,000 Medicare-eligible people per year.

For the individuals with end stage renal disease, benefits include inpatient, outpatient, and home dialysis (including training, equipment and supplies, and drugs) – not paid for are blood, transportation, or dialysis aides or technicians coming to house. Although dialysis facilities reimbursed must be certified by Medicare (CMS), a patient can obtain services at any approved site in the country, so travel is not restricted for individuals who need service usually two or three times a week. Kidney transplant costs are also allowable – organ registration fees, laboratory tests for the patient and potential donors, full cost of care for donor, and immunosuppressant drugs.

Physician participation/availability: Concern about availability of physicians who will accept Medicare patients has emerged in Alaska in the last five years. The issue arose when a two-year special reimbursement rate for Alaska physicians (effective in 2004 and 2005, providing a differential for Alaska physicians 67% above the US average) sunset in January 2006. For the three years 2006-2008, the Medicare differential for Alaska was about 5% above the US average. A new geographic differential for Alaska (29% above the US average) for "physician work" was effective January 1, 2009, but the reports of physician non-participation continue.

First in Fairbanks, then Anchorage, participants at health care forums and articles in newspapers across the state reported that physicians – especially primary care providers -- were refusing to accept new Medicare patients, and in some cases were telling established patients they would no longer see them. This selective refusal to see Medicare patients appears generally not to have been followed up by notification to CMS that the provider was "opting out" of the Medicare program, so the officially reported "participation rate" for Alaska providers is still high (11% opt-out rate reported in March 2009 by ISER).[52]

[52] Frazier, Rosyland and Foster, Mark, "How hard is it for Alaska's Medicare Patients to Find Family Doctors?" March 2009, UA Research Summary No. 14. Institute of Social and Economic Research, University of Alaska Anchorage.

Provider non-participation has major consequences for patients who may have Medicare as "primary" payer and state retirement benefits or state employment or other insurance as secondary payer, since refusal of the primary payer to pay results in denial of all payers. As a result, individuals who thought they were very well insured found themselves paying out of pocket for all their health care costs or having to seek care from new providers. Medicare patients able to reach a federally funded community health center (CHC) can obtain at least primary care services at such clinics.

The CHCs have experienced very large increases in the number of Medicare patients seen each year since 2000 – from about 3,000 in 2002 to 7,000 in 2007. Some of the increase is attributable to the addition of community health center sites, but most of the increase is believed to have occurred in the urban clinics. In 2007 about 15 percent of all Medicare enrollees were using CHCs as at least one source of care. Anchorage Neighborhood Health Center Executive Director has reported dramatically increased numbers of Medicare patients using the Center, and also increased referrals to the Anchorage Project Access, which matches patients to specialists who have volunteered to see a certain number of charity care cases.

ii. Medicaid - $0.303 billion State of Alaska, $0.667 billion Federal (FY 2005)

Medicaid is an "entitlement program" created by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting income and asset standards and by fitting into a specified eligibility category. Under federal rules, DHSS has authority to limit services as long as the services provided are adequate in "amount, duration, and scope" to satisfy the recipient's medical needs.

Medicaid began as a program to pay for health care for poor people who were unable to work. It covered the aged, the blind, the disabled, and single parent families. Over the years, Medicaid has expanded to cover more people. For instance, children and pregnant women may qualify under higher income limits and without asset limits. Alaska's Medicaid expansion for these children and pregnant women is called Denali KidCare. Families with unemployed parents may qualify, and families who lose regular Family Medicaid because a parent returns to work may continue to be covered for up to one year.

There have also been changes in the eligibility rules for people who need the level of care provided in an institution, such as a nursing home. Now, most Alaskans who need — but cannot afford — this expensive care may qualify for Medicaid. In addition, provisions within the Alaska Medicaid program give some people who need an institutional level of care the opportunity to stay at home to receive that care.

iii. Dual Eligibility (for Medicare and Medicaid) – annual expenditure amounts for either program included in above totals

Low income seniors and disabled people may have "dual eligibility" for Medicare and Medicaid coverage, in which case Medicare pays first for what it covers, and Medicaid only pays for services (including beneficiary cost sharing) that are not paid by Medicare. In Alaska, Medicaid generally covers the cost of the Part B (currently $96.40/month) for all recipients. Part B is the part of Medicare that covers physician, outpatient, some pharmaceutical, and other treatment and rehabilitation services. Part A covers hospital services; few people have to pay premiums for Part A, but Alaska Medicaid will pay those for dual eligibles if necessary.

Also Medicaid recipients do not have to pay a Part D (Pharmacy Benefit) ($37/month) premium for basic plans, and have greatly reduced cost-sharing.

iv. Indian Health Service Funds for Alaska Natives and American Indians - $0.401 billion Federal (FY 2005)

Alaska Natives and American Indians in Alaska from Federally recognized tribes are entitled to health care provided by Indian Health Service, in Alaska primarily through tribal contracts to provide health care services. A portion of these funds are used for "contract health services," purchase of specialty or out of area care from non-tribal providers for beneficiaries when the services are not available through the tribal system.

c. Other

i. COBRA: The *Consolidated Omnibus Budget Reconciliation Act* (*COBRA*) provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. It is ordinarily less expensive, though, than individual health coverage. Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.[53]

ii. ACHIA: The Alaska Comprehensive Health Insurance Association (ACHIA) was created by the Alaska State Legislature in 1992 to provide access to health insurance

[53] http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html downloaded 08-17-09

coverage to all residents of the state who are unable to obtain individual health insurance due to a preexisting medical condition and who meet certain eligilibity requirements.[54]

iii. Federal Programs providing care (includes some of the SAMHSA funds)
Military care provision (direct)
Veterans services
Tri-care – insurance-like coverage for dependents
Federal employee benefits

iv. Federal Grants: support operating costs (fixed grant amounts each year) for Community Health Centers, and support Frontier Extended Stay Clinic demonstration project development – also limited direct services provided by several small demonstration projects – but little actually go to patient care which is covered through the claims-based programs.

v. Denali Commission: Federal funding of village clinics, regional clinics and hospital clinics, also some behavioral health facilities.

vi. Anchorage Muni: Maternal Child Health, immunizations (public health activities that relate to provision of health care – there are also many monitoring, assessment, prevention, health education – health promotion, protection and disease prevention activities not addressed here; see http://www.muni.org/departments/health/pages/default.aspx.)

vii. Volunteer activities:

- Anchorage Project Access (APA) uses a volunteer network of providers to increase access to health care for low-income uninsured members of the Anchorage area. Currently, 333 physicians, 98 mid-level providers, and other support services participate in APA's provider network. Patients are carefully screened for income eligibility, and cannot be eligible for other programs. Since December 2005, APA has processed over 2,035 applications for eligibility, with over 1,110 applicants meeting program eligibility guidelines and receiving medical treatment. See www.anchorageprojectaccess.org.

viii. State general funds:

- Public health services that provide direct care – Early and Periodic Screening, Diagnosis and Testing (EPSDT), newborn hearing screening, immunization clinics, other.

- Division of Juvenile Justice, Department of Corrections, Office of Children's Services, Department of Education each pay for health services for clients to some degree.

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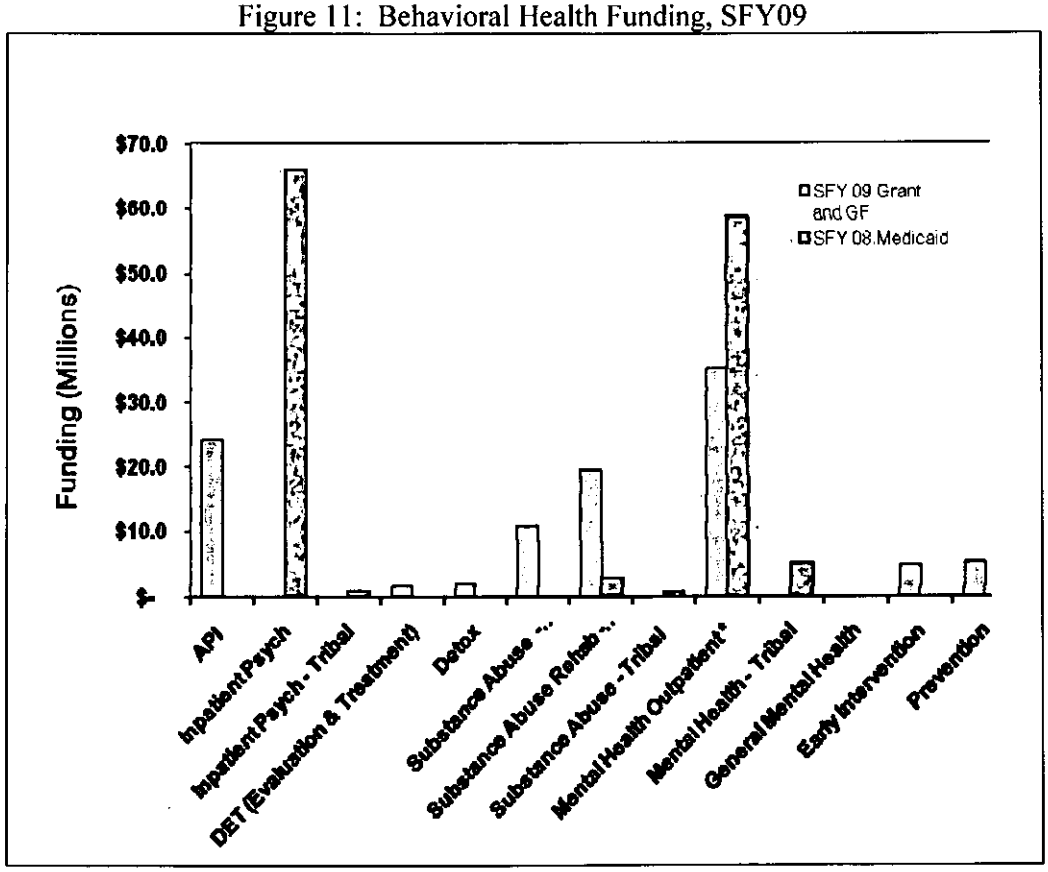
[54] www.achia.com

- Fishermen's Fund: Established in 1951, the Fishermen's Fund provides for the treatment and care of Alaska licensed commercial fishermen who have been injured while fishing on shore or off shore in Alaska. Benefits from the Fund are financed from revenue received from each resident and nonresident commercial fisherman's license and permit fee.

- Division of Behavioral Health funds for provision of behavioral health services (i.e., not services billable to insurance). Note in the figure below, showing the funding of the continuum of care, that the majority of state funding (both Medicaid and operating API) go to the most intensive mental health and substance abuse treatment services.

Figure 11: Behavioral Health Funding, SFY09



Source: Alaska Division of Behavioral Health, Policy and Planning Unit, March 2009

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SB 193

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 4/17/09

FURTHER: Labor and Commerce

Date of 5-Day Notice: March 14, 2010
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: March 18, 2010

Health and Social Services Committee considered SENATE BILL NO. 193

SB 193 LICENSING FOR OPTOMETRY

"An Act relating to licensure as an optometrist; establishing a retired status optometrist license; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DCED	3/5/2010	✓		✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	✓			
	PASKVAN	X			
CHAIR:	DAVIS	X			

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FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB 193**
() Publish Date:

Identifier (file name):SB193-CED-CBPL-3-15-10
Dept. Affected: DCCED
Title: Licensing for Optometry
RDU: Corp, Bus, & Prof Licensing (117)
Component: Corp, Bus, & Prof Licensing
Sponsor: Labor and Commerce Committee by Request
Requester: Senate Health and Social Services Committee
Component Number: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (1156)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other: (1156) RSS							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 193 amends licensing requirements for Optometrists in AS 08.72 to be commensurate with current Optometry education and training; and provides a restricted license to the few licensees that have not achieved the higher-level training and endorsement. The bill also provides for a retired status license.

New funds are not required to implement this bill.

Prepared by: Jennifer Strickler, Division Operations Manager — Phone (907) 465-2144
Division: Corporations, Business & Professional Licensing — Date/Time 3/15/2010 4:15PM
Approved by: Emil Notti, Commissioner — Date 3/15/2010
Commerce, Community, and Economic Development

(Revised 11/6/2009 OMB)

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ALASKA STATE LEGISLATURE

Senator Joe Paskvan

Chair, Labor and Commerce
Vice Chair, Health and Social Services
Member, Transportation
Member, State Affairs
Member, Joint Armed Services

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Sponsor Statement
SB 193

SB 193 makes some necessary changes to the licensure criteria for optometrists in this state.

Currently, Alaska has three levels of licensure for optometrists:

1.) Basic License (no pharmaceuticals)
2.) License with Pharmaceutical Endorsement (in-office eye drops)
3.) License with Pharmaceutical Prescription and Use Endorsement (prescribing authority).

The Board of Optometry would like to have a standard level of care that everyone receives from optometrists. Therefore, some adjustments need to be made in statute to require the highest level of care.

SB 193 brings Alaska statutes in line with current educational levels. Students graduating from optometry schools within the last five years have already received the level of education necessary to obtain a license at the highest level currently provided in Alaska. Further, most licensed optometrists in Alaska have already obtained the level of education necessary for the highest level of licensure. There are only a handful of people who have not received that education and most of these optometrists are nearing retirement age. These optometrists would be issued a restricted license which would allow them to continue to practice but still not allow them to provide services that go beyond their level of education.

The level of education required in SB 193 has been standard in most optometrist schools across the country and most older optometrists have already obtained this level of education on their own. Many states are currently working on or have already passed similar legislation. Our citizens deserve the most current and highest level of care possible; allowing the licensure of optometrists with less than the standard education levels puts our citizens at risk. SB 193 remedies this problem by standardizing the licensure requirements for optometrists in Alaska.

I urge your support of SB 193.

ALASKA STATE LEGISLATURE

Senator Joe Paskvan

Chair, Labor and Commerce
Vice Chair, Health and Social Services
Member, Transportation
Member, State Affairs
Member, Joint Armed Services

Senate District E
Fairbanks and Fort Wainwright

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Sectional Analysis
SB 193

Section 1:

Technical amendments for grammar and removes high school requirement as it is unnecessary. Also outlines educational requirements for required licensure. Applicants must have completed:

1) Examination on ocular pharmacology
2) 23 hours of course work on ocular disease
3) 7 hours of course work on therapeutic pharmaceutical agent injections
4) Other course work established in regulation.

Section 2:

Allows an applicant to retake the exam if they fail.

Section 3:

Requires applicants for licensure by credentials to have a license from a state that has licensure requirements equivalent to Alaska, pass the Alaska state exam, and the National Board of Examiners of Optometry exam.

Section 4:

Deals with renewal of licenses. Outlines requirements that must be obtained before a license may be renewed. The applicant must have:

1) 8 hours of continuing education concerning the prescription of pharmaceutical agents;
2) 7 hours of continuing education on the injection of nontopical therapeutic pharmaceutical agents;
3) Met other requirements outlined by the Board through regulation.

Section 5:

Deals with retired status licenses. Upon retirement a licensee may apply for a retired license. A retired license does not have to be renewed and the person may not practice optometry in Alaska. However, a person may go from retired status to active status upon application and upon meeting certain educational criteria.

Section 6:

Removes reference to certain class of optometry license as the bill creates only one class of license that is allowed to practice in this state.
Also, outlines the circumstances that an optometrist can prescribe pharmaceuticals (already in statute).

Section 7:

Repeals references to different classes of licenses.

Section 8:

Transitional Section: Allows a person who is not currently licensed at the highest level to be grandfathered in and get a restricted license. This will allow them to continue to practice but still not exceed their educational level.

Section 9:

Revisor Instruction: retitling a section heading

Section 10:

Immediate effective date.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB 193**
() Publish Date:

Identifier (file name): SB193-CED-CBPL-3-9-10
Dept. Affected: DCCED
Title: Licensing for Optometry
RDU: Corp, Bus, & Prof Licensing (117)
Component: Corp, Bus, & Prof Licensing
Sponsor: Labor and Commerce Committee by Request
Requester: Senate Health and Social Services Committee
Component Number: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (1156)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other: (1156) RSS							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

HB 245 amends licensing requirements for Optometrists in AS 08.72 to be commensurate with current Optometry education and training; and provides a restricted license to the few licensees that have not achieved the higher-level training and endorsement. The bill also provides for a retired status license.

New funds are not required to implement this bill.

Prepared by: Jennifer Strickler, Division Operations Manager
Phone (907) 465-2144
Division: Corporations, Business & Professional Licensing
Date/Time 3/9/2010 4:15PM
Approved by: Emil Notti, Commissioner
Date 3/9/2010
Commerce, Community, and Economic Development

(Revised 11/6/2009 OMB)

5099

Over the years, more and more states are requiring optometrists to hold an optometry license at the highest level. In fact, effective January 2010, optometrists in the state of Oregon must be licensed at the highest level to even practice optometry. The chart below is a survey of states showing the movement among states to require licensees meet the highest educational requirements.

Initial and Renewal License Requirements to Seek/Maintain Highest Level

Last Revised January, 2010

STATE:	Can an **applicant for initial licensure** (could be a new grad or someone coming from another state) apply for a license other than one at the highest level of prescriptive authority authorized in your state?	Can a **licensee within your state holding an active license** drop "down" to a lower level license at renewal or other time (i.e., they hold a TPA license, but now only want a basic or DPA-only license)?
Alabama	**NO**	**YES** Technically, yes. We hope to tighten up the wording of our law so that this cannot happen. We have had one instance of this with a licensee who was about to retire. He asked to lower his licensure status to non-therapeutic for the few months he planned to practice. We could find nothing in our law that prevented this. He saved $110!
Alaska	**YES** 2010 Legislation is aimed at changing this to No.	**YES** 2010 Legislation is aimed at changing this to No.
Arizona	**NO**	**NO**
Arkansas	**NO**	Yes, under health reasons and maybe has retired, but still wants to keep their basic licenses. The cost difference is $50
California		
Colorado	**NO**	**NO**
Connecticut		
Delaware	**NO**	**NO**
D.C.		
Florida	**NO**	**NO**
Georgia	**NO**	**NO**
Hawaii		
Idaho	**NO**	**NO**
Illinois	**NO** All licensees had to upgrade to the highest level by 2007	**NO**

For more information contact Tracy Oman, Alaska Optometric Association, at (907) 272-2972 or akoa@alaska.com

5100

Indiana	**YES** Our applicants apply for an optometry license and if they are going to be prescribing, administering, or dispensing legend drugs then they can obtain an optometric legend drug certificate. It is not mandatory to obtain the legend drug certificate.	**YES**
Iowa	**NO**	**NO** We have no definite rule but would probably be denied.
Kansas	**NO** As of May 31, 2010, everyone must come in at the highest level.	**NO** As of May 31, 2010, everyone must be at the highest level.
Kentucky		
Louisiana	**NO**	**NO** Must be TPA to practice in the state.
Maine	**NO**	**NO**
Maryland		
Massachusetts	**NO**	**NO**
Michigan		
Minnesota		
Mississippi	**NO**	**NO**
Missouri	**NO**	**NO**
Montana		
Nebraska	**NO**	**NO**
Nevada	**YES** All new licensees come in at a DPA level. Subsequent to licensure, they can apply for TPA certification after they have completed the statutorily required 40 hour preceptorship with an ophthalmologist. They can elect to stay DPA. Most of those who are only DPA are not practicing in the state.	**NO**
New Hampshire	**NO**	**NO**
New Jersey		
New Mexico		
New York		
North Carolina	**NO AND YES** Beginning with the graduating classes of 2008 from the accredited schools and colleges of optometry applicants will come in at the highest level (includes injectables). Current licensees do not have to move up to the highest level with injectables.	**NO**
North Dakota	**NO** As of 2001	**NO**
Ohio	**NO**	The Ohio law does not specifically address this issue one way or another. The law does provide that they MAY renew each certificate of licensure and agents certificate. If

For more information contact Tracy Oman, Alaska Optometric Association, at (907) 272-2972 or akoa@alaska.com

		someone only wanted to renew there license and not a certificate they would drop down to just an optometric license but would not be able to drop from a TPA to a DPA. There have not been any licensees who have dropped to a lower level in the past 5 years. The cost for a TPA or DPA certificate is $25 above the annual renewal cost of $110 for just licensure.
Oklahoma	**NO**	**NO**
Oregon	**NO** As of January 2010 applicants must be at highest level, ***except for*** injectables authority which will remain optional. NOTE: Over the last five years they have had 159 applicants who have not sought licensure at the highest level.	**NO** As of January 2010.
Pennsylvania	**NO & YES** New grads automatically get the highest level of licensure. Older grads coming in from another state may apply for a lower level license, but it is infrequent. The cost is the same.	**NO** They are not given that option.
Rhode Island		
South Carolina	**NO**	**NO**
South Dakota	**NO**	**NO**
Tennessee		
Texas	**NO & YES** An applicant from another state can only come in as a therapeutic OD or higher.	**NO**
Utah		
Vermont		
Virginia		
Washington	**NO**	**NO**
West Virginia	**NO**	**NO**
Wisconsin	**NO** Could until Aug 2006.	**NO** Could until Aug 2006.
Wyoming	**NO**	**NO**

For more information contact Tracy Oman, Alaska Optometric Association, at (907) 272-2972 or akoa@alaska.com

SB 199

5103

ALASKA STATE LEGISLATURE

Rules Committee
•
Finance Committee
•
Health & Social Services Committee
•
Legislative Council
•
Committee on Committees

While in Session
State Capitol, Rm. 103
Juneau, AK 99801
(907) 465-3704
Fax: (907) 465-2529
•
While in Anchorage
716 W. 4th Ave
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SENATE MAJORITY LEADER
JOHNNY ELLIS

SPONSOR STATEMENT – SENATE BILL 199

SB 199 – An Act relating to a two year funding cycle for medical assistance coverage for dentures.

SB 199 makes a simple change to the Adult Medicaid Dental program that would allow patients who are approved for dentures to receive both the uppers and lowers in a single fiscal year. The bill would let patients access two years of funding in a single year, thereby allowing them and their dentists to schedule treatment around the oral health of the patient, rather than the bureaucratic ease of the state fiscal year.

Current law places a limit on expenditures per eligible client at $1,150 per year. This number was designed to pay for ½ of a set of dentures, either uppers or lowers, in a single fiscal year. When the program was created, the idea was that a client who needed dentures could receive one set on June 30th, and the second on July 1st. Unfortunately, this has proven to be impractical. Dentists who are forced to pull teeth can't always do so on the state's fiscal calendar, and Alaskans shouldn't suffer needlessly because their medical emergency occurred in the fall rather than the summer.

Adult Medicaid Dental has been recognized across the political spectrum as a successful government health care program. Over the past three years, the state has saved substantial amounts of money – and poorer Alaskans have been saved immense pain and hardship – by allowing Medicaid to pay for exams, cleanings, fillings, root canals, and dentures before painful and expensive surgery became necessary. SB 199 will fix a small flaw in the cost-containment portion of the program and help protect this important state investment.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB199
() Publish Date:

Identifier (file name): SB199-DHSS-ADPMS-01-22-10
Dept. Affected: Health & Social Services

Title: Medicaid Coverage for Dentures
RDU: Health Care Services
Component: Adult Preventive Dental

Sponsor: Ellis

Requester: Senate HSS
Component Number: 2839

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITU	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	935.0		467.5	0.0	0.0	0.0	0.0
Miscellaneous							
TOTAL OPERATING	**935.0**	**0.0**	**467.5**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	626.5		266.5				
1003 GF Match	308.6		201.0	0.0	0.0	0.0	0.0
1004 GF							
1005 GF/Program Receipt							
1037 GF/Mental Health							
Other Interagency Receipt							
TOTAL	**935.0**	**0.0**	**467.5**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) c

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece*

This bill addresses limitations of coverage for upper and lower dentures within a given state fiscal year with the current $1,150 annual limit. The annual limit provides for expenditures that would typically cover only an upper or lower denture, thus requiring Medicaid recipients to wait until the subsequent fiscal year to obtain the opposing denture under the Adult Preventive Dental (APD) program. The bill would authorize the department to allow for provision of both an upper and lower denture within the same state fiscal year, however when these services are provided the adult recipient would not be eligible for additional services under the APD program for a 2-year period.

In SFY 2009, the total cost of complete, partial and immediate denture claims was approximately $1,620.0. (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Division: Health Care Services
Phone: 269-7827
Date/Time: 1/20/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Finance & Management Services
Date: 1/22/2010

(Revised 11/6/2009 OMB)

ANALYSIS CONTINUATION

We estimate that the cost of denture services in the APD has grown at the same rate as all Health Care Services Medicaid Services costs (forecasted to be 6%) from FY 2009 to 2010. Medicaid growth for APD alone is forecasted to be 8.9% from FY 2010 to 2011 to reach a baseline cost of $1,868.0 for denture services in FY 2011 with no changes to the program.

With the changes proposed in this bill and an expected effective date of July 1, 2010, we estimate the baseline costs noted above for denture services in FY 2011 will increase by 50%, assuming half of denture services recipients would be completing the denture process from FY2010 and the other half would be getting both their upper and lower dentures in FY 2011 for a total cost of $2,803.0 (a difference of $935.0 from baseline). We would still expect some increased costs over baseline in FY2012 as the number of people getting denture services has been growing each year as adults continue to learn about the APD program and this bill allows for them to be paid in one year. For FY2012, we estimate the need for increased funds to be half of the amount needed in FY 2011.

For subsequent years, we would expect the cost of denture services to level out to approximately what we would expect without the changes in this bill, the shift being not in cost but in how many recipients are receiving services.

For FY2011, we estimate 67% of APD services to be federally reimbursable, assuming ARRA FMAP increases are valid through all 4 quarters of FY 2011. For FY2012 we expect a FMAP of 50%. As some ADP services are IHS and reimbursed at 100%, we expect 57% of ADP costs to be federally reimbursable.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB199**
() Publish Date:

Identifier (file name):SB199-DHSS-MAA-01-22-10
Dept. Affected: Health & Social Services

Title: Medicaid Coverage for Dentures
RDU: Health Care Services
Component: Medical Assistance Administration

Sponsor: Ellis

Requester: Senate HSS
Component Number: 242

Expenditures/Revenu (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITU	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	157.0		157.0	157.0	157.0	157.0	157.0
Travel							
Contractual	9.6		9.6	9.6	9.6	9.6	9.6
Supplies	2.0		2.0	2.0	2.0	2.0	2.0
Equipment	15.2						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**183.8**	**0.0**	**168.6**	**168.6**	**168.6**	**168.6**	**168.6**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	91.9		84.3	84.3	84.3	84.3	84.3
1003 GF Match	91.9		84.3	84.3	84.3	84.3	84.3
1004 GF							
1005 GF/Program Receip							
1037 GF/Mental Health							
Other Interagency Receip							
TOTAL	**183.8**	**0.0**	**168.6**	**168.6**	**168.6**	**168.6**	**168.6**

Estimate of any current year (FY2010) c

POSITIONS

Full-time	**2.0**		2	2	2	2	2
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece:*

SB199 is meant to address limitations of coverage for upper and lower dentures within a given state fiscal year under the $1,150 annual limit. The annual limit provides for expenditures that would typically cover only an upper or lower denture, thus requiring Medicaid recipients to wait until the subsequent fiscal year to obtain the opposing denture under the Medicaid program.

The bill would authorize the department to allow for provision of both an upper and lower denture within the same state fiscal year, however when these services are provided the adult recipient would not be eligible for additional services under Medicaid preventative and restorative dental for a two-year period.

Prepared by: William J. Streur, Deputy Commissioner
Division: DHSS Health Care Services
Phone: (907) 334-2520
Date/Time: 1/21/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Finance & Management Services
Date: 1/22/2010

(Revised 11/6/2009 OMB)

5107

STATE OF ALASKA

2010 LEGISLATIVE SESSION

BILL NO. SB199

ANALYSIS CONTINUATION

The Division of Health Care Services estimates that it will need a total of 2 FTE's to fully track expenditures and to authorize procedures up to the limit of the proposed legislation.

Administrative Costs:

1 Medical Assistance Administrator II (Range 18), $84,510; 1 Medical Assistance Administrator I (Range 16), $72, 530. All personal services costs include benefits. Assumes $9.6 per FTE annually for office space, phones, and other contractual costs; $2.6 one time costs per FTE for computers and software; $5.0 one time costs per FTE for office equipment; $2.0 per FTE annually for supplies.

Medical Assistance Administrator I and II Duties

If legislation is passed and implemented to allow recipients the ability to utilize two fiscal year's annual cap for dentures (full sets and partials) during SFY2011, it will create a labor intensive process of tracking the service limits manually. Our current Medicaid Management Information System has the capability of applying service exceptions on an annual basis only. Combining two years limits will require a manual work-around for tracking the 11 denture and partial procedure codes being utilized by approximately 4,400 recipients, and follow-up to ensure limits are not exceeded nor services duplicated at any point in the two year period. To authorize payment of individual dental claims, staff will have to research, review, and evaluate the recipients' claims and treatment history for the two year period in question. The division estimates the need for two Medical Assistance Administrators to handle the increased workload.

INFORMATION FOR SENATOR ELLIS ON DENTAL MEDICAID SERVICES FOR ADULT RECIPIENTS

Note: For all information below it should be noted that providers have up to 12 months to submit Medicaid claims, this information is based on information processed the 4th week of October 2009.

1. How many recipients have taken advantage of the enhanced dental services, (preventative and restorative dental services), for adults enrolled in Medicaid?

April 1, 2007 (implementation date) – June 30, 2009: 14,227
FY2009: 9,715

2. How much has been expended so far for enhanced dental services?

April 1, 2007 – June 30, 2009: $10,512,124
FY2009: $5,669,737

3. What services were funds spent on?

Fillings (1 and 2 surface amalgam and resin restorations):
April 1, 2007 – June 30, 2009: 15, 275 Expenditure: $1,801,888
FY2009: 7,732 Expenditure: $992,027

Root canal therapy (RCT) on a permanent tooth (includes RCT retreatment):
April 1, 2007 – June 30, 2009: 1,672 Expenditure: $772,748
FY2009: 792 Expenditure: $407,579

Dentures (includes complete, immediate & partial dentures):
April 1, 2007 – June 30, 2009: 3,517 Expenditure: $3,283,487
FY2009: 1,737 Expenditure: $1,618,580

Complete Dentures:
April 1, 2007 – June 30, 2009: 1,920 Expenditure: $1,906,075
FY2009: 934 Expenditure: $915,797

Immediate Dentures:
April 1, 2007 – June 30, 2009: 656 Expenditure: $644,310
FY2009: 323 Expenditure: $322,661

Partial Dentures:
April 1, 2007 – June 30, 2009: 941 Expenditure: $733,102
FY2009: 480 Expenditure: $380,122

Note: Immediate dentures are similar to complete dentures but fabricated so they can be placed right after the oral surgery to extract the teeth in the upper or lower arch.

Log 97/2009

4. Do you have any estimates of cost-savings to the state based on the preventative nature of many of the dental services included in the enhanced dental services (preventative and restorative)?

It is anticipated that with services in place for a number of years, there would be infrastructure developed to reduce use of the hospital emergency room for dental related emergent services. It is not uncommon for adults to utilize the emergency room for relief of pain and/or infection related to dental problems. About 2 years ago the medical director at Providence Hospital Emergency Room indicated they were averaging 3-4 adults per day on dental related cases and that their services were often palliative (e.g., providing antibiotics) and not correcting the source of the pain/infection. Offering routine restorative dental services along with attempts to change behaviors related to diet, tobacco use and oral hygiene will reduce dental decay involving the pulp of the tooth – which often leads to the need for root canal therapy or extraction.

Confounding issues to track any reductions include there is not a current system in place to track how many emergency room visits related to dental problems occur statewide for baseline or trend data. Further, there are communities in the state where dentist participation in Medicaid is limited. Finally, it will take time to change behavior in seeking care prior to having pain – often individuals with emergent-based care are fearful of dental services. Despite having coverage they may wait until they have pain to seek dental services. Therefore, it will take time to change attitudes and behaviors for some adult Medicaid recipients to appropriately seek dental care.

Routine exams and restorative care clearly will reduce the number of teeth requiring more significant restorations (e.g., crowns), root canal therapy and/or extractions. However, crowns, root canals and complete/partial dentures were not part of the Medicaid dental services for adults prior to the enhancement – these costs would have been borne by the Medicaid recipient, not the Medicaid program.

In talking with Tribal programs and one of the oral surgeons that participate in Medicaid, there have been savings related to oral surgery although it is not feasible to quantify the savings. These providers indicate that past coverage often resulted in repeated visits for dental extractions as only the teeth that were symptomatic were extracted. With the new services all teeth that are not restorable can be extracted and avoid repeated dental visits along with sedation costs.

The oral surgeon noted under current services some Medicaid recipients refuse extractions of teeth in the opposing arch to a complete denture when they know it will be months before Medicaid will cover the other complete denture. This often means two times the recipient undergoes oral surgery and this can be under general anesthesia. He noted the discussion on covering upper and lower complete dentures for those needing them would reduce the costs associated with two visits required for the extractions and would be an improved quality of care to the adult Medicaid recipients.

Specific to dentures:

5. How many clients were unable to schedule denture procedures to coincide with the June 30/July 1 changeover of the fiscal year?

There is not a way to track individuals that had problems meeting the timing of the June 30th/July 1st period to get an upper and lower denture utilizing the annual limit for the two respective fiscal years – other than the few contacts the department received from individuals faced with not getting the upper/lower dentures during this window. The department heard a number of these complaints with the 4th quarter implementation of the services in FY2007.

The Alaska Mental Health Trust authority may be able to provide some information on this issue from the perspective of their beneficiaries as in many of these cases the Trust assisted with funding for the opposing denture when recipients missed this window for getting the upper/lower denture within a short period of time.

6. Is there an estimate of the number of clients who were provided additional services (flights, room/board, etc) in order to receive a denture procedure? How many of those additional services could be avoided by passing Senator Ellis' proposed legislation?

As noted in the response to Question 4, some recipients have declined extractions of teeth in the opposing arch to a denture when they face a prolonged period that they would be without teeth in that arch. This situation will result in an additional oral surgery visit, with sedation and/or general anesthesia, to extract these teeth when they have coverage under the annual limit for the opposing denture.

If the recipient had to travel for the placement of the opposing denture this would add to travel and/or lodging costs for an additional trip. In addition, it could result in another travel need for adjustments of the denture (especially for complete and immediate dentures).

At this time the department does not have an estimate of the number of adult Medicaid recipients that met criteria for these additional expenditures, however the department will attempt to provide examples or expenditure information prior to the start of the 2010 legislative session.

ALASKA
PRIMARY CARE ASSOCIATION

The Honorable Senator Ellis
Alaska State Senate
State Capitol, Room 103
Juneau, Alaska 99801-1182

Re: Support for Medicaid Coverage for Dentures – SB 199

January 22, 2010

Dear Senator Ellis,

The Alaska Primary Care Association (APCA) represents 26 health care organizations and 142 non-profit Community Health Centers (CHCs), as well as other safety net providers throughout Alaska. In 2009, our sites provided primary healthcare to over 81,000 Alaskans from across the state. According to the Alaska Community Health Center Uniform Data System, Alaska's CHC provided dental services to 16,244 Alaskans and totaled 39,016 dental encounters in 2007.

The APCA supports providing a two-year funding cycle for Medicaid assistance coverage for dentures. The APCA knows that access to dental services improves health outcomes and reduces overall health care costs. Oral health is critical for overall health and adults in the Medicaid program receiving access to dental services reduces the likeliness that they will develop more expensive and acute dental problems.

We appreciate your hard work and service to Alaskans and support your efforts to expand access to health care for all Alaskans.

Respectfully,

Regan Mattingly
State Affairs Coordinator

Shelley S. Hughes
Government Affairs Director

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STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

January 23, 2010

Senator Johnny Ellis
Senate Health and Social Services Committee
Alaska State Capitol, Room 103
Juneau, AK 99801-1182

Subject: Support Letter for SB 199

Dear Senator Ellis:

The Alaska Commission on Aging (ACoA) is pleased to offer support for SB 199, a bill to provide access to Medicaid patients who are approved for dentures using a two-year funding cycle for medical assistance benefits to cover the costs for complete and partial dentures in a single fiscal year. This legislation is authored by you and co-sponsored by Senators Bettye Davis, Dennis Egan, Hollis French, Linda Menard, Donald Olson, Joe Paskvan, Joe Thomas, and Bill Wielechowski.

The Commission believes SB 199 provides a common sense solution that allows patients and their dentists the flexibility to schedule treatment around the oral health needs of the patient, which will improve the quality of care for older Alaskans and other qualifying recipients. Moreover, this legislation enhances the cost-effectiveness of the current Medicaid Adult Dental program by reducing the number of oral surgery visits, medical procedures, and related travel costs required for individuals who need a complete set of dentures but are limited to half of a set of dentures per fiscal year under the existing program. Anecdotally, we have learned that some individuals may even refuse partial extractions in one arch knowing that they could be without teeth for a prolonged period waiting for Medicaid to cover the cost of the other complete denture in the next fiscal year.

Good nutrition is vital for health and wellness across the life span and depends on oral health. Dental pain and missing or decaying teeth can affect dietary choices for seniors that may impact overall health and wellness. Vulnerable older Alaskans are at risk of developing dental infections that have been associated with periodontal disease, diabetes, pneumonia, and other chronic diseases including cardiovascular disease. Restorative dental care can help to prevent the progression of serious dental disease and discomfort which can result in more costly emergency care.

Older Alaskans utilize the Medicaid Adult Dental program. According to data based on Medicaid claims information for persons age 60 years and older for the period April 1, 2007 thru December 31, 2009, there were a total of 3,104 (unduplicated) seniors served by the Medicaid Adult Dental Program. The average cost for partial dentures for seniors ranges between $1,085 (for a complete maxillary denture) to $1,125 (for a complete mandibular denture). The approximate cost for a complete set of dentures is $2,225. The current program cap is $1,150 per year.

As we move forward, the Commission respectfully asks for your consideration of our recommendations below to enhance SB 199 and the Adult Dental Medicaid program for qualifying older Alaskans and other Medicaid recipients:

- Allow eligible patients access to two years of total funding as determined by the cost cap of the Medicaid Adult Dental program to permit individuals receiving partial dentures through the program the ability to access remaining benefits under the cost cap should they need additional denture services during the two-year period.

- Pending approval of SB 199, begin work with the Department of Health and Social Services to expand the two-year access of services to phase in other preventative and restorative services allowed under the Medicaid Adult Dental program in FY 2012.

- Adjust the annual cost cap for dental services (currently in statute for the last three years) to address the rising costs of dental care and encourage more participation of Medicaid dental providers.

Please accept our sincere appreciation for your efforts to improve the Medicaid Adult Dental program by allowing patients who qualify for dentures under the program to receive their full set of dentures according to a treatment schedule determined by the patient with their dentist. We believe that SB 199 will help to improve health and wellness for many older Alaskans who need dentures and we support passage of this legislation. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information. Thank you.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

Cc: Senator Bettye Davis
Senator Dennis Egan
Senator Hollis French
Senator Linda Menard
Senator Donald Olson
Senator Joe Paskvan
Senator Joe Thomas
Senator Bill Wielechowski

Sen. Bettye Davis

From: Steven Bliss [sbliss@alaska.com]
Sent: Saturday, January 23, 2010 7:49 PM
To: Sen. Bettye Davis
Subject: Support for SB199 Medicaid Adult Dental Coverage

Senator Davis

I would like to add my support for the following endorsement from the Alaska Dental Society. We as dental providers really do want to minimize costs to the State and inconvenience for the poor recipients of the needed dental procedures. It would seem to me that there is hardly a downside in paying the same amount of money averaged over two years.

I urge you to support SB-199.

SB199 will remedy an unintended outcome of the adult dental supplemental Medicaid, which hinders patients from receiving care in a timely fashion.

Currently, under the maximum allowable benefit, a Medicaid recipient may receive either an upper or lower denture. Unfortunately many Medicaid recipients need dentures for both the upper and lower jaws or dental arches.

SB199 would allow a Medicaid recipient to combine two years worth of coverage so they could receive a full denture of both upper and lower dentures at the same time.

SB199 provides a benefit for everyone involved - the patient, the doctor and the Medicaid program:

. Medicaid recipients benefit from receiving both dentures at once, restoring their appearance, their ability to talk and chew, and most importantly their dignity.

. Providers benefit as they are no longer placed in the uncomfortable position of deciding which arch is in the worst condition. They can also work in a more efficient fashion constructing both sets of dentures simultaneously.

. The state benefits economically. The cost for both dentures, which would normally be borne over 2 years are now in one year but Medicaid recipients would still be limited to the same benefit total for 2 years. Denture patients frequently have to use travel benefits to reach a provider and for dentures this can be especially costly as dentures require multiple appointments. Providing both dentures at the same time would reduce the states travel expenses in half. Removing diseased and abscessed teeth would also save on costly ER and oral surgery visits.

Thank you for voting for SB199.

Sincerely,

RECEIVED
JAN 25 2010

Steven D. Bliss
502 E Fireweed Ln
Anchorage, AK 99503

This is a form letter. 15 additional copies were received.

5115

Sen. Bettye Davis

From: Ryle Radke III [rradke@mosquitonet.com]
Sent: Thursday, January 21, 2010 5:47 PM
To: Sen. Bettye Davis
Subject: Support for SB199 Medicaid Adult Dental Coverage

Senator Davis

I urge you to support SB-199.

I served almost 10 years at the Salvation Army Dental Access Program before it closed in 2007. One of the most satisfying services that I provided was providing upper and lower dentures to patients that had lost all their teeth. Many patients testified about the change, that having a complete set of teeth, made in how other people related to them, and the improved opportunities for gaining employment.

As a practicing dentist I can also testify on the vastly improved outcome of a denture case if the two sets (upper and lower) are fitted simultaneously as opposed to making one and then later trying to fit the other one to the existing. Fit, form, and function will be much better if dentures are made as a set.

I urge you to vote for SB-199

Sincerely,

Ryle A Radke III, DDS
[redacted]9 Carnegie Way
Fairbanks, AK 99709

RECEIVED
JAN 25 2010

5116

Sen. Bettye Davis

From: Jullie Robinson [jm_robinson05@yahoo.com]
Sent: Friday, January 22, 2010 11:09 AM
To: Sen. Bettye Davis
Subject: Support for SB199 Medicaid Adult Dental Coverage

Senator Davis

I urge you to support SB-199.

SB199 will remedy an unintended outcome of the adult dental supplemental Medicaid, which hinders patients from receiving care in a timely fashion.

Currently, under the maximum allowable benefit, a Medicaid recipient may receive either an upper or lower denture. Unfortunately many Medicaid recipients need dentures for both the upper and lower jaws or dental arches.

SB199 would allow a Medicaid recipient to combine two years worth of coverage so they could receive a full denture of both upper and lower dentures at the same time.

SB199 provides a benefit for everyone involved - the patient, the doctor and the Medicaid program:

. Medicaid recipients benefit from receiving both dentures at once, restoring their appearance, their ability to talk and chew, and most importantly their dignity.

. Providers benefit as they are no longer placed in the uncomfortable position of deciding which arch is in the worst condition. They can also work in a more efficient fashion constructing both sets of dentures simultaneously.

. The state benefits economically. The cost for both dentures, which would normally be borne over 2 years are now in one year but Medicaid recipients would still be limited to the same benefit total for 2 years. Denture patients frequently have to use travel benefits to reach a provider and for dentures this can be especially costly as dentures require multiple appointments. Providing both dentures at the same time would reduce the states travel expenses in half. Removing diseased and abscessed teeth would also save on costly ER and oral surgery visits.

Thank you for voting for SB199.

Sincerely,

Julie M.Robinson, D.D.S.
6222 W Dimond Blvd
Anchorage, AK 99502

RECEIVED
JAN 25 2010

ALASKA
PRIMARY CARE ASSOCIATION

The Honorable Senator Ellis
Alaska State Senate
State Capitol, Room 103
Juneau, Alaska 99801-1182

Re: Support for Medicaid Coverage for Dentures – SB 199

January 22, 2010

Dear Senator Ellis,

The Alaska Primary Care Association (APCA) represents 26 health care organizations and 142 non-profit Community Health Centers (CHCs), as well as other safety net providers throughout Alaska. In 2009, our sites provided primary healthcare to over 81,000 Alaskans from across the state. According to the Alaska Community Health Center Uniform Data System, Alaska's CHC provided dental services to 16,244 Alaskans and totaled 39,016 dental encounters in 2007.

The APCA supports providing a two-year funding cycle for Medicaid assistance coverage for dentures. The APCA knows that access to dental services improves health outcomes and reduces overall health care costs. Oral health is critical for overall health and adults in the Medicaid program receiving access to dental services reduces the likeliness that they will develop more expensive and acute dental problems.

We appreciate your hard work and service to Alaskans and support your efforts to expand access to health care for all Alaskans.

Respectfully,

Regan Mattingly
State Affairs Coordinator

Shelley S. Hughes
Government Affairs Director

Alaska Primary Care Association
903 W Northern Lights Blvd, Suite 200
Anchorage, AK 99503

ph. 907-929-2722
fx. 907-929-2734
www.alaskapca.org

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

January 23, 2010

Senator Johnny Ellis
Senate Health and Social Services Committee
Alaska State Capitol, Room 103
Juneau, AK 99801-1182

Subject: Support Letter for SB 199

Dear Senator Ellis:

The Alaska Commission on Aging (ACoA) is pleased to offer support for SB 199, a bill to provide access to Medicaid patients who are approved for dentures using a two-year funding cycle for medical assistance benefits to cover the costs for complete and partial dentures in a single fiscal year. This legislation is authored by you and co-sponsored by Senators Bettye Davis, Dennis Egan, Hollis French, Linda Menard, Donald Olson, Joe Paskvan, Joe Thomas, and Bill Wielechowski.

The Commission believes SB 199 provides a common sense solution that allows patients and their dentists the flexibility to schedule treatment around the oral health needs of the patient, which will improve the quality of care for older Alaskans and other qualifying recipients. Moreover, this legislation enhances the cost-effectiveness of the current Medicaid Adult Dental program by reducing the number of oral surgery visits, medical procedures, and related travel costs required for individuals who need a complete set of dentures but are limited to half of a set of dentures per fiscal year under the existing program. Anecdotally, we have learned that some individuals may even refuse partial extractions in one arch knowing that they could be without teeth for a prolonged period waiting for Medicaid to cover the cost of the other complete denture in the next fiscal year.

Good nutrition is vital for health and wellness across the life span and depends on oral health. Dental pain and missing or decaying teeth can affect dietary choices for seniors that may impact overall health and wellness. Vulnerable older Alaskans are at risk of developing dental infections that have been associated with periodontal disease, diabetes, pneumonia, and other chronic diseases including cardiovascular disease. Restorative dental care can help to prevent the progression of serious dental disease and discomfort which can result in more costly emergency care.

Older Alaskans utilize the Medicaid Adult Dental program. According to data based on Medicaid claims information for persons age 60 years and older for the period April 1, 2007 thru December 31, 2009, there were a total of 3,104 (unduplicated) seniors served by the Medicaid Adult Dental Program. The average cost for partial dentures for seniors ranges between $1,085 (for a complete maxillary denture) to $1,125 (for a complete mandibular denture). The approximate cost for a complete set of dentures is $2,225. The current program cap is $1,150 per year.

As we move forward, the Commission respectfully asks for your consideration of our recommendations below to enhance SB 199 and the Adult Dental Medicaid program for qualifying older Alaskans and other Medicaid recipients:

- Allow eligible patients access to two years of total funding as determined by the cost cap of the Medicaid Adult Dental program to permit individuals receiving partial dentures through the program the ability to access remaining benefits under the cost cap should they need additional denture services during the two-year period.

- Pending approval of SB 199, begin work with the Department of Health and Social Services to expand the two-year access of services to phase in other preventative and restorative services allowed under the Medicaid Adult Dental program in FY 2012.

- Adjust the annual cost cap for dental services (currently in statute for the last three years) to address the rising costs of dental care and encourage more participation of Medicaid dental providers.

Please accept our sincere appreciation for your efforts to improve the Medicaid Adult Dental program by allowing patients who qualify for dentures under the program to receive their full set of dentures according to a treatment schedule determined by the patient with their dentist. We believe that SB 199 will help to improve health and wellness for many older Alaskans who need dentures and we support passage of this legislation. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information. Thank you.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

Cc: Senator Bettye Davis
Senator Dennis Egan
Senator Hollis French
Senator Linda Menard
Senator Donald Olson
Senator Joe Paskvan
Senator Joe Thomas
Senator Bill Wielechowski

Alaska Dental Society, Inc.
9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
info@akdental.org

The Honorable Johnny Ellis
State Capitol, Rm 103
Juneau, AK 99801 + 1182

5 November 2009

Dear Senator Ellis:

Thank you for sponsoring the legislation to allow Medicaid recipients to utilize two years of benefits to receive a full set of dentures. This will provide a valuable service for Medicaid recipients and will improve the delivery of care for providers. In a true win-win solution this should lessen the overall costs for the Medicaid division when the additional travel costs for delivering the same service twice and the associated medical and dental costs for trying to retain non salvageable teeth during that interim year are factored in.

Respectfully yours

Gary A Moeller

Gary A. Moeller, DDS
President

November 10, 2009

Senator Ellis
716 W. 4th Ave. Suite 500
Anchorage AK, 99501-2133

Dear Senator Ellis:

Thank you for sponsoring a bill to allow Medicaid recipients to use two consecutive years of supplemental benefits in the same year to receive upper and lower dentures at the same time. This will greatly help recipients as a single denture when you have no teeth to oppose it is of limited value. I believe it will ultimately lower costs for the Medicaid division, also, when travel benefits are factored in for this multi step procedure that must be repeated twice under the current system.

A case I did earlier this year may illustrate the problem providers' face. Due to HIPAA concerns I am not using names for this story.

I have a dental office in Juneau. Unfortunately, for a variety or reasons, dental offices in other Southeast communities do not usually accept new Medicaid patients. This patient had to travel over from Sitka and needed dentures, both upper and lower. He currently did not have either upper and lowers having lost both sets. The supplemental system for adult Medicaid benefits would cover a single denture, either the upper or lower. The patient, 78 years old and on fixed income, was unable to afford the second set even at reduced Medicaid fees. I wrote a letter Medicaid division, enclosed, outlining the problem and pointing out that travel costs associated with constructing the second set at a later date (when the new year's benefits kicked in) would ultimately cost more than the Medicaid fee for a denture. I received a reply from the division basically saying their hands were tied given the current statutes in place.

In the case of this patient I did a full set of dentures for the patient and absorbed the cost of construction of the second set. As I write this letter I saw two patients today in the same situation, one who lives here in Juneau that we are constructing an upper denture alone although he has no lower teeth. Currently are plan is construct the lowers after July

2237 N. Jordan Avenue, Juneau, AK 99801
Phone: (907) 780-6066 Fax: (907) 780-4274 info@juneausmiles.com

1, 2010. The second patient traveled here from Angoon and lost both his upper and lower dentures 2 weeks ago. His treatment will be further complicated as his old set was apparently ill fitting and led to a large tissue mass on the lower that will have to be removed prior to denture construction.

Sincerely,

David Logan, DDS

2237 N. Jordan Avenue, Juneau, AK 99801
Phone: (907) 780-6066 Fax: (907) 780-4274 Info@juneausmiles.com
www.juneausmiles.com

December 17, 2008

ACS
Preauthorizations
POB 240808
Anchorage, AK 99524-0808

Re: [redacted]
Medicaid #: [redacted]

Dear Sirs:

Mr. [redacted] is currently edentulous (without teeth) upper and lower. We have previously preauthorized Mr. [redacted] for a lower denture (preauth [redacted]) – working with a Sitka Clinic we had not previously seen Mr. [redacted].

Mr. [redacted] has been without teeth for 6 years. One denture, the maximum allowed under the MEDS system, will provide little improvement for him. Mr. [redacted] will be traveling to our office from Sitka for completion of the denture. The travel costs will ultimately cost more then the fee for the denture given the number of appointments required to properly construct a denture.

I am requesting preauthorization for upper and lower dentures (included) for Mr. [redacted]. This is a case where everyone will benefit: the state will have less overall costs then a second round of travel costs to construct the other denture after July 1, Mr. [redacted] will have opposing dentures to eat with, and my overall costs will be less then repeating the same appointments come July 1.

Sincerely,

, DDS

David Logan, DDS

2237 N. Jordan Avenue, Juneau, AK 99801
Phone: (907) 780-6066 Fax: (907) 780-4274 info@juneausmiles.com

The Trust

The Alaska Mental Health Trust Authority

Alaskan Seniors Living Longer Growing Stronger

from the Alaska Commission on Aging

brain injury network

Governor's Council on Disabilities and Special Education

Advisory Board on Alcoholism and Drug Abuse

abada amhb

Alaska Mental Health Board

Adjust Cap on Adult Dental Services Reimbursed by Medicaid

The Governor's Council on Disabilities and Special Education, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, and Alaska Commission on Aging, in collaboration with the Alaska Mental Health Trust Authority and the Alaska Brain Injury Network, jointly support the developing a solution that will allow for the adjustment of the current cap on adult dental services reimbursed by Medicaid.

- Currently, the annual cap for dental services – such as cleanings, exams, crowns, root canals and dentures – is $1,150 per individual. With the rising cost of dental care, this cap is proving not adequate yet the cap is set in statute and has not been increased in over three years.

- The American Dental Association recommends adult preventive and restorative dental services be included in all state Medicaid programs, and as former U.S. Surgeon General C. Everett Koop stated, "You're not healthy without good oral health."

- Trust beneficiaries continue to list dental services as a priority unmet health needs.

- The challenge this session is to find a current bill or to introduce a new bill that will create a method for adjusting the adult dental Medicaid cap on a regular basis or will at least increase the cap to cover the increase the cost of living increases over a 4 or five year period.

Therefore, we support a legislative solution that will allow for the adjustment of the current cap on adult dental services reimbursed by Medicaid.

11.18.09

5125

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

November 19, 2009

Honorable Johnny Ellis
Majority Leader
Alaska Senate
716 W. 4th Avenue
Anchorage, AK 99501

Dear Majority Leader Ellis:

On behalf of the 97,000 members of AARP in Alaska, we would like to pledge our support for your bill to establish a two year funding cycle for the adult dental benefit in Medicaid.

We understand you are particularly interested in changing the benefit for dentures so that an adult Medicaid beneficiary would be able to use the funds available for two years to pay for dentures. This makes sense for both the client and the provider.

Older persons in need of dentures often have accompanying nutrition problems. These nutrition problems can cause other health issues and create an overall deterioration in health status. For those who need them, dentures are essential to quality health care. Two-year funding for dentures should be considered sensible prevention with the long term possibility of saving Medicaid funds that would not need to be spent of more serious health care problems resulting from poor oral health status.

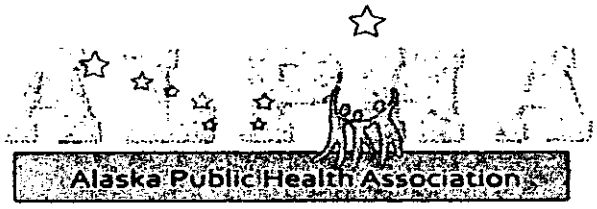
Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)



November 6, 2009

Senator Johnny Ellis
Senate Majority Leader
Alaska State Legislature
716 W. 4th Ave
Anchorage, AK 99501
Fax: (907) 269-017

Dear Senator Ellis;

I am writing on behalf of the Alaska Public Health Association (ALPHA) to extend our support for and thank you for introducing a Bill that will allow Alaska's adult Medicaid recipients to receive a set of dentures within one fiscal year. This Act will meet the needs of patients and dental providers by providing two-years worth of dental benefits for dentures in a single year.

The ALPHA represents over 150 health professionals in Alaska; the primary mission of ALPHA is the enhancement of the public's health. In fulfilling our mission, we support systems that support patient-oriented health service delivery. ALPHA believes that the "Act providing for a two-year funding cycle for medical assistance coverage for dentures" establishes a system enabling patients to receive patient-oriented care.

Thank you for consulting ALPHA in developing this Bill. Please feel free to contact me if you have further questions.

Sincerely,

Karol Fink, MS, RD
ALPHA Health Policy Chair
Karolfink@yahoo.com
907.227.8178

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

December 8, 2009

Senator Johnny Ellis
716 West 4th Ave. Suite 500
Anchorage, AK 99501-2133

Dear Senator Ellis:

The Alaska Commission on Aging (ACoA) is pleased to present to you our FY2011 legislative priorities for the upcoming session. These top issues were identified with input from older Alaskans, family caregivers, providers, and senior advocates statewide. The ACoA is a state agency under the Department of Health and Social Services, established in 1982. Our charge is to plan, educate and advocate on behalf of all older Alaskans (persons aged 60 years and older) through inter-agency collaboration so that Alaska seniors/elders may lead useful and meaningful lives with dignity and independence and have access to quality services when seniors need them to remain safely in their homes and chosen communities for as long as possible.

1. **Establish a regular and periodic schedule of rate reviews for home- and community-based services** that serve persons who are Medicaid-eligible and meet nursing home level of care. This measure will promote ongoing awareness of the true costs of providing services. SB 32, sponsored by Senator Johnny Ellis, passed the Senate and the House Health and Social Services Committee last session and waits to be scheduled for a hearing in House Finance. ACoA encourages passage of this legislation.

2. **Eliminate, or alternatively, adjust the cap on adult dental services reimbursed by Medicaid** to provide program benefits that keep pace with higher health care costs due to inflation, and **allow Medicaid patients access to two-years program benefits in a single year** to permit scheduling of treatment around the oral health care needs of the patient. The current law places a statutory $1,150 limit on dental health care expenditures per eligible client. When the Medicaid Adult Dental program was created in 2005, this amount was sufficient to pay for one half of a set of dentures, either an upper or lower, with the idea that a patient who needed dentures could have both sets if the treatment was scheduled around the turn of the fiscal year. Although health care costs continue to rise, the cap has not been increased in three years. Allowing Medicaid patients access to two years of program benefits in a single year furnishes Alaskans and their dentists the flexibility needed to provide treatment addressing oral health emergencies that can occur at any time.

3. **Provide increased operating and capital funding to establish an Alaskan Public Transportation Fund for operations of local coordinated transportation systems** which the State can use to leverage additional federal funds to improve accessible, affordable transportation for older Alaskans, persons with disabilities, low-income individuals, youth and others without access to transportation so that Alaskans with special needs may have greater access to employment and community participation opportunities. According to the Governor's Coordinated Transportation Task Force Report (2009), Alaska is one of only three states in the nation that does not provide any specific state funding for public transportation.

4. **Provide operating funding to enhance the Aging and Disability Resource Centers**, administered under the Division of Senior and Disabilities Services, to streamline access to more efficient information and referral services by providing eligibility screening, options counseling, and assessments so that Alaskans can make informed decisions and have access to long-term care services through a "one-stop shop," reducing confusion and program fragmentation.

5. **Return to the original wording of AS 47.07.020 (b) (6), the Medicaid statute establishing income eligibility for persons requiring nursing home level of care, referencing 300% of the maximum Supplemental Security Income (SSI) benefit rate rather than the current frozen dollar amount ($1,656 a month) to reflect changes in cost of living** so that seniors and other Medicaid-eligible persons will not be disqualified for services, including home- and community-based waiver services, due to small increases to their Social Security and other benefits. The amount of $1,656 is the monthly amount of 300% of SSI in 2003. The 2009 income equivalent is $2,022 monthly.

We also want to take this opportunity to share with you highlights from the Alaska Elder/Senior Community Forums that we hosted in Kotzebue (August) and Anchorage (December) to increase understanding about the issues that are of most importance to older Alaskans and to identify unmet needs. These forums, to be held in other locations statewide in the coming year, are being conducted to gather public input that will be used to develop the next Alaska State Plan for Senior Services, FY2012-2016. This document, prepared every four years, provides the State with a guide for delivering senior services and meets the requirement of the U.S. Administration on Aging for the state to access funding from the Older Americans Act which provides federal funding for a range of senior programs. Although these forums will be ongoing, Anchorage and Kotzebue participants identified the following issues as the most important:

- Provide improved access to quality and affordable health care, long-term supports that include home- and community-based services in communities where older Alaskans live, and promote disease prevention and wellness programs;
- Promote financial security, increase affordable senior housing, and improve elder safety;
- Provide safe, dependable, and affordable coordinated community transportation services so that seniors/elders can get to medical appointments and remain actively engaged in their communities;
- Enhance information and assistance services to help individuals access long-term support services and make informed decisions regarding their care.

Upon retirement, more seniors are choosing Alaska as their lifelong home to be close to family, friends and the unique Alaskan lifestyle. For the first time, Alaska is now the state with the fastest growing senior population, according to the U.S. Administration on Aging (2008), replacing Nevada, which held that position for many years. Alaska is home to approximately 80,000 persons aged 60 years and older who comprise about 12% of the state's population (Alaska Department of Labor). Alaska's senior population is expected to increase by four to six percent each year through 2020, as baby boomers become of age, by which time the total number of seniors will grow by almost 64 percent. The oldest Alaska seniors, 85 and older, are expected to triple during the next 25 years, vastly increasing the number of Alaskans living with Alzheimer's disease and related disorders.

Please feel free to contact Denise Daniello, ACoA's executive director (465-4879 or denise.daniello@alaska.gov) for additional information about these issues or with any questions concerning Alaska's senior population.

The Alaska Commission on Aging will be meeting in Juneau February 10th-12th, 2010 and hopes to schedule a meeting with you to discuss our priorities in person. We look forward to working with you this legislative session. We appreciate your consideration of these advocacy priorities and thank you for your support of services for older Alaskans.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

SB 215

5130

ALASKA STATE LEGISLATURE

Session
State Capitol, Rm. 115
Juneau, AK 99801
(907) 465-2435
Fax: (907) 465-6615

Interim
716 W. 4th Ave, Ste. 540
Anchorage, AK 99501
(907) 269-0120
Fax: (907) 269-0122

Senator_Bill_Wielechowski@legis.state.ak.us

Co-chair
Joint Armed Services Committee
Resources Committee

Member
Energy Committee
Judiciary Committee
World Trade Committee

SENATOR BILL WIELECHOWSKI

Sponsor Statement: SB 215
Maintaining Federal Prescription Benefits at Pioneer Homes

The intent of SB 215 is to ensure residents of Alaska's Pioneer Homes continue to receive their Federal prescription drug benefits.

This past spring, Veteran residents of Alaska's Pioneer Homes were caught in the middle of a bureaucratic dispute. Officials at the Pioneer Homes would no longer accept prescription medications from the Veterans Administration because of safety concerns with how those medications are packaged and labeled. The VA will not change the packaging or labeling of medications sent to the Pioneer Homes and the Pioneer Homes cannot repackage the medications. Therefore, Veterans who were unable to self-administer medications had no choice but to pay the Pioneer Homes' pharmacy out-of-pocket for necessary medications that they were supposed to receive for free from the VA.

Thanks to a joint effort between the Department of Health and Social Services, the Department of Military and Veterans Affairs, local public veterans' advocates and state legislators, a policy level solution was reached with the Department of Health and Social Services. State administrators found a way to safely administer prescription medications received from the VA and Veterans began to receive their free medications again.

SB 215 will prevent this type of problem from recurring by ensuring that federal prescription benefits will continue to be honored into the future. If state administrators identify a safety concern associated with providing federal prescription benefits, SB 215 will require the Pioneer Homes to cover the value of the denied benefit, so that residents can continue to receive the benefits that they have earned.

This bill would protect not only Veterans, but all Pioneer Home residents receiving Federal prescription benefits, including those from Indian Health Services. The Pioneer Homes have always worked with residents eligible for IHS benefits to ensure they receive their medications. However, if something changes in the future with the distribution of IHS drugs, SB 215 would ensure that Pioneer Homes would continue accepting these Federal benefits or cover the cost for affected residents.

With the passage of SB 215, Veterans and other groups who have earned Federal prescription benefits will no longer have to worry about not receiving their prescription medications because bureaucrats are unable reach, what should be, a simple agreement.

Please join me in supporting this legislation to ensure eligible Alaskans continue to receive the benefits they have earned.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB215
() Publish Date:

Identifier (file name): SB215-DHSS-PH-02-02-10
Dept. Affected: Health & Social Services

Title: Pioneers Home Rx Drug Benefit
RDU: Alaska Pioneer Homes
Component: Pioneer Homes

Sponsor: Wielechowski, Olson

Requester: Senate HSS
Component Number: 2671

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 215 ensures that eligible Pioneer Home residents will continue to have access to federal prescripton drug benefits available from the Veterans Administration or Indian Health Services. There is no fiscal impact to this bill as the Pioneer Homes are already allowing residents to access their federal prescription benefits.

Prepared by: Dave Cote, Director
Phone 465-5737
Division: Alaska Pioneer Homes
Date/Time 1/21/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/2/2010
DHSS Finance & Management Services

5132

SB 215 – Maintaining Federal Prescription Benefits at Pioneer Homes

Fact Sheet

PROBLEM:

- In April 2009, Veterans in the Pioneer Homes who can no longer administer their own medications stopped receiving the free or low cost medications which they are entitled through the VA.

- These veterans were forced to purchase the same medications from the Pioneer Homes pharmacy.

- The Pioneer Homes pharmacy prepares medications in blister packs so that nurse aides can safely and accurately administer medications to patients.

- The VA cannot provide medications in blister packs – the preferred method of disbursing medicine at the Pioneer Homes.

- VA doctors cannot write prescriptions to the Pioneer Homes because the Pioneer Homes are outside the VA system.

- The Pioneer Homes cannot repackage VA medications because the lot number and expiration would change upon repackaging.

- The Pioneer Homes claimed they did not have enough qualified nursing staff to administer medicine from a bottle (using the VA packaging).

SOLUTION:

- Pioneer Homes involved all interested parties to determine appropriate protocol for ordering, receiving, storing, administering and disposing of medications.

- The Alaska VA Healthcare System and Regional Office Chief Pharmacist and Chief of Staff conducted in-service visits to the Pioneer Homes to ensure nurses are properly administering medications directly from original VA bottles.

STATUTORY NEED:

- SB 215 will ensure that the solution put in place by the Pioneer Homes will remain in statute.

- If the Pioneer Homes identify a safety precaution that prevents them from disbursing medications as they currently are, the state run Pioneer Homes would cover the costs of the medications.

- The Pioneer Homes does not anticipate any changes to what they are doing currently.

- SB 215 prevents the need to "re-create the wheel" and ensures that individuals who have earned federal prescription benefits will continue to receive their benefits, even in the face of future administrative staffing changes.

PROBLEM

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Veterans caught in dispute over medicines

By ROSEMARY SHINOHARA
rshinohara@adn.com
(11/03/09 22:26:20)

Military veterans living in the state-run Alaska Pioneer Homes are losing out on free or low-cost prescription benefits they are entitled to for serving their country because two medical bureaucracies can't seem to figure out how to get VA drugs to them.

The problem -- mostly about the packaging the medicines come in -- affects those veterans who need help from staff to take their meds.

Instead of pill bottles, the Pioneer Homes want the medicine to come in blister packs -- foil on one side, plastic on the other, name of pill and patient on the package, with each pill ready to be individually popped out.

That's for safety, says Dave Cote, head of the Pioneer Homes.

But the Veterans Administration isn't set up to make blister packs, says Marcia Hoffman-Devoe, spokeswoman for the agency. "We don't have the space to do that. We do not have the capability to do that."

Bea Combs's stepfather, a Navy man from 1943 to 1945, was affected when the Anchorage Pioneers' Home quit accepting medicine from the VA last spring. So she's trying to get the problem taken care of for all veterans.

"I was very upset when they notified me I had to get drugs from the Pioneer Home pharmacy," she said. That change came with a bill for $120, on top of the $6,178 monthly her family is already paying for care of Melvin Ertwine, who is 86.

Ertwine was a yeoman 3rd class. He went on to become an engineer for the Alaska Railroad. He drove trains, including the engine that sits on the Delaney Park Strip downtown, Combs said.

Between the VA and Ertwine's Blue Cross retirement insurance, Combs didn't have to pay anything for her stepdad's medications until all the Pioneer Homes stopped accepting VA drugs in mid-April, she said.

A PACKAGING DIFFERENCE

Veterans can get prescriptions for free if they are considered more than 50 percent disabled from their service, and the most any honorably discharged veteran has to pay is $8 for a month's prescription.

Many veterans in Pioneer Homes were not taking advantage of VA benefits but instead used private insurance or the Medicare Part D prescription benefit, Cote said. A dozen of the 36 veterans in the Anchorage Pioneers' Home were getting their medicines from the VA, he said. A couple veterans in Palmer may also have been getting VA medicines, but that's about the extent

of the number of people affected, he said.

The state has Pioneer Homes, which are assisted-living facilities, in Anchorage, Palmer, Fairbanks, Juneau, Ketchikan, Palmer and Sitka. There are 114 veterans in Pioneer Home beds statewide, Cote said.

Until last spring, the Pioneer Homes received medicine packaged by the VA pharmacy in bottles. Pioneer Homes nurses would transfer the pills to pill boxes for each resident who needs assistance with medications. All the pills for a particular resident on a particular day and time would be mingled together in the pill boxes, which are similar to the pill boxes, or medi-sets, people might have at home.

Pioneer Homes nurses complained that wasn't safe enough, said Cote.

Once a medicine is in the pill box, it's not easy to identify which pill is what, Cote said. And besides, medication in medi-sets is supposed to be administered only by nurses, not nurse assistants, under state regulation, Cote says. The Pioneer Homes want to be able to use nurse assistants, which is OK if the drugs are in blister packs, he said.

In blister packs, "it's easy to tell if you're supposed to take a medicine on the 27 th of October at noon. If it's not punched out and gone, you can assume it's not administered," he said.

SEEKING A REFEREE

Bea Combs at first went to Cote trying to get her stepdad's VA drugs reinstated, then called Anchorage state Rep. Les Gara's office. Gara, Rep. Nancy Dahlstrom of Eagle River and Sen. Bill Wielechowski of Anchorage began sending letters and meeting with the Pioneer Homes officials.

One possible solution the legislators and Pioneer Homes came up with last week, said Cote, is for the state to contract with a provider to prescribe the medicines the dozen or so veterans who used VA prescriptions in Anchorage need; the state, in consideration of these veterans being unable to use their VA benefits, would then pick up the cost of the medicines. Cote is going to investigate this idea.

Combs doesn't see why it's such a difficult problem to solve.

The pills go from one pharmacy, unopened, to another pharmacy, she said. "To me, the liability doesn't make sense," she said. "Is there something else going on that I don't know?"

The two bureaucracies -- the VA and the Pioneer Homes -- both say they want to resolve the issue somehow.

Find Rosemary Shinohara online at adn.com/contact/rshinohara or call her at 257-4340.

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SOLUTION

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Anchorage Daily News

Veterans in Pioneer Homes will get their medicines from VA

FREE OR LOW COST: Issue of distribution safety resolved.

By ROSEMARY SHINOHARA
rshinohara@adn.com
(11/13/09 23:47:55)

The state announced Friday that it has found a solution that will allow veterans who live in state-run Alaska Pioneer Homes to get the free or low-cost medicines they are entitled to from the VA, but have been denied in recent months.

The state will also refund the money the affected veterans had to pay to fill prescriptions through the Pioneer Homes pharmacy, according to officials from the state Department of Health and Social Services.

The Pioneer Homes quit accepting medicine from the VA last April for veterans who need help from staff to take their pills. The decision affected about a dozen veterans in the Anchorage Pioneers' Home, and perhaps a couple of veterans at the Palmer home.

Pioneer Homes director Dave Cote said the VA medicine wasn't packaged in the right kind of packs to make sure staff could safely distribute it. The Pioneer Homes wanted the medicine to come in blister packs labeled with the patient's name, with foil on one side and plastic on the other and each pill ready to be popped out individually. That way it would be easy to tell if the pill had been administered.

But Cote said after a high-level meeting with Veterans Administration last week, it became clear "they could not be flexible. ... There was not anything they were going to do on their side of things."

Ken Strum, pharmacy chief for the Veterans Administration in Anchorage, said the VA doesn't have equipment needed to package medicine in blister packs as the Pioneer Homes wanted. And, Strum said, it would be against state regulation for the Pioneer Homes pharmacy to repackage in blister packs medicine it receives from the VA pharmacy.

So Cote and the Pioneer Homes nurses instead figured out the safest way to distribute VA medicine from the bottles it comes in, Cote said. Basically, they're going to be more careful.

The Pioneer Homes nursing staff will keep the pills in the original bottles, instead of transferring all of a veteran's pills into a pill box where all meds to be taken at a time would be mixed together. That's to prevent a problem in case certain prescriptions are discontinued, which happens often with older folks, Cote said.

Also, instead of allowing aides to dispense VA pills, nurses will do it, he said.

The dispute between the VA and the Pioneer Homes gained attention this fall after Bea Combs, stepdaughter of Pioneers Homes veteran Melvin Ertwine, went to a legislator's office seeking to get the free or low-cost medicines re-instated.

State Reps. Les Gara of Anchorage and Nancy Dahlstrom of Eagle River and Sen. Bill Wielechowski of Anchorage began sending letters and meeting with state administrators about it.

"I think it's a great solution," Wielechowski said Friday. "It was sort of two large bureaucracies clashing with each other. Somebody had to give."

The state was able to be "a little more nimble," he said. "One reason we were able to do it is it's a small number of people."

Find Rosemary Shinohara online at adn.com/contact/rshinohara or call her at 257-4340.

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MEMORANDUM for the STATE OF ALASKA

To: Senator Bill Wielechowski **Date:** 5 Feb 2010

From: Verdie Bowen
Director, Office of Veterans Affairs **Phone:** 907-428-6016

Subject: Senate Bill No. 215

I support Senate Bill No. 215 in its entirety. The problem experienced this past year to issue prescription medication through the Veterans Administration Pharmacy to the veterans population at the Alaska Pioneer Home should have been an easy one, but when federal and state governments are involved it becomes very complicated. Each time a solution was reached between the government agencies, a new reason was found not to issue the medications. Several work a rounds were attained until finally a good solution was reached. The time that passed between solution and implementation was way too long for the veterans and their families. The stress caused on the family members was enormous.

The basic issue of this problem was it affected the veterans who could not speak for themselves. I am speaking of those veterans with severe Alzheimer's and Dementia. I know a good solution was attained in the end and it does help the veterans who live in the Pioneer Homes now. But, I fear when we are all gone and this problem arises again no one will have the corporate knowledge to help these veterans again. By enacting Senate Bill 215 this will take the administration solution today and make it law and the concern I have about this issue arising again will be unfounded.

Thanks you for your support of SB 215.

v/r

Verdie A. Bowen

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Verdie.bowen@alaska.gov

ALASKA STATE COUNCIL

February 5, 2010
Senator Wielechowski
REF: SB215

Senator:

As one of the Veteran Service Organizations that worked through a number of meetings last year with you and other Members of our State Legislature including Rep Les Gara and Rep Nancy Dahlstrom and staff, I wanted to ensure each of you know how appreciated for your efforts and your willingness to step up for our veterans is as they face ongoing issues in relation to their care both at our State Pioneer Homes and the Alaska Veterans Home.

Each of you became intimately aware of the knot veterans face with differing government agencies attempting to untie their regulatory webs to meet the real day-to-day needs of our veterans. It was difficult, complex, and troubling. The leadership of this team of Legislators and the Commissioner of Health and Social Services in finding a solution was most welcome and appreciated. It will be remembered.

We are delighted you have decided to formally codify this new understanding in state law by the introduction of SB215. We have read the bill and discussed it with your staff and others and wanted you to know that you have the full support and appreciation of the veterans of Alaska, and specifically those Vietnam Veterans we represent here in Alaska and nationally. We will be forwarding this bill to other states who also face similar challenges.

I hope to be able to testify in support of this bill when it is before the various committees, but travel and work may keep me away. Please advise the members of any committee this bill is heard before that SB215 has our strong support and is listed as one of our top state legislative priorities for 2010.

If there is anything we can do to assist in moving this bill through this session, just ask.

It is an honor.

Ric Davidge
President

3705 Arctic Blvd #415, Anchorage, Alaska 99503
907 222 6945 907 222 6933 fax 907 229 5328 Chairman's Cell 907 748 1722 Ex Dir

5140

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/10

FURTHER: Finance

Date of 5-Day Notice: 2/3/10
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/9/10

Health and Social Services Committee considered SENATE BILL NO. 215

SB 215 PIONEERS HOME RX DRUG BENEFIT

"An Act requiring the Department of Health and Social Services to accept federal prescription drug benefits or to provide comparable benefits for residents of the Alaska Pioneers' Home."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DHSS	2/9/10			X	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Thomas	✓			
	ELLIS	X			
	PASKVAN	X			
	DYSON	X			
CHAIR:	DAVIS	X			

5141

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/10

FURTHER: Finance

Date of 5-Day Notice: 2/3/10
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/9/10

Health and Social Services Committee considered SENATE BILL NO. 215

SB 215 PIONEERS HOME RX DRUG BENEFIT

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[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DHSS	2/2/10				

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Thomas	✓			
	ELLIS	X			
	PASKVAN	X			
	DYSON	X			
CHAIR:	DAVIS	X			

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SB 219

ALASKA STATE LEGISLATURE

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Senate Special Committee on Energy
Senate Committee on World Trade,
Technology and Innovations

Co-Chair
Senate Resources Committee

Member
Senate Judiciary Committee

SENATOR LESIL MCGUIRE

Sponsor Statement
CS for Senate Bill 219 (26-LS1312\R)

The CS for Senate Bill 219R establishes a traumatic or acquired brain injury program and registry in the Department of Health and Social Services. Currently, Alaska has no specific program specifically to deal with brain injury and yet Alaska has one of the highest rates in the nation. Annually, there are about 800 Alaskans hospitalized with a traumatic brain injury resulting from falls, car crashes, domestic violence, All Terrain Vehicle crashes, and snow-machine crashes, among others. Furthermore, an approximately equal number of Alaskans are suffering from acquired brain injuries resulting from stroke, aneurism, or tumors.

Alaska urban and rural residents, including military are being discharged to their homes with little understanding of brain injury or access to in-state rehabilitation, severely impacting their families. Limited education about the injury, learning to cope with a person who has changed, overwhelming stress from insurance, bureaucracy, and financial burdens and change in family roles may render families dysfunctional.

With appropriate and available care, rehabilitation, community and family support, even the individual who is most severely injured can live at home, return to school or work, or engage in meaningful and productive lives.

Funding a Traumatic or Acquired Brain Injury (T/ABI) Program gives authority to the Department of Health and Social Services to collect data on the injured, positioning the state to access Medicaid funds for T/ABI. Medicaid services for T/ABI will be matched 50% by federal funds. The bill allows for streamlining department services and activities that are unique to T/ABI. This would better assist families and individuals with T/ABI in knowing how to access services and supports.

Early treatment may reduce future medical and social costs. Without appropriate services, some individuals with T/ABI may pose a threat to themselves or others. Without assistance, individuals with TBI often end up homeless, in jail or in nursing homes. Service coordination, rehabilitation, and appropriate supports can help to minimize these risks.

(2) On a mandatory basis under section 1932 (a)(1) of the Act or under section 1915(b) or section 1115 waiver authority.

[67 FR 41115, June 14, 2002]

§440.169 Case management services.

(a) *Case management services* means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with §441.18 of this chapter.

(b) T*argeted case management services* means case management services furnished without regard to the requirements of §431.50(b) of this chapter (related to statewide provision of services) and §440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.

(c) [Reserved]

(d) The assistance that case managers provide in assisting eligible individuals obtain services includes—

(1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:

(i) Taking client history.

(ii) Identifying the needs of the individual, and completing related documentation.

(iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.

(2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

(i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.

(ii) Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.

(iii) Identifies a course of action to respond to the assessed needs of the eligible individual.

(3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:

(i) Services are being furnished in accordance with the individual's care plan.

(ii) Services in the care plan are adequate.

(iii) There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

(e) Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

[72 FR 68091, Dec. 4, 2007, as amended at 74 FR 31196, June 30, 2009]

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LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 9, 2010

SUBJECT: Sectional Summary (SB 219 (Work Order No. 26-LS1312\R))

TO: Senator Lesil McGuire
Attn: Esther Cha

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds longitudinal data on traumatic or acquired brain injury from the registry established under sec. 5 of the bill to the list of databases that the Department of Health and Social Services is authorized to collect, analyze, and maintain.

Section 2. Adds case management services for traumatic or acquired brain injury to the optional services provided to recipients of state medical assistance (Medicaid).

Section 3. Defines "case management services for traumatic or acquired brain injury" and "traumatic or acquired brain injury" for purposes of the optional services added by sec. 2 of the bill.

Section 4. Requires the Department of Health and Social Services to provide medical assistance services under a waiver if approved by the federal government and if the legislature appropriates necessary funding for the services.

Section 5. Establishes a statewide traumatic or acquired brain injury program in the Department of Health and Social Services to evaluate the effectiveness and availability of information and services for the prevention and treatment of traumatic or acquired brain injury in the state. Requires consultation and collaboration with public and private entities to fulfill a list of programmatic requirements including development of a statewide service delivery plan and registry of information and evaluation of current laws and standards pertaining to traumatic or acquired brain injury.

JMM:ljw
10-078.ljw

26-LS1312\R
Mischel
2/5/10

CS FOR SENATE BILL NO. 219( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS MCGUIRE, Ellis

A BILL

FOR AN ACT ENTITLED

"An Act establishing a traumatic or acquired brain injury program and registry within the Department of Health and Social Services; and relating to medical assistance coverage for traumatic or acquired brain injury services."

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

*** Section 1.** AS 18.15.360(a) is amended to read:

(a) The department is authorized to collect, analyze, and maintain databases of information related to

(1) risk factors identified for conditions of public health importance;

(2) morbidity and mortality rates for conditions of public health importance;

(3) community indicators relevant to conditions of public health importance; [AND]

(4) **longitudinal data on traumatic or acquired brain injury from the registry established under AS 47.80.500(c)(1); and**

(5) any other data needed to accomplish or further the mission or goals of public health or provide essential public health services and functions.

*** Sec. 2.** AS 47.07.030(b) is amended to read:

(b) In addition to the mandatory services specified in (a) of this section and the services provided under (d) of this section, the department may offer only the following optional services: **case management services for traumatic or acquired brain injury;** case management and nutrition services for pregnant women; personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; advanced nurse practitioner services; clinic services; rehabilitative services for children eligible for services under AS 47.07.063, substance abusers, and emotionally disturbed or chronically mentally ill adults; targeted case management services; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; psychologists' services; clinical social workers' services; midwife services; prescribed drugs; physical therapy; occupational therapy; chiropractic services; low-dose mammography screening, as defined in AS 21.42.375(e); hospice care; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for individuals under age 21; and reasonable transportation to and from the point of medical care.

*** Sec. 3.** AS 47.07.030 is amended by adding a new subsection to read:

(e) In this section,

(1) "case management services for traumatic or acquired brain injury" means

(A) care and service coordination to assist individuals and families affected by traumatic or acquired brain injury to minimize the disabling effects of the injury;

(B) collaboration with providers and other organizations to expand and strengthen the local capacity for delivery of needed services, including housing, for the care and support of a recipient who is diagnosed with traumatic or acquired brain injury;

(C) participation in planning and accessing services within the community for the care and support of a recipient who is diagnosed with traumatic or acquired brain injury;

(D) the provision of information, referral, and case consultation services to a recipient who is diagnosed with traumatic or acquired brain injury;

(2) "traumatic or acquired brain injury" has the meaning given in AS 47.80.590.

* **Sec. 4.** AS 47.07 is amended by adding a new section to read:

Sec. 47.07.046. Traumatic or acquired brain injury services. (a) The department shall provide traumatic or acquired brain injury services under a waiver in accordance with 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act), this chapter, and regulations adopted under this chapter, if the department has received approval from the federal government and the department has appropriations allocated for the purpose. In addition to the annual assessment required in (b) of this section, the department shall establish in regulation additional standards for eligibility and payment for the services.

(b) Before the department may terminate payment for services provided under (a) of this section, the recipient must have had an annual assessment to determine whether the recipient continues to meet the standards established by regulation under (a) of this section.

(c) In this section, "traumatic or acquired brain injury" has the meaning given in AS 47.80.590.

* **Sec. 5.** AS 47.80 is amended by adding new sections to read:

Article 5A. Traumatic or Acquired Brain Injury.

Sec. 47.80.500. Statewide traumatic or acquired brain injury program. (a) A statewide traumatic or acquired brain injury program is established in the department for the purpose of evaluating the effectiveness and availability of information and services for the prevention and treatment of traumatic or acquired brain injury in the state. The department shall consult and collaborate with state agencies, private nonprofit entities, and other organizations in the state that provide

brain injury services in implementing all aspects of the program.

(b) The program established under this section must include

(1) review and consideration of data collected under (c)(1) of this section;

(2) supervision and coordination of services provided to persons with traumatic or acquired brain injury;

(3) evaluation of standards and laws pertaining to the prevention of traumatic or acquired brain injury and to the treatment, care, and support of persons with traumatic or acquired brain injury;

(4) assessment of the availability of acute and long-term treatment, care, and support options in and outside the state for persons with traumatic or acquired brain injury;

(5) evaluation of the need for and scope of community services for persons with traumatic or acquired brain injury throughout the state;

(6) investigation of the models of service coordination that can be replicated at a local level in the state;

(7) coordination and expansion of publicly and privately funded residential and nonresidential acute and long-term services to persons with traumatic or acquired brain injury, including education, referral, and home and community-based services;

(8) facilitation of admissions to and discharges from acute and long-term care facilities for the treatment of traumatic or acquired brain injury;

(9) identification and description of available treatment and care facilities of all types for persons with traumatic or acquired brain injury based on length of stay, patient capacity, available services, and barriers encountered to community placement after discharge;

(10) a plan that describes recommendations for the development of a statewide service delivery continuum of comprehensive rehabilitative, supportive living, and community programs.

(c) The department shall

(1) establish and implement a traumatic or acquired brain injury

registry of information from service providers that includes

(A) health status, including age, cause, and severity of injury and region of brain affected;

(B) acute recovery period;

(C) location of the

(i) event that caused the injury;

(ii) hospital treating the injury; and

(iii) residence of the person with traumatic or acquired brain injury;

(D) access to and use of rehabilitation services, including behavioral, vocational, and long-term care services;

(E) access to and use of neuropsychological assessment;

(F) status of long-term recovery at five-year intervals;

(G) financial and social effects on family;

(H) cost associated with services;

(2) establish standards and recommendations for improvement of prevention, assessment, treatment, and care of persons with traumatic or acquired brain injury in the state;

(3) contract with service providers and qualified entities to carry out the purposes of this section;

(4) provide a standardized reporting form for use in gathering data for the registry.

(d) In (c) of this section, "service provider" means a public or private entity that provides health education, group shelter, or criminal justice services to individuals in the state.

Sec. 47.80.590. Definition. In AS 47.80.500 - 47.80.590, "traumatic or acquired brain injury" means an insult from physical force or internal damage to the brain or its coverings, not of a degenerative or congenital nature, that produces an altered mental state and that results in a decrease in cognitive, behavioral, emotional, or physical functioning.

ALASKA STATE LEGISLATURE

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Senate Special Committee on Energy
Senate Committee on World Trade,
Technology and Innovations

Co-Chair
Senate Resources Committee

Member
Senate Judiciary Committee

SENATOR LESIL MCGUIRE

Summary of Changes
Between SB 219\A and CS for SB 219\R

This document is an identification of the changes between W.O. 26-LS1312\A and W.O. 26-LS1312\R. Some of the changes between SB 219A and CS for SB 219R are based on recommendations from the Department of Health and Social Services.

Title of SB 219A is amended so that "traumatic brain injury" is replaced with "traumatic or acquired brain injury" in CS for SB 219R because the program, registry, and medical assistance coverage deals with brain injury that is not only a result of sudden trauma but also otherwise acquired through stroke, aneurism, or tumors. All other references in **SB 219A** to "traumatic brain injury" have been replaced by "traumatic or acquired brain injury" in **CS for SB 219R**.

Section 1 of CS for SB 219R amends AS 18.15.360(a)(4) to state "longitudinal data on traumatic or acquired brain injury from the registry established under AS 47.80.500(c)(1); and." This section refers to a registry established under AS 47.80.500(c)(1) in **CS for SB 219R**, which lists specific longitudinal data on traumatic or acquired brain injury that the Department of Health and Social Services is authorized to collect.

4(A) through 4(D) in **Section 1 of SB 219A** is moved to **Section 5(c)(1) in CS for SB 219R** as (A) through (H).

Based on recommendations from the Department of Health and Social Services, the **CS for SB 219R** establishes the registry under AS 47.80, which deals with Persons with Disabilities under the Welfare, Social Services and Institutions. Persons with traumatic or acquired brain injury are currently under the jurisdiction of this sub-department. Originally in **SB 219A**, the registry would have fallen under AS 18.15, which deals with Disease Control and Threats to Public Health under Health, Safety, and Housing.

Section 2 of SB 219A is moved and established in **Section 5 of CS for SB 219R**. As a result, CS for SB 219R establishes the brain injury program in Title 47 of Alaska Statute, removing the program from Title 18 as established in SB 219A. The specifications in (c)(1) and (c)(2) in **SB 219A** are deleted in the **CS SB 219R**.

CS SB 219R therefore also amends the placement of the definition of "traumatic or acquired brain injury" to AS 47.80.590 from AS 18.15.590 in **SB 219A**. The CS for SB 219R changes the definition to "an insult from physical force or internal damage to the brain or its coverings, not of a degenerative or congenital nature, that produces an altered mental state and that results in a decrease in cognitive, behavioral, emotional, or physical functioning."

Some further clarifications are made in the CS for SB 219R, which are detailed later.

Section 3 of SB 219A is moved and established as **Section 2 of CS for SB 219R**. Section 2 of CS for SB 219R amends the bill to offer case management services for traumatic or acquired brain injury. The wording has not been changed between SB 219A and CS for SB 219 except for the use of "traumatic or acquired brain injury."

Section 4 of SB 219A is moved and established as **Section 3 of CS for SB 219R**.

Section 3 of CS for SB 219R:

- Adds a new subsection (e)(1) in AS 47.07.030 that defines what "case management services for traumatic or acquired brain injury" means as referred to in AS 47.07.030(b).
- Amends AS 47.07.030(e) by replacing "In this section, case management services for traumatic brain injury means" with "In this section,"
- Adds subsections AS 47.07.030(e)(1)(A), which further defines case management services as "care and service coordination to assist individuals and families affected by traumatic or acquired brain injury to minimize the disabling effects of the injury;"
- Moves what was AS 47.07.030(e)(1), AS 47.07.030(e)(2), and AS 47.07.030(e)(3) **in SB 219A** to AS 47.07.030(e)(1)(B), AS 47.07.030(e)(1)(C), and AS 47.07.030(e)(1)(D) in **CS for SB 219R**.
- Adds 47.07.030(e)(2), which indicates where the definition of "traumatic or acquired brain injury" can be found in Alaska Statute.

Section 5 of SB 219A is moved and established as **Section 4 of CS for SB 219R**.

Section 4 of **CS for SB 219R** adopts the new section AS 47.07.046 as established in **SB 219A**. The CS for SB 219R adds subsection AS 47.07.046(c) which specifies that the definition of "traumatic or acquired brain injury" can be found in AS 47.80.590.

Section 6 of SB 219A is removed in its entirety. However, **CS for SB 219R** does add a subsection (b)(10) in AS 47.80.500 which suggests that the Department of Health and Social Services deliver "a plan that describes recommendations for the development of a statewide delivery continuum of comprehensive rehabilitative, supportive, living, and community programs."

Section 5 of CS for SB 219R adds new sections to AS 47.80 that define "Article 5A. Traumatic or Acquired Brain Injury" and establish a statewide program under AS 47.80.500. The change was recommended by the Department of Health and Social Services because a traumatic or acquired brain injury registry would be better placed under AS 47.80, which deals with Persons with Disabilities under the Welfare, Social Services and Institutions.

The CS for SB 219R:

a. Establishes that a statewide traumatic or acquired brain injury program will be covered under AS 47.80 in **CS for SB 219R. SB 219A** had the program under AS 18.15.

b. Clarifies what must be included under the statewide traumatic or acquired brain injury program in AS 47.80.500(b).

   1. AS 47.80.500(b)(1) amends that the data collected under the registry can be found in AS 47.80.500 (c)(1) in **CS for SB 219R** and not AS 18.15.360(a)(4) in **SB 219A**

   2. AS 47.80.500(b)(2) in **CS for SB 219R** is now what was AS 18.15.500(b)(2) in **SB 219A**

   3. AS 47.80.500(b)(3) in **CS for SB 219R** is now what was AS 18.15.500(b)(3) in **SB 219A**

   4. The CS for SB 219R clarifies in AS 47.80.500(b)(4) that there needs to be an "assessment of the availability acute and long-term care treatment, care, and support options in and outside the state for persons with traumatic or acquired brain injury;" rather than an "assessment of the availability of acute and long term care options in and outside the state for persons with traumatic brain injury."

   5. AS 47.80.500(b)(5) in **CS for SB 219R** is now what was AS 18.15.500(b)(5) in **SB 219A**

   6. AS 47.80.500(b)(6) in **CS for SB 219R** is now what was AS 18.15.500(b)(6) in **SB 219A**

   7. The CS for SB 219R specifies in AS 47.80.500(b)(7) that there needs to be "coordination and expansion of public and privately funded residential and non-residential acute and long-term services, which includes education, referral, and home and community-based services."

   8. AS 47.80.500(b)(8) in **CS for SB 219R** is now what was AS 18.15.500(b)(8) in **SB 219A**

   9. Adds AS 47.80.500(b)(9), which further defines that there is more than just the traditional treatment and care facilities, which may include long-term acute care hospitals, neurobehavioral programs, neuro-rehabilitation, supportive living, clubhouse model, and home and community based services.

   10. Adds AS 47.80.500(b)(10), which describes recommendations for the development of a statewide service delivery continuum of comprehensive rehabilitative, supportive, living and community programs. This change replaces what was originally Section 6 in **SB 219A**, which developed a pilot project for a statewide traumatic brain injury program under the uncodified law of the State of Alaska.

c. CS for SB 219R adds a new subsection AS 47.80.500(c), which calls the Department of Health and Social Services to "establish and implement a traumatic or acquired brain injury registry of information from service providers" in AS 47.80.500(c)(1)

   1. Moves what was originally AS 18.15.360(a)(4)(A), AS 18.15.360(a)(4)(B), AS 18.15.360(a)(4)(C), and AS 18.15.360(a)(4)(D) **in SB 219A** under AS 47.80.500(c)(1) **in CS for SB 219R**

      A. Clarifies what constitutes "health status" in AS 47.80.500(c)(1)(A)

B. Identifies "acute recovery period" in AS 47.80.500(c)(1)(B)

C. Adds "location of the" in AS 47.80.500(c)(1)(C)

i. Adds location of the "event that caused the injury" in AS 47.80.500(c)(1)(C)(i)

ii. Adds location of the "hospital treating the injury" in AS 47.80.500(c)(1)(C)(ii)

iii. Adds location of the "residence of the person with traumatic or acquired brain injury" in AS 47.80.500(c)(1)(C)(iii)

D. Clarifies what "access to and use of rehabilitation services" includes in AS 47.80.500(c)(1)(D)

E. Adds "access to and use of neuropsychological assessment" under AS 47.80.500(c)(1)(E)

F. Adds "status of long-term recovery at five-year intervals" under AS 47.80.500(c)(1)(F)

G. Clarifies "family impacts" in **SB 219A** as "financial and social effects on family" in **CS for SB 219R** with AS 47.80.500(c)(1)(G)

H. Adds "cost associated with services" in AS 47.80.500(c)(1)(H)

2. Moves what was originally AS 18.15.500(c)(3) **in SB 219A** to AS 47.80.500(c)(2) in **CS for SB 219R**

3. Moves AS 18.15.500(c)(4) in **SB 219A** to AS 47.80.500(c)(3) in **CS for SB 219R**

4. Adds AS 47.80.500(c)(4), which calls the Department of Health and Social Services to "provide a standardized reporting form for use in gathering data for the registry"

d. Adds AS 47.80.500(d) which establishes the definition of "service provider" mentioned in AS 47.80.500(c)

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB219(HSS)
() Publish Date:

Identifier (file name): SB219CS(HSS)-DHSS-SDMS-2-12-10
Dept. Affected: Health & Social Services

Title: Traumatic Brain Injury: Program/Medicaid
RDU: Senior and Disability Services
Component: Senior and Disability Medicaid Services

Sponsor: McGuire

Requester: Senate HSS
Component Number: 2662

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITU	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	1,272.0		1,221.0	1,230.0	1,239.0	1,248.0	1,257.0
Miscellaneous							
TOTAL OPERATING	**1,272.0**	**0.0**	**1,221.0**	**1,230.0**	**1,239.0**	**1,248.0**	**1,257.0**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	777.4		610.5	615.0	619.5	624.0	628.5
1003 GF Match	494.6		610.5	615.0	619.5	624.0	628.5
1004 GF							
1005 GF/Program Receipt							
1037 GF/Mental Health							
Other Interagency Receipt							
TOTAL	**1,272.0**	**0.0**	**1,221.0**	**1,230.0**	**1,239.0**	**1,248.0**	**1,257.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece:*

SB 219 requires the Department of Health & Social Services (DHSS) to establish a traumatic or acquired brain injury (TABI) program and to provide Medicaid coverage for TBI services.

Section 2 amends the Medicaid statutes to include case management services for individuals with TABI to the list of optional Medicaid services. The provision adding TABI case management services to Alaska's optional Medicaid services has the potential to increase Medicaid utilization. This would necessitate an amendment to the state Medicaid Plan.

(continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 269-7827
Division: Health Care Services
Date/Time 2/3/10 1:00 PM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/12/2010
DHSS Finance & Management Services

ANALYSIS CONTINUATION

Assumptions:
The Alaska Brain Injury network estimates approximately 1,300 new hospital discharges per year due to TABI. The department estimates approximately 20% of new TABI discharges would be on Medicaid, which is the same prevalence of Medicaid enrollees in the general population. Also the number of new TABI cases is expected to grow with the population at 1% per year.

1,300 * 0.20 = 260 new cases in FY11
260*1.01=262.6, rounded to 263 new cases in FY12, and so on

Case management services, based on an examination of similar services covered by Medicaid, is estimated to cost $250/month for new TABI cases.

New Case Cost for FY12: 263*(12*250)=789,000

In addition, there were approximately 9,200 hospital discharges due to TABI from 2001-2007 and it is estimated that 30% of these discharged individuals are still living with TABI related effects. It is estimated that 30% of people living with disabilities or effects from past TABI (existing cases) are currently on Medicaid. This estimate is somewhat higher than the general population due to a higher prevalence of disability, unemployment and lower income in this group.

9,200 past discharges * 0.30 living with effects from TABI = 2,760
2,760 * 0.30 on Medicaid = 828 existing TABI cases

It is expected that approximately half of those cases would continue services. For existing cases - Medicaid currently has about 100 persons on waiver due to TABI (see below).

828 - 100 on waiver = 728

This would mean approximately 360 existing cases using case management services in FY11. Although it is anticipated that in the first year there would be a higher demand for services that in following years meaning an additional 50 cases in FY11. Future years the demand would level at about 360 continuing cases each year.

It is estimated that these existing cases would use services , but at a lower level than new cases, so $100/month for 12 months.

Continuing Case Cost for FY12: 360*(12*100) = 432,000

Total FY12 Case Management Costs Estimate: 432,000+789,000 = 1,221,000

For 2011, Title XIX services are expected be reimbursed at 61.12%, in further years, the federal reimbursement rate is estimated at 50%.

The department will also be required to either develop a new TBI Medicaid waiver or modify an existing waiver to accommodate the needs of TABI survivors. Federal regulations require that in order for individuals to be eligible for home- and community-based waivers, they must meet the state's criteria as needing an institutional level of care. Currently, those individuals with TABI who meet this level of care are already being served under the current waiver program. As of February 1, 2010 that number is 102 individuals. An increase in the cost of waiver service is not expected with this bill.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB219(HSS)
() Publish Date:

Identifier (file name): SB219CS(HSS)-DHSS-SDSA-2-12-10
Dept. Affected: Health & Social Services

Title: Traumatic Brain Injury: Program/Medicaid
RDU: Senior and Disabilities Services
Component: Senior and Disabilities Services-Administration

Sponsor: McGuire

Requester: Senate HSS
Component Number: 2663

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING							
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill will establish a Traumatic or Acquired Brain Injury (TABI) Registry, establish a TABI case management program within the Division of Senior and Disabilities Services, and add case management services for people with TABI to the list of optional Medicaid services available in Alaska .

Two positions are required: a TABI Program Manager who will supervise data collection and analysis, coordinate services to people with TABI, evaluate standards and laws related to TABI, assess the availability of and evaluate acute and long-term care community services, investigate model community services, and coordinate funding of TABI care; and a Research Analyst to develop procedures for the collection of TABI information statewide, design and present statistical data, construct and modify research procedures and instruct others in their proper use.

Current resources within the Division of Senior and Disabilities Services are sufficient to meet program needs.

Prepared by: Rebecca Hilgendorf, Director
Phone 907-269-2083
Division: Division of Senior and Disabilities Services
Date/Time 2/10/10 1:00 PM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/12/2010
DHSS Finance & Management Services

5158

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB219(HSS)
() Publish Date:

Identifier (file name): SB219CS(HSS)-DHSS-SDSA-2-12-10
Dept. Affected: Health & Social Services

Title: Traumatic Brain Injury: Program/Medicaid
RDU: Senior and Disabilities Services
Component: Senior and Disabilities Services-Administration

Sponsor: McGuire

Requester: Senate HSS
Component Number: 2663

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	172.0		172.0	172.0	172.0	172.0	172.0
Travel	6.0		6.0	6.0	6.0	6.0	6.0
Contractual							
Supplies							
Equipment	12.0		0.0	0.0	0.0	0.0	0.0
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**190.0**		**178.0**	**178.0**	**178.0**	**178.0**	**178.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	95.0		89.0	89.0	89.0	89.0	89.0
1003 GF Match	95.0		89.0	89.0	89.0	89.0	89.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**190.0**		**178.0**	**178.0**	**178.0**	**178.0**	**178.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time	**2.0**		2	2	2	2	2
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill will establish a Traumatic or Acquired Brain Injury (TABI) Registry; establish a TBI case management program within the Division of Senior and Disabilities Services; and expand Medicaid waivers to include TABI program participants.

Two additional positions will be required along with one-time setup costs for those positions, which include office furniture, telephone, and computer equipment. The first position, a TABI Program Manager (Range 19), will supervise the review and consideration of data collection; coordination of services to people with TABI; evaluation of standards and laws related to TABI; assessment and availability of acute and long-term care evaluation of available community services; investigation of model community services; coordination of funding of TABI care; facilitation of admissions and discharges; and identification and description of treatment and facilities for clients with TABI. The second position, a Research Analyst (Range 18), will develop forms, procedures and draft regulations regarding the collection of TABI information statewide; design and present statistical data; construct and modify research procedures and instruct others in their proper use. There are also annual travel costs associated with the work of this program. Federal funding for this position is 50% of total expenses. The salary and benefits for the two additional position totals $172.0.

Prepared by: Rebecca Hilgendorf, Director
Phone 907-269-2083
Division: Division of Senior and Disabilities Services
Date/Time 2/10/10 1:00 PM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/12/2010
DHSS Finance & Management Services

5159

(Revised 11/6/2009 OMB)

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB 258**
() Publish Date:

Identifier (file name): SB258-CED-INS-2-11-10
Dept. Affected: DCCED
Title: Dental Care Insurance
RDU: Insurance
Component: Insurance
Sponsor: Senator Huggins
Requester: Senate Health and Social Services Committee
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost: None

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill would prohibit health care insurers that provide dental care coverage from setting a minimum age for receiving dental care coverage, allow those insurers to set a maximum age for receiving dental care coverage as a dependent, and prohibit those insurers from setting fees that a dentist may charge for dental services not covered under the insurer's policy.

The department does not expect additional operating expenses as a result of this legislation.

Prepared by: Linda Hall, Director — Phone 907-269-7900
Division: Insurance — Date/Time 2/11/10 9:30 AM
Approved by: Emil Notti, Commissioner — Date 2/11/2010
Department of Commerce, Community and Economic Development

(Revised 11/6/2009 OMB)

5160

SUPPORTING DOCUMENTS RECEIVED FROM:

1. St. Elias Specialty Hospital
2. Alaska Statewide Independent Living Council, Inc.
3. Sean Murphy

~~4. St. Elias Specialty Hosp.~~

4. The AK MENTAL Health Trust

St. Elias
Specialty Hospital
a Providence Partner

1

January 29, 2010

The Honorable Lesil McGuire
Alaska State Capitol
Room 125
Juneau, Alaska 99801

Dear Senator McGuire,

Thank you for introducing Senate Bill 219, which establishes a traumatic or acquired brain injury program registry within the Department of Health and Human Services, and also relates to the medical assistance coverage for traumatic or acquired brain injury services.

At St. Elias Specialty Hospital, we treat and assist many patients who are affected by brain injury. Our patients' stories are personal to them and to us; but the outcomes of their injuries effect us all. Frequently, many patients who have suffered from a brain injury come to St. Elias on a ventilator and are unable to speak, eat, or walk. We have been fortunate to be able to watch many patients walk out of the hospital. Others have suffered injuries too significant and are not that lucky. We are very concerned about the resources available to our patients after they leave St. Elias.

We, at St. Elias, support SB219 because it would provide a mechanism for better tracking of the traumatic brain injury (TBI) patients in Alaska. We also feel that it would identify what services are lacking for patients post hospital discharge. This bill would create a more public awareness of the increasing numbers of Alaskans living with TBI, who may not be receiving the necessary help for their condition. Sadly, due to lack of rehabilitative services, many of our patients and families have been forced to leave the state for much needed long term rehabilitative services. We think Senate Bill 219 would combine all entities including profit, not for profit, military, and native to better serve all Alaskans. Possibly, the outcome would be an inpatient rehabilitation unit that would serve all Alaskans.

St. Elias Specialty Hospital is expanding its programs to better serve patients with traumatic and acquired brain injuries; however, we believe Senate Bill 219 could help us provide a better discharge plan for our patients with brain injury so they can continue their recovery and lead productive lives.

Senate Bill 219 would also help identify TBI patients who need early treatment. This in turn may reduce future medical and social costs and would help TBI patients integrate into the community positively as active and participating Alaskans.

Senator McGuire, thank you for your consideration and introduction of this bill. It is vital to the hospitals, our state, and most importantly, our patients.

Sincerely,

Sharon Kurz

Sharon Kurz, PhD
Chief Executive Officer
St. Elias Specialty Hospital

5162

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ALASKA STATEWIDE INDEPENDENT LIVING COUNCIL, INC.

1057 W. Fireweed Lane, Ste. 206
Anchorage, AK 99503

Toll Free 1 888 294 7452
Phone 907 263-2092, 2011
Fax 907 263-2012

February 1, 2010

The Honorable Lesil McGuire
Alaska State Capitol, Room 125
Juneau, Alaska 99801

Dear Senator McGuire,

Thank you for introducing SB 219, the act which relates to medical assistance coverage for traumatic or acquired brain injury services and which will establish a traumatic or acquired brain injury program and registry within the Department of Health and Social Services.

The State Independent Living Council (SILC) is comprised of Alaskans, a majority of whom have disabilities, and who are appointed by the Governor to promote the philosophy of independent living, including a philosophy of consumer control, peer-support, self-help, self-determination, equal access, and individual and system advocacy in order to maximize opportunities for individuals with disabilities, and the integration and full inclusion of individuals with disabilities into the mainstream of society.

The program supports four Centers for Independent Living (CILs). These Centers provided a wide array of services in 2009 to 3,828 Alaskans with disabilities and seniors who seek to live independently in their communities. Many of those Alaskans have sustained traumatic or acquired brain injuries and are in desperate need for services to become available in Alaska that can be tailored to their individual circumstances.

The SILC is very supportive of SB 219, which will streamline services delivered by the State of Alaska by helping families with TBI better access services and supports. The bill directs the Department of Health and Social Services to assess both the needs of individuals with TBI and the state capacity for services based on data collected. This will ensure any planned services and supports are targeted to meet needs effectively and economically.

SB 219 facilitates and links services from hospital to home and community in order to ensure that individuals have resources necessary to live independently in their homes. It will allow for them to return to work, thus diverting them from more expensive alternatives.

SHB 219 will help people in the community access case management services, which will, in turn, promote better access to TBI services. Case managements helps to support families and individuals with TBI by bringing resources together and avoiding potential duplication of efforts across agencies.

SB 219 provides many benefits to the State of Alaska. It positions the state to potentially access a federal funding stream for TBI services. The bill would give the Department of Health and Social Services the authority to access Medicaid funds for TBI, thus maximizing resources.

The Statewide Independent Living Council appreciates your ongoing support of this important legislation. Please let us know if there is anything we can do to promote swift passage of this bill.

Sincerely,

Andra Nations
Executive Director

Esther Cha

From: Murphy, Sean [Sean.Murphy@asrcenergy.com]
Sent: Wednesday, February 03, 2010 2:04 PM
To: Esther Cha
Cc: jill@alaskabraininjury.net
Subject: SB 219
Attachments: TBI Accident.pdf

3

Sean & Dee Murphy
5745 Greece Dr.
Anchorage, AK 99516
Feb 3rd, 2010

The Honorable Lesil McGuire
Alaska State Capitol, RM 125
Juneau, Alaska, 99801

Dear Senator Lesil McGuire:

First, I would like to thank you for introducing SB 219: An Act establishing a traumatic or acquired brain injury program and registry within the Department of Health and Social Services; and relating to medical assistance coverage for traumatic or acquired brain injury services.

My name is Sean Murphy and I am recovering from a traumatic brain injury from a skiing accident two years ago at Whistler/Blackcomb B.C. I hit a tree at nearly 30 MPH head first, thankfully I was wearing a helmet or the recovery process could have been much worse. I was air lifted down the mountain to the clinic at W/B where they kept me on life support until the second air medivac was available to transport me to Vancouver General Hospital. Three days later I awoke from my coma and my wife realized she would have to raise another child (husband) since I could not talk, walk or even feed myself.

SB 219 gives the Department of Health and Social Services many specifics to help address issues related to TBI which are all necessary here in Alaska. However, the main reason for writing you today is not for me or the treatment and support from my injury; but the needed support for family members dealing with TBI patients. TBI patients often have emotional issues that impact the entire family. It was extremely difficult to obtain any information, a single agency to assist in identifying resources, support groups, etc. would have been most beneficial for families in this situation.

As I found out weeks or understood months later, was the amount of stress that my wife had to endure. From first, being out of the country, then in Seattle and then again in Anchorage my wife had to continually start the processes over again to get me needed treatment. Again, having case management services to assist would have been extremely helpful in finding a neurologist, physical therapist, and the resources needed to aide in the recovery process. While researching these types of injuries, my wife and I noticed that the majority of states have facilities to assist people in obtaining the information and contacts needed. We could not find this in the state of Alaska. With the many outdoor activities and amount of highway accidents in Alaska we were surprised to find that this was the case.

Sincerely,

Sean Murphy

My husband Sean and I spent a week in Whistler/Blackcomb, BC. Sean was skiing expert terain all week. On the last day of the trip, he and his buddies stopped for a bowl of soup before heading home. After lunch, he got into his skis and picked a casual groomed ski trail to head down the mountain. He was the first one back in his skis as they started down the mountain. When his friends started down the trail, they saw him veer across the trail over an embankment into the tree line. To this day, having lunch is the last thing that he remembers. They both called down to see if he was ok, when he doesn't respond, one friend came down to check on him and found that he was not conscious. The second friend began stopping others for assistance. A doctor and nurse happened to ski near the accident and began CPR and a ski instructor stopped and contacted ski patrol. Ski patrol arrived within minutes and provided an open airway and artificial respiration while packaging Sean for transport to a helicopter arriving. We believe that due to preparation for the Olympics, the response time of the ski patrol and helicopter was extremely quick, within minutes, Sean was transported to the clinic at the base of the mountain, examined and prepped for another helicopter ride to Vancouver General Hospital.

Our friends and I packed and drove from Whistler to Vancouver only to discover that he had still not awaken and they might have to drill into his brain to release some of the pressure due to swelling caused from severe bruising and 8 sub dermal hematomas. The good news was that after a full body CAT scan to determine the extent of his injuries, other than the head injury, he had a broken finger. After three unconscious days in the ER Sean finally came out of a coma. The doctors asked if he knew what happened, he shook his head no, he asked if he knew who was next to him. All he could do was say wife, but that was more than enough considering we were told that his long term memory would probably be affected by the injury.

On the evening of the third day, Sean was transferred to the Neurological Intensive Care Unit. He was unable to speak coherently, sit up, walk, and other basic motor functions. The doctors informed me that the recovery process would more than likely take months and that we would need to stay in Vancouver until the pressure on his brain decreased considerably and he was able to walk with assistance. The Neurologist stated that if he hadn't been wearing a helmet he would not be here today. In fact, his helmet was used during several meetings to encourage the use of helmets with the staff at VGH.

Sean began the process of recovery, and I began the process of notifying employers and family of our situation. Luckily for me, two of the friends that were on vacation with us offered to stay in Vancouver for support. I was surprised to find out that Canada does not accept health insurance, so having to figure out how to pay for this care, and my stay in Vancouver and trying to keep our daughter from knowing how serious the injury was since she was alone in Anchorage was almost more than I could tolerate. To this day, I cannot thank our friends enough who stayed with us in Vancouver.

The days following consisted of me massaging his legs and arms, little stretches to keep him from stiffening up and numerous trips to the nurse's station trying to reach the Doctor for an update. I was told that he did not see patients during visiting hours because time was allotted for surgeries. The only care provide for the first two days in NICU were hourly vitals check by the nursing staff and my attempts to do stretches with him lying in bed. After 3 days in the NICU, and dozens of requests to see the doctor, he finally stopped in to provide an update. He stated that the bruising was improving, but had not decreased enough for air travel and that air travel could cause further damage to his brain. I asked about road travel so that we could get back to the US, he indicated that since he was barely able to feed himself, had not walked yet, and could not speak more than a word or two when responding to questions, that we needed to realize that long term hospital care and physical therapy was required. I asked when physical therapy would begin, and he indicated that the physical therapist would be by to see us that day.

I increased our efforts to get him to do more on his own. I asked that he feed himself; even though he wore more of the food then he ate. I got him to stand next to the bed with me and our friend on either side to see if he was able. He was not able to take a step or stand on his own, but it strengthened my resolve to get him walking again. Later that date, the PT examined Sean and gave us stretches that we could do to help him improve and that we could attempt to get him to stand periodically throughout the day. We followed the regiment for two days, than were given approval to see if he could walk. We began walking him to the restroom, which was only about 8-10 steps from the bed. The following day the Physical Therapist was surprised to see how much he had improved. Much less food on his clothes, able to speak short sentences and could walk with assistance to the restroom. She then gave us permission to walk the halls as long as our friend and I were with him at all times. We began this trek immediately after she left and continued every hour if he was awake. Day 8, he can walk two times around the NICU floor and we attempt the stairs without the PT's knowledge. He was able to take two steps. We continued to walk as often as possible so that he could build up his strength and improve his balance. The following day, I asked that he be examined again to see if the bleeding and swelling had gone down. It had, I then ask the PT if we can attempt the 5 steps so that we could travel to Washington by car. Sean climbed 5 stairs with Danny and me on either side. The PT consulted with the doctor and they gave us authorization to travel to Washington after resting at the hotel for 1-2 days to ensure that he is able to travel. I asked that they provide a CD of his cat scan and all medical records; they indicated that they would fax the reports to the doctor in Seattle and would provide the CD prior to checkout. So with a stop by accounting, I paid the bill by check and credit card. (I had contacted our credit card company earlier in the week and told them of the situation. They agreed to increase our limit enough to cover the hotel and hospital bill). Sean rested in the hotel and our friends from Seattle came to pick us up. I felt we were one step closer to getting home.

In Seattle, I made numerous calls to Neurologists, but none would take a new patient without a referral. After several calls to Vancouver General and little success in

getting help, our friend Jane said she had an appointment and we could go with her, so we did. We explained to her doctor why we were crashing Jane's appointment, and to our surprise, she examined Jane in 10 minutes and the remainder of the appointment was Sean's. She was astounded that this accident was less than two weeks prior and immediately contacted a Neurologist that she knew and had an appointment for Sean the following day. Again, we were told that it would be several weeks before we could travel and were surprised that we were given approval to leave Vancouver as there were still several areas still swollen and bleeding on the brain. Three times a week, Sean and I went to see the Neurologist. They worked motor skills and did brain teasers and each visit seemed to be better than the last. At the end of the third week, we were given the green light to travel home to Anchorage.

I thought the process would be much easier in Anchorage, only to find out we had to start the process all over again. Neurologists and Physical Therapists require a referral. We went to our family physician and were referred. My Dad agreed to come to Alaska to help care for Sean since he could not be left alone and I needed to get back to work since we had used all of our vacation time and all that could be done now FMLA, which is family medical leave without pay. Without both our incomes, this was not an option.

Sean could not be left alone, could not cook, could not take stairs on his own, etc. So I was so thankful that my Dad was with me to care for him because I needed to get back to work at least part time. As I finish this letter, I have a tough time keeping my composure, I reflect on the stress that I had to endure due to Sean's accident and the fact there wasn't someone I could talk to that understood what we were going through. The angry outburst from Sean which are typical of head injuries, the fact that he was basically having to develop mentally and physically, newborn through adult hood all over again.

After two years, there are still outburst, but they are less frequent, and his short term memory has been affected where he must keep more detailed notes. But on a positive note, the recovery was much quicker than anyone thought it would be and physically he is in the best shape of his life. He is running under 6 minute miles now and he continues to improve emotionally, mentally and physically.

The TRUST

The Alaska Mental Health Trust Authority

February 10, 2010

The Honorable Lesil McGuire
Alaska State Senate
Alaska State Capitol, Room 125
Juneau, Alaska 99801

Re: **Letter of Support for SB 219**

Dear Senator McGuire,

The Alaska Mental Health Trust Authority (The Trust) is pleased to support SB 219, an act establishing a traumatic or acquired brain injury program and registry within the Department of Health and Social Services (DHSS); and relating to medical assistance coverage for traumatic or acquired brain injury services. This bill is a significant step forward and will bolster the existing statewide efforts of a diverse and active committee which has been focused on brain injury services for several years.

The Trust is a state corporation that administers the Alaska Mental Health Trust, a perpetual trust managed on behalf of Trust beneficiaries who include individuals with mental illness, developmental disabilities, chronic alcoholism and those with dementia or other related disorders; many also have a co-occurring traumatic brain injury. Our goal is to partner with the Department of Health and Social Services as well as other state departments and branches of government, as a catalyst for change towards the improvement in Alaska's mental health continuum of care. The Trust has and will continue to partner with DHSS and the aforementioned statewide committee to ensure a system of care for Alaskans with brain injuries is developed.

It is an unfortunate reality that Alaska has one of the highest rates of TBI in the country. Upwards of 800 Alaskans are seriously injured or die from a TBI annually. It is estimated that at least 10,000 Alaskans are currently living with TBI in our communities, some with support services, most undoubtedly without. This bill will assure the development and implementation of services for Alaskans with brain injuries; specifically, it provides direction to the Department of Health and Social Services to assess prevalence, service gaps, and the development services in a targeted, effective, and fiscally responsible manner. Thereby, increasing and improving access to much needed services and supports for these Alaskans. Furthermore, this bill places the State of Alaska in position to access federal dollars for payment of these services through grants and Medicaid.

The Trust appreciates your leadership on this very important issue. Please let us know if there is anything we can do to further support your efforts and the successful passage of this bill.

Sincerely,

Jeff Jessee, CEO

3745 Community Park Loop, Suite 200 Anchorage, Alaska 99508 **Tel:** 907-269-7960 **Fax:** 907-269-7966 www.mhtrust.org

alaska brain injury network

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Anchorage, Alaska 99508
office: (907) 274-2824 fax: (907) 274-2826
www.alaskabraininjury.net

The Honorable Lesil McGuire
Alaska Senate
Alaska State Capitol, Rm 125
Juneau, Alaska 99801

Dear Senator McGuire,

Thank you for introducing SB219, the act which relates to medical assistance coverage for traumatic or acquired brain injury services and which will establish a traumatic or acquired brain injury program and registry within the Department of Health and Social Services.

The Alaska Brain Injury Network, Inc (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury. ABIN's eighteen member board represents all regions of Alaska and at least 50 percent are TBI survivors or family members.

The primary ABIN mission is to educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families. ABIN also serves as a statewide resource navigation agency specializing in information and referral for brain injury services and supports available in Alaska. ABIN has heard from 600 Alaskans requesting brain injury services since 2007. In addition, ABIN has heard public testimony from hundreds of Alaskans from Anchorage, Juneau, Fairbanks, Kenai, Barrow, Nome, Kodiak, Dillingham, Bethel, Copper River Basin, Tok, Ketchikan, Sitka, and more.

In the past several years, ABIN has worked collaboratively with the State of Alaska, Alaska Mental Health Trust Authority, the Alaska Native Tribal Health Consortium, Alaska Federal Health Care Partnership, major hospital providers, community providers, and many more agencies to coordinate the development of brain injury services in Alaska. We have coordinated meetings with these agencies to identify:

1. the services we have available in the State,
2. the services we do not have available,
3. which providers have the capacity to develop different segments in the continuum of care,
4. barriers; and
5. solutions for the development of this care.

The agencies participating and the findings are depicted in a document titled "Demonstrating the Need for Community-Based Rehabilitation."

Barriers to treating brain injury include:

- Brain injury as a medical condition versus a long-term condition: Patient often enters an injury-based medical model to treat what may become a manageable, chronic condition.
- Post-acute/Treatment/Rehabilitation funding for those who are Medicaid eligible: Currently, Medicaid funding is available for acute care, but does not cover brain injury specialty residential and day programs, often resulting in a higher level of care (more expensive) than what is needed.
- Workforce capacity- Alaska is too small of a state, with a strong yet limited workforce, to support separate brain injury systems of care in each service sector: military, tribal, and civilian.

- Screening/assessment in all state programs and primary care clinics- appropriate identification begins with screening and then assessment. Behavioral Health is the only state program that includes brain injury screening questions.

SB219 provides many direct and indirect opportunities to resolve these barriers:

- Creates longitudinal data on persons with brain injury to identify demographics, cause of injury, severity, diagnosis, treatments, medical and social costs which will help determine future policy and budget recommendations.
- Increases access to case management for those who are Medicaid eligible.
- Evaluates the need for and scope of acute, post-acute, long-term, and community treatment, care, and supports.
- Positions the state to identify the best 'menu' of brain injury services to include under a Medicaid Waiver.
- Positions the state to access federal funding for TBI services and for targeted case management.
- Encourages a seamless transition from acute settings to transitional and community settings.
- Establishes standards and recommendations for improvement of prevention, assessment, treatment, and care.

Indirect Opportunities

- Many Alaskans with undiagnosed or unrecognized brain injury currently access State of Alaska services and supports. The T/ABI program encourages screening and identification, as well as development of and access to appropriate treatment.
- A T/ABI program may create cost savings in acute care costs and existing state programs budgets, including behavioral health, juvenile justice, corrections, homeless initiatives, and long-term care in institutional facilities.
- Research shows, Medicaid funding specifically for brain injury services supports the growth of community-based rehabilitation programs (residential and day programs).
- Provides framework for the Department of Defense (DoD), Alaska Veterans Affairs Health System, Alaska Tribal Health System, State of Alaska, and private/non-profit entities to coordinate planning and implementation of rehabilitation and community re-entry programs.
- Development of these programs increases access for all Alaskans with a variety of pay sources, including insurance, private pay, and federal health care.
- Research shows early treatment and access to appropriate brain injury services may reduce future medical and social costs.

The Alaska Brain Injury Network has worked diligently to create a 'framework' for successful development of a seamless system of care for Alaskans with brain injury, including the development of a comprehensive plan and the coordination of the many key providers that will build the system. The State of Alaska T/ABI program will be the 'foundation' that will allow the 'entire state system' to develop and grow. The State T/ABI Program, the 'foundation', is the first step to resolving the barriers, so providers can act, and Alaskans will have an opportunity for a more successful and positive life.

The Alaska Brain Injury Network appreciates your ongoing support of this important legislation.

Our organization is made up of many professionals, providers, and specialists. If you have any questions I would be happy to answer them or connect you to someone with that knowledge.

Sincerely,

Jill Hodges
Executive Director

Rutgers Centers for State Health Policy, Issue Brief: A Survey of Medicaid Brain Injury Programs, March 2008

State	Waiver year ending	Number Serviced	Expenditures (GF and Federal match)	Annual Per Capita Costs	Average Length of Stay	Per Diem Costs
New York	2006	1953	$79,029,120	$40,465	310	$131
[redacted]						
Illinois	2006	3,601	$42,541,226	$11,814	264	$45
Connecticut	2006	344	$25,691,011	$74,683	305	$245
Wisconsin	2006	334	$20,095,110	$60,165	351	$171
New Jersey	2006	276	$18,374,797	$66,575	329	$202
South Carolina	2006	497	$12,247,128	$24,642	338	$73
New Hampshire	2006	140	$11,487,626	$82,054	332	$247
Iowa	2006	825	$10,883,459	$13,192	296	$45
Colorado	2006	293	$9,027,736	$30,811	247	$125
Pennsylvania	2005	152-324	$6,897,762	$45,380	285	$159
[redacted]	2005	98	$6,532,587	$66,659	285	$234
Kansas	2006	269	$6,289,071	$23,379	242	$97
Florida	2006	283	$5,903,410	$20,860	316	$66
Massachusetts	2006	90	$4,883,813	$54,265	315	$172
Wyoming	2006	137	$3,940,878	$28,766	297	$97
Indiana	2006	131	$3,390,758	$25,884	355	$73
Utah	2006	91	$2,079,141	$22,848	333	$69
Maryland	2006	23	$1,489,321	$64,753	255	$254
Idaho	2006	19	$1,133,542	$59,660	354	$169
North Dakota	2006	29	$797,371	$27,496	315	$29
Nebraska	2006	26	$733,247	$28,202	335	$84
Vermont	2006	68		$5,500/month	no data	
Alaska	2008	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

$150,000 FY10 MHTAAR for brain injury case management-DHSS SDS Administration

Blue states have been identified has Waiver programs that may meet Alaska's needs (more up to date funding levels needed)

Yellow areas are Waiver programs that have a rehabilitation focus and long-term care option

alaska brain injury network

Attachment: ABIN Letter of Support for SB 219/HB 328

Why brain injury begins as an emergency medical condition and often becomes a social catastrophe?

Several decades ago brain injury was viewed solely as a medical condition, more specifically a life or death injury. Because of the advances in emergency medical services and intensive/acute care, more people are surviving very severe brain injuries. These advances have created an entire new system of care, a brain injury continuum of care. This system of care is essential because of the long-term cognitive effects caused by the injury. After 30 years of state and federal government recognition, research, and longitudinal studies, it is now understood that 'brain injury begins as an emergency medical condition, and often becomes a social catastrophe.' Because of the potential for many different social challenges, it is essential that those who survive brain injuries receive timely, appropriate services and ongoing supports.

How did other states develop brain injury programs?

In addition to the local networking, ABIN is well connected to many state brain injury programs (public and private) outside of Alaska. Through conferences and ongoing dialogue, ABIN has learned the role legislation (in other states) has played in developing a seamless, comprehensive service system for after hospital care for brain injury. In 1980 the first appropriation for brain injury funding for case management was accomplished in Missouri. Legislation for a T/ABI program soon followed. 2005 data shows at least 44 states had a formal T/ABI program in their state government or funded brain injury specific programs.

The following is an example of the order in which legislation and funding has progressed in other states.

Step 1: Establish a T/ABI program in statute
Step 2: Approve general funds for case management, position state to access federal funds to expand this service to more people (targeted case management).
Step 3: Approve a Medicaid brain injury waiver (50% Federal match)
Step 4: Prevention and concussion management legislation.
Step 5: Screening and case management for military

HB 328/SB 219 gives Alaska the opportunity to not only 'catch up' developmentally with other States, but it also positions Alaska to become a national leader in providing brain injury case management and treatment to rural and remote citizens across service sectors (military, tribal, civilian).

How do other states fund and sustain a T/ABI Program?

States use a variety and combination of funding streams for planning, policy, prevention and research activities, and to serve individuals with brain injuries and their families who have no other access to needed care or supports. Medicaid, Home and Community-Based Services and Medicaid Waivers, and Federal Block Grant programs are used to serve individuals with disabilities and special health care needs including people with brain injury. At the State level, common non-Federal funding sources for TBI service delivery include trust funds, general

revenue and special revenue. Often when two or more sources exist, funds from one are used to leverage funds from the other.
There are 24 States that have a Brain Injury Medicaid Waiver (2006). There are 20 states that have General Revenue or Special Revenue specific to brain injury (NASHIA 2005).

Medicaid waivers targeted to individuals with brain injuries operate in half of the states and are small when compared to waivers targeting other groups. These waivers provide significant cost savings, on average $30,000 annually per person, when compared to institutional facility-based services (Rutgers 2008).

These waivers have been successful both programmatically and financially. In addition to cost savings, these waivers have provided other significant benefits. The existence of these waivers supports the growth of community non-profit brain injury agencies. There is clear evidence of the desirability of home and community-based services among those directly affected by brain injury: there has been growth of these waivers that has resulted in a doubling of the number of persons served over five years; in addition, there is a visible role played by advocates in encouraging states to develop these waivers. These waivers, over time, have contributed to states' efforts to create and grow an in-state service capacity to provide services to individuals with brain injuries.[1]

[1]Hendrickson, L. & Blume, R. (2008). Issue brief: A survey of Medicaid brain injury programs. *Rutgers Center for State Health Policy*

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Dave Eubank
9527 Victor Rd.
Anchorage, AK 99515

Good afternoon:

My name is Dave Eubank and I approve this message. A few long years ago I sustained an acquired brain injury, not to be confused with traumatic; it was pretty traumatic to me but acquired? I didn't ask for any of this but it seems as though it was required because I see life through a different set of eyes and have been blessed with a different set of values. I, as well as a host of many others, have had to work twice as hard to get back half of what I lost but I appreciate life more than twice as much so in a sense, ... doesn't that make me twice the person I once was?

Just for starters I have an awful lot of admiration for the people who are in the health care industry for the support, care, and understanding they provide to others who are less fortunate than you. The T.B.I. Resource Navigator allows access to monitor a wealth of information for this silent minority. The DHSS provides additional funding for thankful services to a thankful people. I am not thankless; I am thankful, I am thankful I do not require such needful things but I know. I know exactly what it's like to be on the inside looking out and I know exactly what it's like to have the ability to absorb the incoming information but not having the capability to process it and I know exactly how frustrating that can be and for some people there is no way out and I know that too.

****

You see, once upon a time, in a land far, far, away, I collapsed as the result of a life threatening, death defying, brain aneurysm; grade 5. You name it and I did not have it but in comparison to what I had lost, I have gained a whole lot more and what it was that I really lost, really was not even worth having and I am thankful for the things I have gained rather than being resentful over the things I have lost but it literally turned my life upside down yet here I am ... 10 years post, standing right side up and sitting right side down, still there are an awful lot of questions and *not* many answers; **however:**

Would a T.B.I. Care Coordinator have been helpful in my own recovery? Absolutely! We all have to crawl before we can walk and we seem to forget all about that but not me because in the bitter end of this past century I tried to walk before I could crawl and I fell flat on my face. But when I went down, I got up and when I got up, I woke up, and when I woke up, I got a grip and I can see much more clear this second time around but instead of taking my life, it gave me a life *however;* I may have gotten it a whole lot quicker with a T.B.I. Care Coordinator.

Would the funding for T.B.I. Care Coordination and Case Management have been helpful in my situation? Absolutely! I as well as a host of many others often felt like beating my head up against a brick wall but soon discovered that there was nobody home but suddenly on one bright, sunny, and cheerful summer day, a light bulb went off, BING!!! And as I wondered my way through this maze of uncertainty, I realized that I could not change people. I could not change anything about them. The only thing I could change was *myself* and when I changed myself? Poof!!! It was magic because I would change the perception of how others perceived me. A T.B.I. survivor is scarred for life and even though it may not be the kiss of death, there is a distinction and it is *not* a real good one but, ... *By choosing the path of least resistance and combining the elements of good with that of the bad, you rise above the distinguished height of an unjust society and you still embrace it* (Martin Luther King).....and yet it works.

Do I have any regrets on how I've approached and sidestepped the obstacles that have obstructed my most difficult challenges? Absolutely not! Very few of us get out of here alive without being rudely slammed down by some sort of adversity but there's an old saying that adversity has a peculiar way of introducing you to yourself. Welcome to my world; we all make choices in life but I really don't know anyone who chose to walk a path which has no end and for some people there is no end but for others who wish to boldly go where many have gone before, with careful consideration of care coordination and case management there is. You probably think it's pretty easy for me to discuss this stuff; it's not easy, ... it's not easy at all. That's it, my work is done here.

Thank you

Title 47. Welfare, Social Services and Institutions.

Chapter

05. Administration of Welfare, Social Services and Institutions (§§ 47.05.010 — 47.05.390)
07. Medical Assistance for Needy Persons (§§ 47.07.010 — 47.07.900)
08. Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions (§§ 47.08.010 — 47.08.150)
10. Children in Need of Aid (§§ 47.10.005 — 47.10.990)
12. Delinquent Minors (§§ 47.12.010 — 47.12.990)
14. Juvenile Programs and Institutions (§§ 47.14.010 — 47.14.990)
15. Uniform Interstate Compact on Juveniles (§§ 47.15.010 — 47.15.080)
17. Child Protection (§§ 47.17.010 — 47.17.290)
18. Programs and Services Related to Adolescents (§§ 47.18.010 — 47.18.900)
20. Special Services for Certain Children (§§ 47.20.060 — 47.20.390)
21. Adventure-Based Education (§§ 47.21.010, 47.21.020)
24. Protection of Vulnerable Adults (§§ 47.24.010 — 47.24.900)
25. Public Assistance (§§ 47.25.001 — 47.25.990)
27. Alaska Temporary Assistance Program (§§ 47.27.005 — 47.27.990)
30. Mental Health (§§ 47.30.011 — 47.30.915)
31. Mental Health Treatment Assistance Program (§§ 47.31.005 — 47.31.100)
32. Centralized Licensing and Related Administrative Procedures (§§ 47.32.010 — 47.32.900)
33. Assisted Living Homes (§§ 47.33.005 — 47.33.990)
37. Uniform Alcoholism and Intoxication Treatment Act (§§ 47.37.010 — 47.37.270)
40. Purchase of Services (§§ 47.40.011 — 47.40.120)
45. Older Alaskans (§§ 47.45.010 — 47.45.309)
55. Alaska Pioneers' Home and Alaska Veterans' Home (§§ 47.55.010 — 47.55.900)
60. Multipurpose Senior Centers (§§ 47.60.010 — 47.60.090)
62. Office of the Long Term Care Ombudsman (§§ 47.62.010 — 47.62.090)
65. Service Programs for Older Alaskans and Other Adults (§§ 47.65.010 — 47.65.290)
70. Interstate Compact on the Placement of Children (§§ 47.70.010 — 47.70.080)
75. Social Services Planning (§§ 47.75.010 — 47.75.060)
80. Persons with Disabilities (§§ 47.80.010 — 47.80.900)
90. Displaced Homemakers (§§ 47.90.010 — 47.90.070)

Revisor's notes. — The provisions of this title were redrafted in 1984 to remove personal pronouns pursuant to § 4, ch. 58, SLA 1982, and in 1984, 1990, 1995, and 2008 to make other minor word changes.

Administrative Code. — For health and social services, see 7 AAC.

For hearings, see 7 AAC 49.

Chapter 05. Administration of Welfare, Social Services and Institutions.

Article

1. General Administrative Provisions (§§ 47.05.010 — 47.05.100)
2. Oversight of Medical Care Programs (§§ 47.05.200 — 47.05.290)
3. Criminal History; Registry (§§ 47.05.300 — 47.05.390)

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Title 18. Health, Safety, and Housing.

Chapter

05. Administration of Public Health and Related Laws (§§ 18.05.010 — 18.05.070)
07. Certificate of Need Program (§§ 18.07.021 — 18.07.111)
08. Emergency Medical Services (§§ 18.08.010 — 18.08.200)
10. Health Units and Districts (§§ 18.10.010 — 18.10.260)
13. Genetic Privacy (§§ 18.13.010 — 18.13.100)
15. Disease Control and Threats to Public Health (§§ 18.15.150 — 18.15.900)
16. Regulation of Abortions (§§ 18.16.010 — 18.16.090)
20. Hospitals and Nursing Facilities (§§ 18.20.075 — 18.20.390)
23. Health Care Services Information and Review Organizations (§§ 18.23.005 — 18.23.100)
25. Assistance to Hospitals and Health Facilities (§§ 18.25.010 — 18.25.120)
26. Alaska Medical Facility Authority (§§ 18.26.010 — 18.26.900)
28. State Assistance for Community Health Aide Programs (§§ 18.28.010 — 18.28.100)
31. Asbestos (§§ 18.31.010 — 18.31.500)
35. Public Accommodations and Facilities (§§ 18.35.010 — 18.35.365)
40. Shelter Cabins and Comfort Stations (§§ 18.40.010 — 18.40.070)
45. Atomic Energy (§§ 18.45.020 — 18.45.900)
50. Vital Statistics Act (§§ 18.50.010 — 18.50.990)
55. Housing, Public Buildings, Urban Renewal, and Regional Housing Authorities (§§ 18.55.010 — 18.55.998)
56. Alaska Housing Finance Corporation (§§ 18.56.010 — 18.56.900)
57. Regional Electrical Authorities (§§ 18.57.010 — 18.57.110)
60. Safety (§§ 18.60.010 — 18.60.890)
62. Certificates of Fitness (§§ 18.62.010 — 18.62.080)
63. Hazardous Painting Certification (§§ 18.63.010 — 18.63.100)
65. Police Protection (§§ 18.65.010 — 18.65.870)
66. Domestic Violence and Sexual Assault (§§ 18.66.010 — 18.66.990)
67. Violent Crimes Compensation Board (§§ 18.67.010 — 18.67.180)
68. Sexual Assault Investigations (§§ 18.68.010 — 18.68.040)
70. Fire Protection (§§ 18.70.010 — 18.70.900)
72. State Regulation of Fireworks (§§ 18.72.010 — 18.72.100)
74. Cigarette Fire Safety (§§ 18.74.010 — 18.74.290)
76. Alaska Avalanche Warning System (§ 18.76.010)
80. State Commission for Human Rights (§§ 18.80.010 — 18.80.300)
85. Public Defender Agency (§§ 18.85.010 — 18.85.180)

Revisor's notes. — The provisions of this title were redrafted in 1986 to remove personal pronouns pursuant to § 4, ch. 58, SLA 1982, and in 1986, 1991, 1994, and 2002 to make other minor word changes under AS 01.05.031.

Administrative Code. — For health and social services, see 7 AAC.

5177

Alaska Brain Injury Network

Alaska Scorecard and TBI Dashboard – (DRAFT)

DRAFT #1 – May 22, 2008

○ Getting worse ⟺ Not changing ● Improving

	5-year Trend	Current Data	Source
SCORECARD: A "scorecard" provides a snapshot of the status of TBI issues in the State of Alaska			
Traumatic Brain Injury Non-fatal Incidence Rates			
TBI rate per 100,000	●	98.6	1
Causes			
Falls	○	28.7	1
Motor Vehicle Transportation Occupant	●	24.7	1
Assault	●	12.2	1
ATV	○	6.5	1
Bicycle	●	4.5	1
Snowmachine	●	4.4	1
Pedestrian	●	3.6	1
Sports	●	1.8	1
Water Transport	⟺	1.3	1
Suicide Attempt	●	.8	1
Gender			
TBI percentage among males		65.4 %	1
TBI percentage among females	⟺	33.2 %	1
Ethnicity			
Percentage of TBI population that is Alaska Native		34%	1.a
Percentage of TBI population that is White		53%	1.a
Percentage of TBI population that is Other; unknown, Pacific Islander, Hispanic, Black, American Indian, Asian		22%	1.a
Those at highest risk for hospitalization due to TBI (rate per 100,000)			
Males age 80+		301.3	1
Females age 80+		217.2	1
Males age 70-79		215.7	1
Males age 15-19		200.9	1
Traumatic Brain Injury Numbers			
TBI hospitalizations/year		640	1.b
TBI deaths/year		150	1.b
Est. TBI-related Emergency Department Visits		2953	2

1 Alaska Trauma Registry 2001-2005 – Non-fatal TBI hospitalizations
1.a Alaska Trauma Registry 1996-2005 – Non-fatal TBI hospitalizations
1.b Alaska Trauma Registry 2006 – Non-fatal TBI hospitalizations
2 HRSA TBI Implementation Grant

Alaska Trauma Registry records those who are hospitalized for more than 24 hours. This does not include the number of people who visit the emergency department and are sent home in the same day. This does not include the number of returning service members with traumatic brain injury.

DASHBOARD: A "dashboard" provides a way to see how well an activity is working to affect the TBI population			
O Getting worse	⟺ Not changing	O Improving	
Dashboard: Behavioral Health			
TBI and Mental Health	**Spot look trend**	**Current Data**	**Source**
Percentage BH clients screening positive for TBI	⟺	32%	3
TBI and Substance Use			
Alcohol-related TBI 100,000		33%	1
TBI and Suicide			
Percentage of suicide victims with history of TBI		32%	4
Dashboard: Education			
Special Education			
Number of children in Special Education statewide with TBI diagnosis (2007)	⟺	66	5
Dashboard: Justice			
Corrections			
Percent of incarcerated Alaskans (adults) who are Trust beneficiaries, including those with cognitive disabilities		42%	6
Dashboard: Employment			
Vocational Rehabilitation			
Number of TBI cases		167	7
Number of TBI cases closed employed		17	7
Number of TBI cases closed with plan for employment		11	7
Average wage at closure		$12.54	7
Dashboard: Providence			
ImPACT Program			
Number of baselines (ImPACT)		57	8
Number of student/athletes seen in program (ImPACT)		25	8
Emergency Department			
Patients given the diagnosis of "head injury" or "concussion in Emergency Department in 2006		547	8
% of TBI-related ED visits that led to hospitalizations		1%	8
% of ED visits that are Pediatric		15%	8
Dashboard: Alaska Brain Injury Network			
TBI Advisory Board			
Est. Board Member Volunteer hours/year	⟺	1054	9
Board Member Participation in Quarterly Board Meetings		83%	9
Ex-officio participation in quarterly board meetings		65-80%	9
% of survivors/family members on TBI board		55%	9
% Board Members who give a financial contribution		100%	9
TBI Resource Navigation			
Average new consumer contacts per month	⟺	30	9
Average unique visitors/month to ABIN website	⟺	750	9
Number of people on Alaska Brain Matters Listserve	⟺	100+	9

3 AKAIMS
4 Suicide Follow-back Study
5 http://www.eed.state.ak.us/stats/
6 Trust/DOC Study 07
7 Division of Vocational Rehabilitation (FY07)
8 Providence Neuroservices
9 Alaska Brain Injury Network

Alaska is Combating Traumatic Brain Injury

Jill Hodges
Executive Director
Alaska Brain Injury Network

Jeff Jessee
Chief Executive Officer
Alaska Mental Health Trust Authority

Pat Hefley
Deputy Commissioner
Department of Health and Social Services

Past legislative hearings

2007- What is traumatic brain injury?
What does treatment look like?
Guest presenters: Dr. Tina Trudel (national expert) and partner boards

2008- Impact of TBI on the state.
Military issues related to TBI
Guest presenters: Capt. Richard Barker, Elmendorf; Dr. Russell Cherry, Providence; Stephanie Tanner, military wife of TBI survivor

2009- Importance of Medicaid Waiver to develop coordinated, comprehensive brain injury services in-state
Guest Presenters: Dr. Christie Artuso, Providence Neuroscience Director

Today's presentation- State System Development, ready to operationalize

- Jill Hodges, Past 20 years of AK efforts
- Jeff Jessee , Trust Role
- Pat Hefley , DHSS Role
- Public testimony:
  - Martha Moore, ABIN Chair
  - Providers, partnerships essential
  - Consumer, treatment works, family support
- Jill Hodges-Questions and Solutions
  - State and Legislature

TBI Systems Development in AK-1990-2000

Phase 1: 1990-1995

Advocacy

- Brain injury survivors mobilize
- Early 1990's
  - Testimony to GDCSE, Legislature, AMHTA
- Brain Injury Association of Alaska organizes

Phase 2: 1995-2000

Advocacy Continues

State of Alaska

- State of Alaska-Public Health recognizes TBI
- Public Health awarded CDC grant
  - TBI Registry
- MHDD awarded Federal Grant-systems

TBI Systems Development in AK 2000-2007

Phase 3: 2000-2003

Advocacy

State of Alaska

Federal TBI HRSA Grant

- Needs Assessment
- 1st State Action Plan
- TBI Program Coordinator (FTE)
- Advisory Board

AMHTA-beneficiary group

Alaska Brain Injury Network

- TBI Advisory Board (ABIN) organizes and becomes 501 c3

Phase 4: 2003-2005

Advocacy/TBI Advisory Board

State of Alaska

- Behavioral Health (lead agency)

Data/Surveillance

- DBH mandates screening and data collection
- Consumer Satisfaction Surveys
- AK Trauma Registry Data

Phase 5: 2005-2007

State of Alaska: TBI Dir. turnover

Data- AKAIMS(32% in BH screen TBI)

Workforce: 1st AK Brain Injury Conf

Momentum builds- 2007-2009

Phase 6: 2007-2009

ABIN

- "Service" recommendation
  - Info and Referral
  - Case Management

AMHTA-Funds ABIN recomm.

State of Alaska

- Lead agency transfers to SDS
- TBI Case Management Program developed

Workforce:

Intro to TBI Course

Advance Brain Injury Workshop

Vocational Rehabilitation Counselors

Legislation

- SB 118 introduced-medical assistance for TBI

Medicaid Funding: Waivers

- Preliminary research on Medicaid Waivers
- Targeted Case Management

Treatment

- After Hospital/Post-Acute
  - Site Visits
  - AK Providers Coalition
  - Military/Tribal partnerships sought

Key Points

- System Planning– created framework and foundation for action
- Next step: operationalize
- General Funds or GF/MH essential

- Phases 1-4 (1990-2005)
  - advocacy, planning, increasing awareness.
- Phases 5-6 (2005-2009):
  - Direct 'services':
    - info and referral;
    - case management
  - Workforce development
- Phase 7 – 10 (2010-2020)
  - Case Management
  - Treatment: Funding for Residential and Day Program
  - Workforce

2010 Session: SB 219 and HB 328

SB 219 and HB 328

- Traumatic/Acquired Brain Injury Program
  - Gives statutory authority to develop/improve program.
  - Establishes standards for treatment and services.
  - Defines brain injury.
  - Develops cost/ longitudinal data
  - Planning for Medicaid Waiver/Targeted Case Management

Opportunities

- Positions the state to access federal funding for TBI services.
- The existence of brain injury waivers supports the growth of community-based rehabilitation programs.
- DoD/VA/Tribal/State coordinate planning and implementation of rehabilitation and community re-entry programs.
- Early treatment may reduce future medical and social costs.
- Potential cost savings in acute care, existing state programs; behavioral health, juvenile justice, corrections, homeless activities, and long-term care in institutional facilities.

The Trust's Role- Jeff Jessee

- TBI as a beneficiary group (late 1990's)
- Trust role: planning, demonstration
- Maximize collaboration
- Alaska too small of a state to have separate TBI treatment systems of care (VA, DoD, Tribal, State)
- Treatment: General Fund commitment

Past 10 years, Trust has invested $2.8 million in brain injury systems development

- Trust FY09 Funding specifically for brain injury program: $628,000
  - Core Services Development
    - Information and Referral
    - Case Management
    - Technical Assistance for planning treatment
  - Systems Development
    - Public Awareness-anti stigma
    - Workforce development
    - Statewide planning- TBI Advisory Board

Department of Health and Social Services Role- Pat Hefley

- Development, now operationalizing.
- 44 States use General Revenue and Medicaid Waivers for brain injury treatment/ services.
- TBI folks are already in the system - need to move them into specialty programs in order to see results.
- Appropriately staged incremental GF/MH budget requests.

Upcoming 2010 Activities

- Federal Grant- $250.0/year 4 years
  - lead agency: Senior and Disabilities Services
- State of Alaska T/ABI program
  - Case Management
  - Research federal funding opportunities: Medicaid Waiver/Targeted Case Management
- Data/Prevention: regional study, Alaska Native and Non-Native

Public Testimony

- Martha Moore: ABIN Chair
  - Composition of ABIN
  - Recommendation Philosophy
  - Perspective: State role (data collection) and ABIN chair.
- Alaska providers: readiness to partner- TBI post-acute programs
  - Dr. Lester, St. Elias (LTACH)
  - Margaret Carloni, Trauma Nurse, ANMC
- Shannon- Juneau resident, experienced TBI
  - TBI treatment works
  - Family support

Many of Alaska's challenging questions have been asked and answered by other States

- Alaska can learn from 30 years of state system experience; and
- treatment research by the Federal Government, State experiences, military advances

Questions and Solutions

Is brain injury impacting State government?

1980 findings...
- Uninsured or underinsured
- Unemployment
- Trauma/EMS
- Long-term care and support needs
- Family Support

1990 findings...
- Educational System
- Vocational Rehabilitation

2000 findings...
- Criminal Justice
- Behavioral Health

Question and Solutions

How will State Gov't know how to develop TBI systems?

TBI Act of 1996

- Federal Statute
  - Defined TBI in Federal Statute
  - Authorized funding to HHS
  - Established TBI program in CDC
  - Created State grant program (HRSA)
- State experience has broadened program definition to ABI- same service needs.
- National Association of State Head Injury Administrators (1990)
- TBI Technical Assistance Center-specifically for state administrators (since 1996)

Question and Solutions

Is recovery possible after a TBI?

Does treatment work?

- Feds fund TBI model systems since 1987, over 20 years of longitudinal data- yes with specialized support, recovery/ independence is possible
- Research at acute/medical level led to need for community reentry programs
- Military funding is supporting research of community reentry programs and Mild TBI assessment and treatment

Question and Solutions

How will States pay for brain injury treatment?

- 1990's, Centers for Medicare/Medicaid Services (CMS) developed TBI HCBS Waiver prototype
- IDEA 1990 added TBI as disability to report
- State General Funds
- TBI Trust Funds

Question and Answer

How will states develop <u>treatment</u> and prepare a <u>specialty workforce</u>?

- Many providers have 30 years of experience.
  - Utilize existing models: medical, community reentry, clubhouse, and long-term living..
- TBI specific workforce will build as TBI programs are operationalized.
  - Professional/para-professional specialists have on the job training, does not take special educational training.

Question and Answer

How will rural residents have access to these treatment and services?

- Military and a few states utilize telemedicine for treatment.
- Opportunity for Alaska to become the national leader in providing care to rural areas?

Question and Answer

What type of legislation is/has been successful?

- Resolutions- awareness
  - Last five years
- Prevention
  - AK primary seatbelt law and child safety/ booster seat)
- T/ABI Program into Statute
  - SB 219 and HB Companion
- Interagency Taskforce
- Prevention-concussion management
- Military-screening

Alaska has an opportunity!

- Alaska can operationalize at a faster rate.
- Alaska can become the leader in rural TBI treatment and supports

Alaskans Thank the Legislature...

For recognizing the 10,000+ Alaskans with TBI and working to bring more services close to home

Brain injury rehabilitation and treatment is standard in many states. The following document explains two federal initiatives focusing on TBI rehabilitation research. Excerpted from: ***www.nashia.org/programs/federal/docs/nidrr.doc***

NIDRR funds both Rehabilitation Research and Training (RR&T) Centers and TBI Model Systems of Care.

Rehabilitation Research and Training (RR&T) Centers

The National Institute of Disability Rehabilitation Research funds two RR&T Centers on brain injury. Both are housed at The Institute for Rehabilitation and Research (TIRR), Houston, Texas. The two RR&T Centers are: (1) Rehabilitation and Training Center on Community Integration in Persons with TBI and (2) Rehabilitation Research and Training Center on Rehabilitation Interventions Following Traumatic Brain Injury.

The Rehabilitation and Training Center on Rehabilitation Interventions following Traumatic Brain Injury promotes the scientific advancement of rehabilitation research by focusing on several areas identified as needing further research. These include areas of weakness in the current knowledge and future research regarding TBI recovery and rehabilitation effectiveness: improvement of the diagnosis and treatment of persons with mild TBI; development of interventions to assist school-age children with TBI; the needs of minority groups members with TBI; evaluation of the effectiveness of rehabilitation interventions; and treatment for the family members of people with TBI. Activities include publishing an informational and technical assistance resource for consumers and professionals; training for medical and neuropsychological fellows in rehabilitation research; coordinating a state-of-the-science conference on mild TBI; and producing an educational videotape to train family members in effective coping skills. Through representation on the advisory committees, consumers are involved in all aspects of planning and evaluating research and training activities

TIRR's National Database of Educational Resources on Traumatic Brain Injury

This National Database of Educational Resources on TBI is a part of TIRR's Rehabilitation Research and Training Center in Rehabilitation Interventions in TBI grant from the National Institute on Disability and Rehabilitation Research (NIDRR). The database contains information on more than 350 educational videotapes, audiotapes, and written materials that people with TBI, their family members and health care professionals can use. Information can be retrieved directly from the web site or by calling the TIRR Department of Education. To retrieve information from the database or for more information, visit www.braininjuryresearch.org/birc/database.htm.

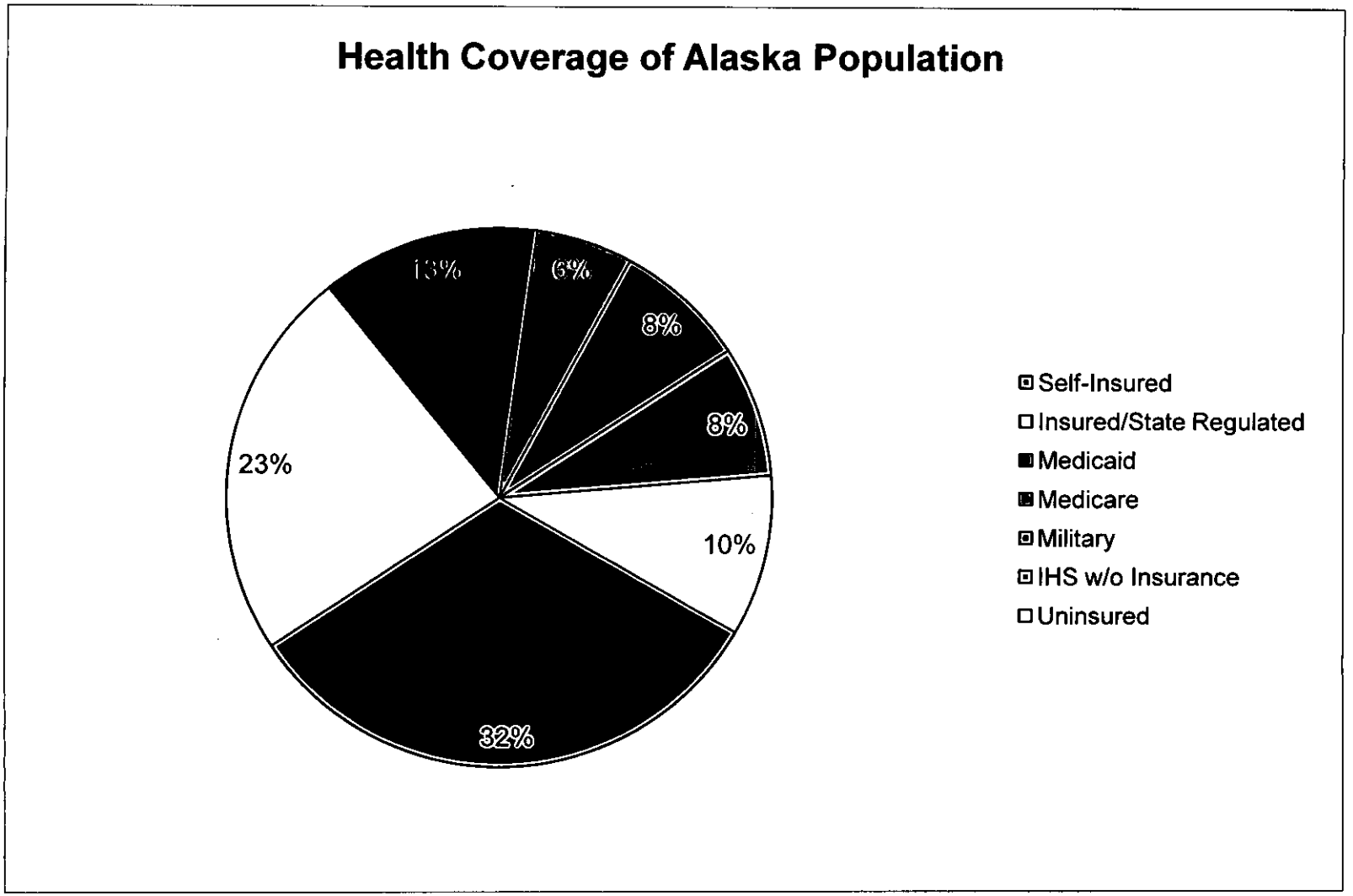
TBI Model Systems of Care

In 1987 the National Institute on Disability and Rehabilitation Research (NIDRR) in the U.S. Department of Education established the Traumatic Brain Injury Model Systems of Care (TBI Model Systems). NIDRR's multi-center model systems program is designed to study the course of recovery and outcomes following the delivery of a coordinated system of care including emergency care, acute neurotrauma management, comprehensive in-patient rehabilitation and long-term interdisciplinary follow-up services. Each Center systematically collects important data about each individual who meets criteria for inclusion in the TBI National Database and sends this information to the TBI National Data Center. The Centers are currently located at 16 sites throughout the United States that provide comprehensive systems of brain injury care to individuals who sustain a traumatic brain injury, from acute care through community re-entry. The mission of the TBIMS is to improve the lives of persons who experience traumatic brain injury, their families, and communities by creating and disseminating new knowledge about the course, treatment, and outcomes relating to their condition.

The TBI Model Systems serve a substantial number of individuals, allowing the projects to conduct clinical research and program evaluation, which maximize the potential for project replication. In addition, the TBI Model Systems have the advantage of a complex data collection and retrieval program with the capability to analyze the different system components and provide information on project cost effectiveness and benefits. Information is collected throughout the rehabilitation process, permitting long-term follow-up on the course of injury, outcomes, and changes in employment status, community integration, substance abuse, and family needs. The TBI Model Systems serve as regional and national models for program development and as information centers for customers, families, and professionals.

Initially, approximately $1.5 million funded five centers: Wayne State University in Michigan, Mt. Sinai Hospital in New York, Santa Clara Valley Medical Center in California, The Institute for Rehabilitation Research in Texas, and the Medical College of Virginia in Richmond. For a few years, there were only four (Mt. Sinai left the program), and by 1997, Virginia's center no longer participated, but the Moss Rehabilitation Center in Pennsylvania won a grant for a center as did Ohio State University in Ohio.

In the fall of 1997, the Brain Injury Association of America and others successfully advocated for an additional $5 million for the program so that more centers could be established. Twelve new sites were awarded funds to establish model systems of care for traumatic brain injury.



*Navigant 2003 Report, 2008 Population

Celeste Hodge

From: Jill Hodges [jill@alaskabraininjury.net]
Sent: Wednesday, February 03, 2010 4:20 PM
To: Celeste Hodge
Subject: RE: Alaska Brain Injury Network
Attachments: Senate_Outline for TBI Presentation to HSS.doc; Skeleton_BrainInjurySystemsChange2010.ppt

Cancelled request will provide testimony the 15th when bill is scheduled for hearing

Hi Celeste, thank you for your ongoing work on this. Attached is an outline. I have also attached the power point for the presentation we are giving to House HSS this week. The Senate presentation will be a shorter version of this power point.

Jeff Jessee, CEO, Alaska Mental Health Trust
Pat Hefley, Deputy Commissioner, Department of Health and Social Services
Myself

Are all available on the 24th at 1:30. We will be prepared for a 30 min. presentation.

Past presentation focused on: What is TBI, What does treatment look like?, Military impact? (focus was to show the need to recognize TBI as an AK public health issue).

This year's presentation will focus on coordinated state efforts (Trust, DHSS, ABIN, AK providers) to improve the state system to better meet the needs of Alaskans with brain injury. It will highlight the importance of SB 219, as well as funding in the Gov. budget. The presentation focuses on solutions, roles, timeline/phases, implementation.

Equipment: computer, projector

I do have additional materials that I will send you a week before the presentation.

Jill Hodges
Executive Director

Alaska Brain Injury Network
3745 Community Park Loop #140
Anchorage, Alaska 99508

office: 907 274-2824
fax: 907 274-2826

www.alaskabraininjury.net

"Educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families."

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Wednesday, February 03, 2010 3:20 PM

To: 'Jill Hodges'
Subject: RE: Alaska Brain Injury Network

Okay. Just checking. Thanks.

Celeste Graham-Hodge, Legislative Administrator
Office of Senator Bettye Davis - AK State Legislature
State Capitol, Rm 30, Juneau, AK 99801
T (907) 465-4906, F (907) 465-3756
716 W. 4th Ave., #400, Anchorage, AK 99501
T(907) 269-0144, F(907) 269-0148
Celeste_Hodge@legis.state.ak.us

From: Jill Hodges [mailto:jill@alaskabraininjury.net]
Sent: Wednesday, February 03, 2010 1:34 PM
To: Celeste Hodge
Subject: RE: Alaska Brain Injury Network

This was before our phone conversation, sorry for the confusion. I have sent a note to state folks to see if 24th works.

Jill Hodges
Executive Director

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"Educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families."

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Wednesday, February 03, 2010 11:13 AM
To: 'Jill Hodges'
Subject: RE: Alaska Brain Injury Network

Was this before our conversation or did you want the 15th? Let me know. Thanks.

Celeste Graham-Hodge, Legislative Administrator
Office of Senator Bettye Davis - AK State Legislature
State Capitol, Rm 30, Juneau, AK 99801
T (907) 465-4906, F (907) 465-3756
716 W. 4th Ave., #400, Anchorage, AK 99501
T(907) 269-0144, F(907) 269-0148
Celeste_Hodge@legis.state.ak.us

From: Jill Hodges [mailto:jill@alaskabraininjury.net]
Sent: Wednesday, February 03, 2010 9:37 AM

To: Celeste Hodge
Subject: RE: Alaska Brain Injury Network

Hi Celeste, we will take the 15th. Thank you.

Jill Hodges
Executive Director

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3745 Community Park Loop #140
Anchorage, Alaska 99508

office: 907 274-2824
fax: 907 274-2826

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"Educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families."

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Wednesday, February 03, 2010 8:25 AM
To: 'Jill Hodges'
Subject: RE: Alaska Brain Injury Network

Jill,
Hello. As soon as I hear from you regarding the two dates (Feb. 8 and 15th), I'll be in a position to confirm your participation. Please let me know this morning. Thanks.

Celeste Graham-Hodge, Legislative Administrator
Office of Senator Bettye Davis - AK State Legislature
State Capitol, Rm 30, Juneau, AK 99801
T (907) 465-4906, F (907) 465-3756
716 W. 4th Ave., #400, Anchorage, AK 99501
T(907) 269-0144, F(907) 269-0148
Celeste_Hodge@legis.state.ak.us

From: Jill Hodges [mailto:jill@alaskabraininjury.net]
Sent: Tuesday, February 02, 2010 10:55 AM
To: Celeste Hodge
Subject: RE: Alaska Brain Injury Network

Hello Celeste. I know we are presenting on the 4th to the house hSS committee. I can check with Jeff and Pat Hefley to see if they are available for the Senate HSS on Monday at 1:30. I just arrived in Juneau this morning and will come by your office to catch up.

Jill Hodges
Executive Director

Alaska Brain Injury Network
3745 Community Park Loop #140
Anchorage, Alaska 99508

office: 907 274-2824
fax: 907 274-2826

www.alaskabraininjury.net

"Educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families."

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Tuesday, February 02, 2010 8:42 AM
To: 'jill@alaskabraininjury.net'
Subject: Alaska Brain Injury Network

Jill,
Hello. I'm waiting on a response from Matt regarding a joint House and Senate H&SS meeting. If we're not successful at scheduling a joint meeting. The Senate H&SS has some time on Monday, February 8th at 1:30 PM and can schedule your presentation at that time. Because there's a process for scheduling notices, I'll need to know ASAP whether this date and time works. Please let me know.

Celeste Graham-Hodge, Legislative Administrator
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Celeste_Hodge@legis.state.ak.us

Outline for TBI Presentation to Senate HSS, Feb. 24th 1:30 committee hearing
30 min.

Presenters:
Pat Hefley, Deputy Commissioner, Department of Health and Social Services
Jeff Jessee, CEO, Alaska Mental Health Trust Authority
Jill Hodges, Executive Director, Alaska Brain Injury Network

Jill Hodges	• Do an overview of the 30 min. presentation • Review previous presentations • Walk through phases-system capacity building last 20 years • Roles of State, Trust, ABIN, Providers, legislators • Highlight 10 Year plan, treatment gap analysis • Talk about SB 219, FY11 budget recommendation, ($350.0 Gov. Budget)	10 min.
Jeff Jessee	• Alaska too small of a state to have separate TBI treatment systems of care (VA, DoD, Tribal, State) • Purpose: max collaboration, so everyone comes out a winner • History of establishing TBI as a beneficiary group • Trust funding has supported planning, pilot projects, technical assistance, workforce • Trust role- development, efficacy of programs.	10
Pat Hefley	• State of Alaska needs to catch up- 24 States have been utilizing TBI Medicaid Waivers, and 20 states have General Funds/General Revenue for brain injury specific programming. • TBI folks are in some level of care now, but need specialized type of care. • TBI folks are already in the system-need to move them into specialty programs in order to see results. • For several years, been in development mode, now moving into operationalizing. • Timeline • *As we progress, there will be appropriately staged incremental budget requests. The waiver will have a GF component. • Military efforts: ongoing	10
HSS members	Questions, Comments	

Celeste Hodge

From: Celeste Hodge
Sent: Tuesday, February 02, 2010 8:42 AM
To: 'jill@alaskabraininjury.net'
Subject: Alaska Brain Injury Network

Jill,
Hello. I'm waiting on a response from Matt regarding a joint House and Senate H&SS meeting. If we're not successful at scheduling a joint meeting. The Senate H&SS has some time on Monday, February 8th at 1:30 PM and can schedule your presentation at that time. Because there's a process for scheduling notices, I'll need to know ASAP whether this date and time works. Please let me know.

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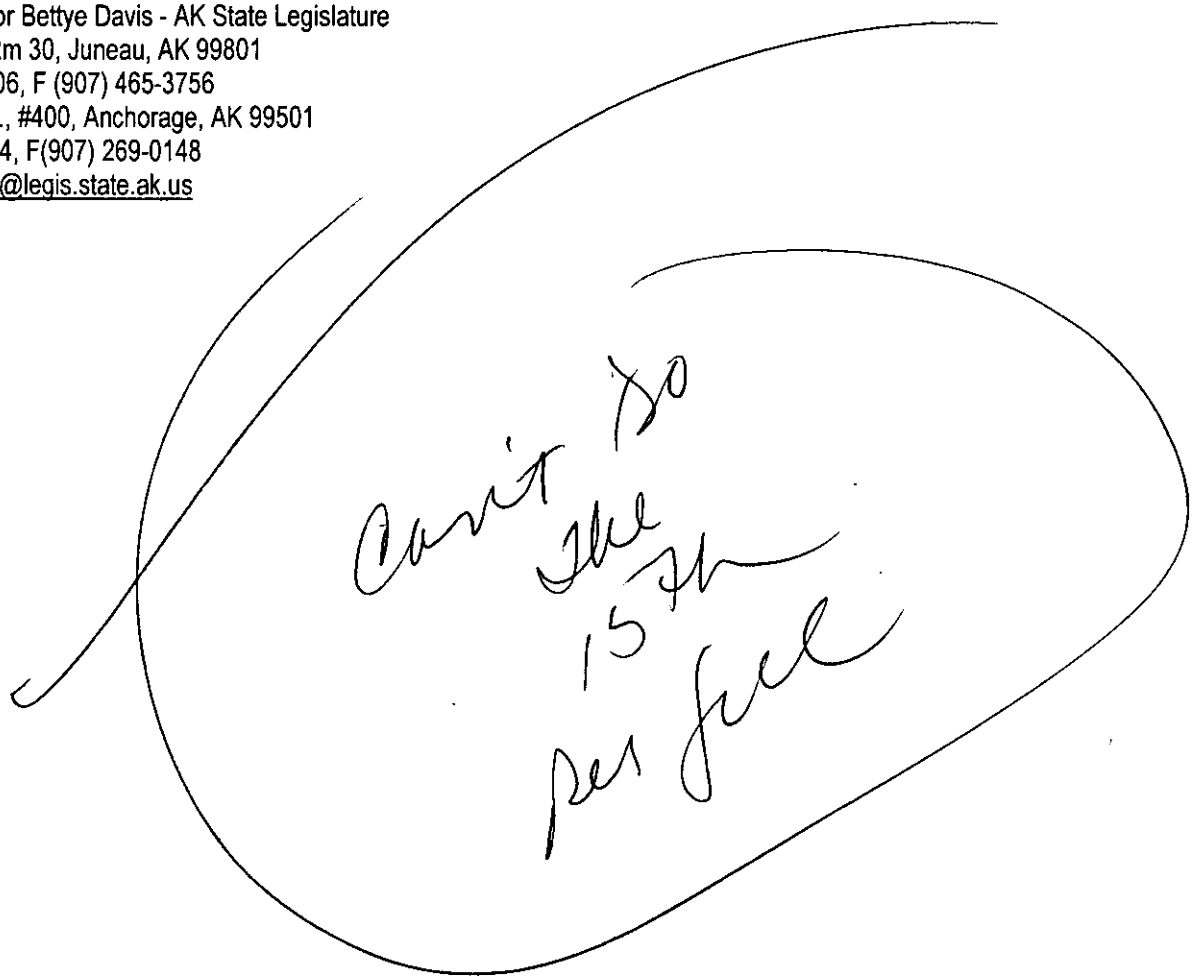

Celeste Hodge

From: Jill Hodges [jill@alaskabraininjury.net]
Sent: Monday, January 25, 2010 11:27 AM
To: Celeste Hodge
Cc: Matthew Johnson
Subject: Request for a Brain Injury Presentation to Senate/House HSS, first week in February

Good morning Celeste, as requested, here is an email with a request for a presenation for Senator Davis's HSS committee. I have been in contact with Matt Johnson in Rep. Keller's office as well. Should a joint presentation be possible, we would welcome that as an option.

The past few years, ABIN has organized a presentation on brain injury. Topics have included: what is brain injury, how brain injury affects Alaskans, military issues, and service/program recommendations. Senator Davis had shared in previous presentations that she understands the need and would like to learn more about the solutions and strategies.

This year, we would like to do a joint presentation with Commissioner Hogan (DHSS), Jeff Jessee (Alaska Mental Health Trust Authority), and myself (Alaska Brain Injury Network, Exec. Director) so we can speak to the coordinated efforts focusing on improving the current gaps and building state systems capacity to better meet the needs of Alaskans with brain injury. We would describe the joint efforts, current strategies, barriers, and outcomes of planning and developing a state system of care for Alaskans with brain injury.

We would be interested in presenting next week. I spoke with Matt this morning and he still needs to check with his boss. (preliminary discussions have highlighted February 4th date (3pm) as an option). I have checked with Jeff Jessee and he thinks that would be a good time. Commissioner Hogan has asked that I connect with Wilda when a day/time has been decided.

I appreciate everyone's efforts and flexibility as we try to organize lots of very busy people ☺.

Email or call if you have any questions 907 250-9597.

Jill Hodges
Executive Director

Alaska Brain Injury Network
3745 Community Park Loop #140
Anchorage, Alaska 99501

office: 907 274-2824
fax: 907 274-2826

www.alaskabraininjury.net

"Educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury and their families."

5210

SB

238

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
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TTY 1-877-434-7598
www.aarp.org/ak

RECEIVED
MAR 29 2010

March 29, 2010

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 13
Juneau, AK 99801-1182

The Honorable Bob Herron, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 411
Juneau, AK 99801-1182

RE: SB 238 (Davis)--Support

Dear Co-Chairs Keller and Herron:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health and Social Services Committee to support SB 238, authored by Senator Bettye Davis.

SB 238 corrects a situation which occurred in 2003 when the Legislature changed eligibility for long-term care services in facilities from 300% of the SSI level to $1,656 per month. Since then, each year some Alaskans would find themselves no longer eligible than when the 300% level was used.

Alaska has a long history of using home and community based services in preference to institutionalized care. SB 238 will allow our most frail and vulnerable citizens to remain in their homes and communities or in institutional settings, when appropriate.

The beneficiaries of SB 238 are not well off financially. They are at risk economically as well as from a health standpoint.

AARP recommends an "AYE" vote on SB 238.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Representative Tammie Wilson
Representative Sharon Cissna
Representative Bob Lynn
Representative Lindsey Holmes
Representative Paul Seaton
Senator Bettye Davis

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 4, 2010

SUBJECT: Sectional Summary (SB 238 (Work Order No. 26-LS1362\A))

TO: Senator Bettye Davis
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Amends the eligibility threshold for medical assistance applicants who are in a medical or intermediate care facility from a specified monthly income limit to 300 percent of the Social Security income benefit rate.

JMM:ljw
10-060.ljw

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 238 - "An Act amending the eligibility threshold for medical assistance for persons in a medical or intermediate care facility."

SPONSOR STATEMENT

In 2003 the Legislature changed Alaska Statute Section 47.07.020(b)(6), the Medicaid long-term services income eligibility limit for persons in medical or intermediate care facilities from 300% Supplemental Security Income (SSI) to an equivalent fixed dollar amount at $1,656 per month. This change created an income ceiling for waiver eligibility, effectively freezing the eligibility limit for the last seven years, rather than allowing the limit to adjust annually in tandem with the SSI. The result was that small Social Security cost of living adjustments have disqualified many needy disabled people from the program.

Near the end of 2008 many individuals who were aged, blind, or disabled and requiring institutional care received notices that they would no longer be eligible for the Home and Community-Based Services (HCBS) waivers after the 2009 Cost of Living Adjustment went into effect. Because the waiver eligibility limits no longer increased with the cost of living, it placed a number of people over the $1,656 per month limit, or 300% of the 2003 SSI benefit rate. The 2009 income equivalent at 300% SSI was $2,022 per month. Alternatives for preserving eligibility, particularly for those requiring lifetime or long-term care, include creation of a Medicaid qualifying income trust, also known as a Miller Trust. Trusts have procedural drawbacks, including numerous responsibilities and restrictions, limited access to income, assistance of an attorney, and a trustee to manage trust assets.

The Supplemental Security Income (SSI) program is a federal needs-based disability program for low income adults over age 65, blind, or disabled. For an adult, the SSI disability requirement is based on the ability to work. An adult is considered disabled if the person cannot do the work that he/she performed before the disability occurred or cannot do alternate work because of a severe physical or mental condition. For a child to be eligible, he/she must suffer from serious physical and/or mental problems. For both adults and children, the disability must last, or be expected to last for at least a year.

Medicaid services are critical to the well-being of Alaska's most vulnerable citizens. Supporting SB 238 will ensure that eligible Alaskans can continue to receive nursing home care and in-home services. It also will save the Legislature from amending statutes every year or two as the Federal Poverty Level guidelines and Supplemental Security Income levels increase with the cost of living.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB238
() Publish Date:

Identifier (file name): SB238-DHSS-SDMS-1-29-10
Dept. Affected: Health & Social Services

Title: Medicaid for Medical & Intermediate Care
RDU: Senior and Disability Services
Component: Senior and Disability Medicaid Services

Sponsor: Davis

Requester: Senate HSS
Component Number: 2662

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITU	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipt							
1037 GF/Mental Health							
Other Interagency Receipt							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) c

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece*

This bill would increase the Medicaid income eligibility standard for individuals who reside in medical institutions, typically nursing facilities. This standard is also used for people who receive home and community-based waiver services. Currently, this standard is fixed at $1,656 per month. The bill would increase the amount to 300 percent of the federal Supplemental Security Income (SSI) monthly benefit, which is currently $674, adjusted for cost of living each year. Initially, the new standard for Medicaid nursing facility residents and waiver recipients would be $2,022 per month.

DHSS does not anticipate that increasing the monthly standard for this eligibility category will increase the number of Medicaid recipients receiving services. While this is contrary to DHSS expectations when the Legislature fixed the standard at a set dollar amount in 2003, experience shows that as individuals receive cost of living increases in pensions or Social Security payments that raise their incomes over $1,656 per month, they use Medicaid qualifying income trusts to reduce their countable income below that amount and continue to qualify for Medicaid.
(Continued on Page 2).

Prepared by: William J. Streur, Deputy Commissioner
Phone 269-7827
Division: DHSS Health Care Services
Date/Time 1/29/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 1/29/2010
DHSS Finance & Management Services

ANALYSIS CONTINUATION

Another consideration is that Medicaid recipients who qualify under this institutional income standard are required to make a contribution toward the cost of the Medicaid institutional or waiver services they receive if their countable income exceeds the personal needs allowance established for their living arrangement. The personal needs allowance for people on waivers has historically been set in regulation and the amount varies depending on the person's living situation, and is not linked to the institutional income standard. DHSS has not assumed an increase to the personal needs allowance. Therefore, DHSS does not anticipate an increase in Medicaid spending as a result of this legislation. If DHSS increased the personal needs allowance in conjunction with increasing the income eligibility standard, it would increase Medicaid expenditures.

ALASKA STATUTES
1962

Volume 10

TITLE 45 TO TITLE 47

NOVEMBER 2002

Published by
THE ALASKA LEGISLATIVE COUNCIL

Annotated and Printed by
LexisNexis

Under the Supervision of
JANICE COFFIELD, THOMAS D. CRANFIELD, JR.,
AND BRIAN YOST

Effective Date of Statutes

See Alaska Constitution, art. II, § 18

Annotated through Sup. Ct. Op. No. 5589. For complete scope of annotations, see preface. For detailed information on the use of the Alaska Statutes, see User's Guide in Volume 1.

LexisNexis™

AS 2002

claims under medicaid, medicare, or similar welfare programs providing medical services. 32 ALR4th 671.

Criminal liability of pharmacy or pharmacist for welfare fraud in connection with supplying prescription drugs. 16 ALR5th 390.

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the Aid to Families with Dependent Children program;

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.220;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

ALASKA STATUTES
1962

2003 SUPPLEMENT

NOVEMBER 2003

Published by

THE ALASKA LEGISLATIVE COUNCIL

Annotated and Printed by

LexisNexis

Under the Supervision of

TERESA BUCHHOLZ, ANN GRADY, THOMAS D. CRANFIELD, JR., AND BRIAN M. YOST

Effective Date of Statutes

See Alaska Constitution, art. II, § 18

Annotated through Sup. Ct. Op. No. 5704. For complete scope of annotations, see preface. For detailed information on the use of the Alaska Statutes, see User's Guide in Volume 1 of the 2002 main set.

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DEC 1 6 2003
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AS 2003

(12) "medical assistance record" means records required to be kept by state or federal law or regulation regarding claims to a medical assistance agency;

(13) "organization" has the meaning given in AS 11.81.900;

(14) "person" has the meaning given in AS 11.81.900;

(15) "property" has the meaning given in AS 11.81.900;

(16) "reckless disregard" means acting recklessly, as that term is defined in AS 11.81.900;

(17) "services" or "medical assistance services" means a health care benefit that may qualify for reimbursement under AS 47.07 or AS 47.08, including health care benefits provided, attempted to be provided, or claimed to have been provided to another, by a medical assistance provider, or "services" as defined in AS 11.81.900;

(18) "unconditional discharge" has the meaning given in AS 12.55.185. (§ 3 ch 66 SLA 2003)

Chapter 07. Medical Assistance for Needy Persons.

Section

10. Purpose
20. Eligible persons
30. Medical services to be provided
32. Inpatient psychiatric services for persons under 21 years of age
35. [Repealed]
36. Cost containment measures authorized
42. Recipient cost-sharing
70. Payment rates for health facilities
73. Uniform accounting, budgeting, and reporting
74. Audits and inspections
110 — 190. [Repealed]
900. Definitions

Sec. 47.07.010. Purpose. It is declared by the legislature as a matter of public concern that the needy persons of this state who are eligible for medical care at public expense under this chapter should seek only uniform and high quality care that is appropriate to their condition and cost-effective to the state and receive that care, regardless of race, age, national origin, or economic standing. It is equally a matter of public concern that providers of services under this chapter should operate honestly, responsibly, and in accordance with applicable laws and regulations in order to maintain the integrity and fiscal viability of the state's medical assistance program, and that those who do not operate in this manner should be held accountable for their conduct. It is vital that the department administer this chapter in a manner that promotes effective, long-term cost containment of the state's medical assistance expenditures while providing medical care to recipients. Accordingly, this chapter authorizes the department to apply for participation in the national medical assistance program as provided for under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act). (§ 1 ch 182 SLA 1972; am § 4 ch 66 SLA 2003)

Effect of amendments. — The 2003 amendment, effective September 9, 2003, rewrote the first sentence, added the second sentence, and in the last sentence substituted "department" for "Department of Health and Social Services."

NOTES TO DECISIONS

Cited in Garner v. State, 63 P.3d 264 (Alaska 2003).

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

AS 2003

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed $1,656 a month but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the Aid to Families with Dependent Children program;

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

December 8, 2009

SB 238 - See item #5, page 2

Senator Johnny Ellis
716 West 4th Ave. Suite 500
Anchorage, AK 99501-2133

Dear Senator Ellis:

The Alaska Commission on Aging (ACoA) is pleased to present to you our FY2011 legislative priorities for the upcoming session. These top issues were identified with input from older Alaskans, family caregivers, providers, and senior advocates statewide. The ACoA is a state agency under the Department of Health and Social Services, established in 1982. Our charge is to plan, educate and advocate on behalf of all older Alaskans (persons aged 60 years and older) through inter-agency collaboration so that Alaska seniors/elders may lead useful and meaningful lives with dignity and independence and have access to quality services when seniors need them to remain safely in their homes and chosen communities for as long as possible.

1. **Establish a regular and periodic schedule of rate reviews for home- and community-based services** that serve persons who are Medicaid-eligible and meet nursing home level of care. This measure will promote ongoing awareness of the true costs of providing services. SB 32, sponsored by Senator Johnny Ellis, passed the Senate and the House Health and Social Services Committee last session and waits to be scheduled for a hearing in House Finance. ACoA encourages passage of this legislation.

2. **Eliminate, or alternatively, adjust the cap on adult dental services reimbursed by Medicaid** to provide program benefits that keep pace with higher health care costs due to inflation, and **allow Medicaid patients access to two-years program benefits in a single year** to permit scheduling of treatment around the oral health care needs of the patient. The current law places a statutory $1,150 limit on dental health care expenditures per eligible client. When the Medicaid Adult Dental program was created in 2005, this amount was sufficient to pay for one half of a set of dentures, either an upper or lower, with the idea that a patient who needed dentures could have both sets if the treatment was scheduled around the turn of the fiscal year. Although health care costs continue to rise, the cap has not been increased in three years. Allowing Medicaid patients access to two years of program benefits in a single year furnishes Alaskans and their dentists the flexibility needed to provide treatment addressing oral health emergencies that can occur at any time.

3. **Provide increased operating and capital funding to establish an Alaskan Public Transportation Fund for operations of local coordinated transportation systems** which the State can use to leverage additional federal funds to improve accessible, affordable transportation for older Alaskans, persons with disabilities, low-income individuals, youth and others without access to transportation so that Alaskans with special needs may have greater access to employment and community participation opportunities. According to the Governor's Coordinated Transportation Task Force Report (2009), Alaska is one of only three states in the nation that does not provide any specific state funding for public transportation.

4. **Provide operating funding to enhance the Aging and Disability Resource Centers**, administered under the Division of Senior and Disabilities Services, to streamline access to more efficient information and referral services by providing eligibility screening, options counseling, and assessments so that Alaskans can make informed decisions and have access to long-term care services through a "one-stop shop," reducing confusion and program fragmentation.

5. **Return to the original wording of AS 47.07.020 (b) (6), the Medicaid statute establishing income eligibility for persons requiring nursing home level of care, referencing 300% of the maximum Supplemental Security Income (SSI) benefit rate rather than the current frozen dollar amount ($1,656 a month) to reflect changes in cost of living** so that seniors and other Medicaid-eligible persons will not be disqualified for services, including home- and community-based waiver services, due to small increases to their Social Security and other benefits. The amount of $1,656 is the monthly amount of 300% of SSI in 2003. The 2009 income equivalent is $2,022 monthly.

We also want to take this opportunity to share with you highlights from the Alaska Elder/Senior Community Forums that we hosted in Kotzebue (August) and Anchorage (December) to increase understanding about the issues that are of most importance to older Alaskans and to identify unmet needs. These forums, to be held in other locations statewide in the coming year, are being conducted to gather public input that will be used to develop the next Alaska State Plan for Senior Services, FY2012-2016. This document, prepared every four years, provides the State with a guide for delivering senior services and meets the requirement of the U.S. Administration on Aging for the state to access funding from the Older Americans Act which provides federal funding for a range of senior programs. Although these forums will be ongoing, Anchorage and Kotzebue participants identified the following issues as the most important:

- Provide improved access to quality and affordable health care, long-term supports that include home- and community-based services in communities where older Alaskans live, and promote disease prevention and wellness programs;
- Promote financial security, increase affordable senior housing, and improve elder safety;
- Provide safe, dependable, and affordable coordinated community transportation services so that seniors/elders can get to medical appointments and remain actively engaged in their communities;
- Enhance information and assistance services to help individuals access long-term support services and make informed decisions regarding their care.

Upon retirement, more seniors are choosing Alaska as their lifelong home to be close to family, friends and the unique Alaskan lifestyle. For the first time, Alaska is now the state with the fastest growing senior population, according to the U.S. Administration on Aging (2008), replacing Nevada, which held that position for many years. Alaska is home to approximately 80,000 persons aged 60 years and older who comprise about 12% of the state's population (Alaska Department of Labor). Alaska's senior population is expected to increase by four to six percent each year through 2020, as baby boomers become of age, by which time the total number of seniors will grow by almost 64 percent. The oldest Alaska seniors, 85 and older, are expected to triple during the next 25 years, vastly increasing the number of Alaskans living with Alzheimer's disease and related disorders.

Please feel free to contact Denise Daniello, ACoA's executive director (465-4879 or denise.daniello@alaska.gov) for additional information about these issues or with any questions concerning Alaska's senior population.

The Alaska Commission on Aging will be meeting in Juneau February 10th-12th, 2010 and hopes to schedule a meeting with you to discuss our priorities in person. We look forward to working with you this legislative session. We appreciate your consideration of these advocacy priorities and thank you for your support of services for older Alaskans.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

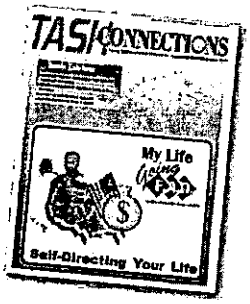
Denise Daniello
ACoA Executive Director

5225

My Life Going F.A.R.
Freedom * Authority * Responsibility

Supporting Individuals and Families to Self Direct Their Lives Through the Maryland New Directions Medicaid Waiver

About the Project
MD New Directions Waiver
New Directions Fact Sheets
Person-Centered Planning
Individualized Budgeting
What is Self-Direction?
Regional Workshops
Planning Workshops
Creating an Individualized Budget
Resources and Links
Calendar of Events
Glossary of Acronyms & Terms
Position Announcement
Outreach Tools
Contact Us



Inside the March - April 2005 Issue of TASH Connections:
Self-Directing Your Life (.pdf file)

My Life: Going FAR is a project of TASH.

This project is funded by the Maryland Developmental Disabilities Council, in cooperation with the Maryland Developmental Disabilities Administration.

What is a Medicaid Waiver?

This information is based on a Policy Brief of the National Center for Family Support. The entire brief can be found at www.familysupport-HSRI.org

The Medicaid program is an enormously important source of money to pay for services and supports for people with developmental disabilities. About $3 of every $4 that states spend for developmental disabilities services comes by way of Medicaid. Once, Medicaid dollars only paid for institutional services. Today, Medicaid allows more diverse services and supports for individuals in the community, by "waiving" the need to get those same services in an institution.

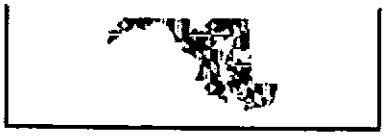
Why is it important to learn all about Medicaid?

Advocates need to keep in mind that states have the ability to decide who gets funded for what services (criteria for eligibility and coverage). To realize many of the opportunities afforded by federal policy, a state must elect to include an "option" or change its current policies. Medicaid policy change at the state level means convincing policy makers (governors and legislators) to take advantage of key options if they have not done so already. This is why it is important for individuals, families and other stakeholders to be "at the table" when Medicaid policy is discussed.

The Way Medicaid Works

Federal law (Title XIX of the Social Security Act) and regulations spell out the requirements that a state must meet in operating its Medicaid program. If a state meets these requirements, then the federal government pays a percentage of money (called the Federal Medical Assistance Percentage (FMAP)) of the amount of money that the state spends for services to people who are eligible for Medicaid. The FMAP rate varies, depending on income levels in each state. The lowest FMAP for high-income states is 50%; the maximum rate allowed is 83%. The highest rate currently being paid is about 77% (Mississippi).

States must use their own or local tax dollars (called "matching dollars") to meet their share of Medicaid costs. In order to expand Medicaid services, a state must provide more of their own tax dollars to get more money from the federal government. In the federal budget, Medicaid is an "open-ended entitlement" program. This means that the federal government is required by law to pay its share of state Medicaid costs regardless of the total amount. Each state spells out what is available under its Medicaid program in a document called the "state plan." The state plan describes the groups of individuals who can receive Medicaid services and the services that the state will make available to them. A state can amend its plan to change its program. State plan amendments are subject to federal review and approval. Each state must designate one of its agencies (called the "single state Medicaid agency") to administer its Medicaid program. The Medicaid



Sign up for the My Life: Going FAR email discussion group. This group is for sharing questions, ideas, and sucess stories related to self-directing support services and for supporting people to self-direct and use the Maryland New Directions Medicaid Waiver.

Individuals with developmental disabilities, families, and interested advocates or supporters are welcome and encouraged to participate.

If you or someone you know is interested in the information, but does not have regular access to email or the internet, please call us at 410-828-8274 x109 and we will add you to our regular mailing list.

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agency may enter into agreements with other state agencies (e.g., the state developmental disabilities agency) to administer specific services.

The federal agency responsible for the Medicaid program is the Center for Medicaid and State Operations (CMSO), a branch of the Health Care Financing Administration (HCFA) in the Federal Department of Health and Human Services. HCFA issues regulations and other policy guidance concerning Medicaid. It also oversees state Medicaid program operations. There are ten HCFA Regional Offices located around the country that work with individual states concerning the operation of their Medicaid programs.

Key Requirements For States

There are key requirements with which a state's Medicaid program must comply. These basic requirements govern Medicaid programs nationwide. They include:

- A state must make services available to individuals on a *comparable* basis. With some exceptions, a state may not provide services that differ in amount or type to one group of beneficiaries than others.
- A state must guarantee that recipients have *free choice* in selecting from among qualified service providers when obtaining Medicaid services. That is, a state cannot require a person to obtain services from a specific provider to the exclusion of others.
- A state must make Medicaid services are available *statewide* and provide that individuals have ready *access* to them.
- A state must accept and make a *prompt decision* concerning a person's application for Medicaid services.
- A state may not limit or ration services due to a funding shortfall. A state is obligated to provide services in its state plan to all eligible persons. If a state cannot afford to provide the services, it must change its state plan.
- A state also must permit individuals to appeal adverse decisions concerning their eligibility or the authorization of services. This is called the Fair Hearing process.

In some cases, a state may request *waivers* of some of these requirements. Medicaid home and community-based service waiver programs operate under such waivers. The HCBS waiver program will be discussed in more detail below. When a state decides to use a managed care arrangement to obtain services for individuals (thereby limit their freedom of choice), there are federal laws and regulations concerning how such arrangements must be set up in order to safeguard their interests. Medicaid services must be obtained from "qualified providers." A state must spell out the qualifications that an individual or agency must meet in order to furnish services. States have considerable latitude in specifying these qualifications. At a minimum, providers must meet requirements spelled out in state law. In addition, each provider must enter into a contract (called a "provider agreement") with the state in order to be paid for services it provides to beneficiaries.

Medicaid is a "vendor payment" program. Typically, states pay providers directly on a fee-for-service basis once the provider has furnished a service. Subject to federal requirements, a state may pay for Medicaid services through prepayment ("capitation") arrangements when services are provided by health maintenance organizations (HMOs) or similar organizations. States have broad discretion in determining the amount of payments for services. Federal law requires that payment rates must be

sufficient to attract enough providers so that recipients can access needed services.

Eligibility: The Portal to Medicaid Services

Medicaid services are available only to individuals determined eligible for a state's program. Eligibility is the "portal" through which people must pass in order to obtain Medicaid services. On the other side of this portal lie services that people can obtain.

There are two parts to Medicaid eligibility. One is *financial eligibility*. Medicaid is a *means-tested* program. To qualify for Medicaid, a person cannot have income or assets that exceed the amounts that the state has specified. *The second leg of eligibility is whether a person is a member of a "group" that recognized in federal law* (e.g., people with disabilities who receive federal Supplemental Security Income (SSI) benefits). In order to receive Medicaid services, a person has to meet both tests. "Mandatory" groups (e.g., individuals that all states must serve) essentially include SSI recipients and children who live in very low-income households. But, there are many options or "doors" available to states to widen Medicaid eligibility beyond the mandatory groups. People with developmental disabilities qualify for Medicaid by meeting financial eligibility tests and being members of recognized but broader groups (e.g., individuals with disabilities). It is important to understand that over the past fifteen years, federal Medicaid policy has changed to permit states to offer Medicaid services to more groups of individuals who do not actually receive public assistance payments. Medicaid no longer is closely tied to "welfare." Even though the program is still means-tested, new mandates and options have been added so that individuals and families who have income above the poverty line can pass through the portal.

There are certain eligibility options that can play an important role in enabling people with developmental disabilities to qualify for Medicaid services, even though these options are not reserved exclusively for such individuals. These options revolve around children and adults who do not qualify as members of a mandatory group, generally because their or the family's income prevents them from being eligible to receive an SSI or other public assistance payment. It is helpful to discuss these options in terms of those that are relevant to children, adults and those that cut across all ages.

- **Children**. Not all children and youth with severe disabilities can qualify for an SSI payment and, thus, Medicaid. In the case of children with severe disabilities who live with their families, SSI rules require that a portion of the family's income be counted as available ("deemed") to the child. Even in the case of low-to-moderate income families, this requirement can result in the child's not qualifying for an SSI payment and, thus, make the child ineligible for Medicaid. However, if the child were placed permanently out of the family home in an institutional setting, the family's income would not be counted and the child would qualify for Medicaid. In order to correct this problem, in 1982 Congress enacted the "Katie Beckett option" (also known as "TEFRA 134"). Under this option, a state can decide not to count the family's income when the child meets SSI disability criteria and would be eligible for Medicaid if s/he were in an institutional setting. Several states have adopted this option. One state where this option is used extensively is Wisconsin. See the _ for how to obtain more information about Wisconsin's Katie Beckett program.

- Children who do not receive SSI also can qualify for Medicaid in a variety of other ways. They can qualify as members of low and moderate income households (needy families). There can be other avenues available, depending on the state. The Vermont Parent-to-Parent Network has identified six ways (including the Katie Beckett option) that children with disabilities can obtain Medicaid eligibility in Vermont. See the _ for how to access this information.

- Congress is considering a bill (the Family Opportunity Act) that would give states still another option for extending Medicaid eligibility to children with disabilities who live in higher income households eligible for Medicaid services. We discuss this bill more in the final section.
- **Adults**. Family income does not play a role in Medicaid eligibility for adults with disabilities, including when the person lives with his/her family. Only the adult individual's own income and resources are considered. As noted previously, states must extend Medicaid eligibility to individuals who receive SSI payments. SSI program rules permit individuals to earn income up to a certain level and still qualify for SSI. Recently, these earning limits were raised to $740/month. There also are special rules that continue SSI and Medicaid benefits for a period of time after a person exceeds the earned income ceiling. It is not true that having a job automatically disqualifies a person for Medicaid. But, problems can arise once the person's income climbs above levels that SSI permits.
- Not all adults with severe disabilities qualify for an SSI payment. People who receive "adult disabled child" Social Security benefits or who have other income (including employment income) that exceed SSI maximums can qualify for Medicaid under other options. A state can set higher income thresholds that permit more of these individuals to qualify even though they do not receive SSI. Many states also permit individuals to qualify as "medically needy." In a medically needy program, people who have income above the state's maximum qualify for Medicaid by "spending down" their income on health services until it reaches the state's maximum (e.g., if a state's maximum is $600 per month and a person has income of $800, the person will qualify once he or she spends $200 on health services). Recently, HCFA issued new rules that give states more options to make it easier for people to qualify as medically needy and thus obtain Medicaid eligibility. In addition, starting in 1997, Congress has added more eligibility options that permit states to extend or continue Medicaid eligibility for adults with disabilities whose employment earnings would otherwise disqualify them for Medicaid. See the _ for how to obtain information on this new options (which some states already have adopted). The rules concerning Medicaid eligibility for adults with disabilities differ considerably from state to state with the exception of the requirement that states include SSI recipients. As with children, it is important to have solid information concerning the rules in your state.
- **Long-term Services Eligibility**. In most states, Medicaid financial eligibility rules are more liberal for people who require long-term services. For example, a state may grant Medicaid eligibility to such persons who have incomes as high as three-times the basic grant standard for the SSI program (i.e., as high as $1,590 per month). In operating an HCBS waiver program, a state may employ the same financial rules to determine eligibility as it does for institutional services. For children, this yields the same result as the Katie Beckett option. However, the Katie Beckett option is broader since it

does not hinge on whether the child participates in a waiver program. In the case of adults, using institutional financial eligibility rules can make a big difference in enabling individuals to obtain Medicaid eligibility. But, again, these special provisions apply to people who qualify for long-term services.

Medicaid operates under a simple rule: no Medicaid card, no services. States have many options for widening the eligibility portal for both children and adults with disabilities beyond those who receive an SSI payment. Advocacy with respect to Medicaid eligibility centers on urging states broaden eligibility options to more children with severe disabilities who live with their families and adults who do not qualify for SSI.

Once a person successfully navigates through a Medicaid portal, the next question is what services they can obtain that would be valuable in meeting his or her needs? Answering this question revolves around "coverage" -- the collection of "services" or "benefits" a state offers to Medicaid beneficiaries.

Medicaid coverage also has two parts. Every state must provide all Medicaid recipients with a core set of *mandatory services* (e.g., hospital, physician, nursing facility, home health services). A state also may elect to provide additional *optional services* (e.g., personal assistance, home and community-based waiver services). See the _ for how to locate information about the all the services that a state must or may offer. States can operate Medicaid programs that have either wide or narrow benefits. Usually you can find out about all the services your state offers at the Medicaid agency's website (_). Like other health insurance programs, whether a person requires a service is based on "necessity" (medical or otherwise) criteria (e.g., does a person's condition require a treatment or service that is covered under the state plan?).

State-to-state, the basic services that are available depend on whether the person is a child or adult as well as the decisions that a state has made with respect to the services it offers. Everyone who has a Medicaid card can access the services that a state offers through its Medicaid state plan. Here, we describe some key "regular" Medicaid services (e.g., services that a state can provide without seeking special waivers). In the next section, we will discuss services that a state can over through an HCBS waiver program.

There are differences in the services that a state must or may offer children and adults. In particular:

- **Children**. For more than a decade, Congress has focused on strengthening the role that the Medicaid program plays in ensuring that children (with or without disabilities) have access to health care. In 1989, Congress extensively revamped federal Medicaid law what are labeled "Early and Periodic Screening, Diagnosis and Treatment" (EPSDT) services. States must provide EPSDT services to all children who are eligible for the Medicaid program. It is one of the mandates that states must meet in operating a Medicaid program. Through EPSDT, children must be seen periodically by health care professionals. If the child is identified as having a medical condition, further diagnoses must be performed and a state must follow through to provide all necessary treatment services. However, needed services can be identified at any time by professionals other than the child's own physician. The 1989 law

changes required states to step up their performance in operating EPSDT programs. It also mandated that states furnish any necessary Medicaid service (including dental care) that a child requires – regardless of whether the state specifically covers the service as part of its regular Medicaid program or not. The EPSDT mandate, for example, means that Medicaid eligible children with severe disabilities who require therapeutic services must be provided them. A state cannot restrict the services that it provides under the EPSDT mandate; it must make all types of services available, including the services that children with severe disabilities or special health care needs require. Such services can include home health services and personal assistance. However, EPSDT services do not include services (like respite) that only can be furnished through an HCBS waiver program. It is this EPSDT mandate that potentially makes obtaining Medicaid eligibility so valuable for children with disabilities.

- **Adults**. Except for the mandatory services that all states must include in their Medicaid programs, states have latitude in terms of the types of services that they make available to adults with disabilities. With respect to adults, there is no equivalent to the EPSDT mandate. States vary considerably with respect to the optional services that they make available to adults. For example, states frequently make available only very limited dental services or restrict the provision of therapeutic services only to people who need such services to "restore function," a restriction that frequently results in persons with developmental disabilities not being able to obtain such services. In addition, often states impose restrictions on optional services that can narrow their scope considerably.

There are three "regular" Medicaid services that are especially relevant to meeting the needs of people with developmental disabilities:

- One is home health, which all states must offer in their Medicaid programs. Home health services are provided to individuals at their place of residence. Home health services must include part-time or intermittent nursing services, home health aide services, and certain medical supplies and equipment. Physical, occupational therapy and speech pathology and audiology services also may be provided on an optional basis. In some states, access to home health services has been restricted to "homebound" individuals. But in July 2000, HCFA issued a policy clarification that states cannot restrict the availability of these services to people whose condition prevents them from leaving the home. This is expected to increase access to home health services by individuals who live in the community.
- The second important "regular" Medicaid service coverage is personal care (a.k.a., "personal assistance" or "attendant care"). When this service is offered, workers can provide assistance to people with disabilities in a wide variety of ways (helping with activities of daily living, grocery shopping, or getting about in the community). Once, federal rules limited the provision of these services to the person's home and described them in "medical model" terms. In 1993, Congress changed federal law so that personal assistance could be provided out in the community and "demedicalized" them. In 1999, HCFA issued new guidelines that gave states increased flexibility in providing these services, including sanctioning the use of consumer-directed personal care services (____). A state may provide personal care/assistance services without obtaining a waiver from HCFA and people do not have a

demonstrate a "need for institutional services" in order to obtain these services. Personal care is a potentially very flexible benefit that states can make available to all beneficiaries. However, fewer than 30 states offer personal care under their regular Medicaid programs and many have imposed more stringent restrictions on them than federal policy requires. A few states (e.g., Washington) make personal assistance available relatively widely.

- Another service is "targeted case management." The service is labeled "targeted" because it is one of the few regular Medicaid services that a state can cover but limit to specific groups of individuals. Many states use this coverage to fund their service coordination systems for people with developmental disabilities. States can offer these services to one or many groups of beneficiaries. Targeted case management is designed to help Medicaid beneficiaries access any of a wide range of services -- including social and educational services – not just health care services.

The "regular" services that a state offers through its Medicaid state plan make up a "core" benefit package available to all Medicaid beneficiaries. Federal policy is very liberal with respect to the range of benefits that states may offer. But, many states are reluctant to add more services to their Medicaid programs or loosen up the restrictions that apply to the services that they presently offer. It is not surprising that concerns about increased spending lie behind this reluctance. Once a service is included in the core benefit package, it becomes an entitled service that might be very costly to provide. Nonetheless, advocates should be vigilant for opportunities to urge states to take advantage of opportunities to add services that are important to people with disabilities or remove overly stringent restrictions.

This information is based on a Policy Brief of the National Center for Family Support. The entire brief can be found at www.familysupport-HSRI.org

My Life: Going FAR is a project of TASH.
This project is funded by the Maryland Developmental Disabilities Council,
in cooperation with the Maryland Developmental Disabilities Administration.

01/24/05

ABOUT OUR PROGRAMS

MARYLAND MEDICAL ASSISTANCE FOR FAMILIES NEW!

MARYLAND MONEY FOLLOWS THE PERSON

HEALTHCHOICE

SEARCH OUR HEALTHCHOICE PROVIDER DIRECTORY

DIVISION OF COMMUNITY SUPPORT SERVICES

MONTHLY INCOME & ASSET GUIDELINES FOR MEDICAL CARE PROGRAMS

MARYLAND CHILDREN'S HEALTH PROGRAM

PRIMARY ADULT CARE PROGRAM (PAC)

MARYLAND MEDICAID PHARMACY PROGRAM

LONG TERM CARE

SPECIALTY MENTAL HEALTH SERVICES

WAIVER PROGRAMS

LISTING OF LOCAL DEPARTMENTS OF SOCIAL SERVICES

MEDICAL PROGRAMS HOME

MARYLAND MEDICAID ADVISORY COMMITTEE

EARLY & PERIODIC SCREENING, DIAGNOSIS & TREATMENT (EPSDT)

EMPLOYED INDIVIDUALS WITH DISABILITIES PROGRAM (EID) INFORMATION

MESSAGE TO COMMUNITYCHOICE ADVISORY GROUP

SITE TABLE OF CONTENTS

Waiver Programs

The Medicaid Program is responsible for the implementation and ongoing administration of home and community-based services waivers and targeted case management programs for special population groups. The Program studies, plans, and implement services relating to the needs of special populations such as the elderly, the mentally ill, and the physically and mentally disabled.

- Waiver Programs Overview
- Reportable Event Information
- Provider Billing Forms and Instructions
- Registry Policy for Closed Waivers
- Older Adults Fact Sheet Updated
- Autism Waiver Fact Sheet
- Model Waiver Fact Sheet
- TBI Waiver Fact Sheet
- Living at Home Waiver Program
- Frequently Asked Questions List
- Estate Fact Sheet
- Estate Fact Sheet - Spanish Version
- Medical Day Care Waiver Fact Sheet NEW!
- Medical Day Care Waiver Application NEW!
- Medical Day Care Services Waiver NEW!
- Residential Treatment Center (RTC) Waiver NEW!
- Waiver Program Updates
  - Autism Waiver Application
  - Approved Living at Home Waiver Application
  - 1915 (b)(4) waiver application for Living at Home Case Management. Submitted July 2009

What is a waiver?

Under Section 1915(c) of the Social Security Act, Medicaid law authorizes the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid statutory requirements. These waivers enable States to cover a broad array of home and community-based services (HCBS) for targeted populations as an alternative to institutionalization. Waiver services may be optional State Plan services which either are not covered by a particular State or which enhance the State's coverage. Waivers may also include services not covered through the State Plan such as respite care, environmental modifications, or family training.

The four basic types of 1915(c) HCBS waivers available for states based on the target population's level of alternative long-term institutional care are:

- intermediate care facility-mental retardation (ICF-MR) level of care for mentally retarded and/or developmentally disabled individuals;
- chronic or rehabilitative hospital level of care for individuals who are medically fragile, chronically ill, or severely disabled;
- psychiatric hospital level of care for individuals who are severely or chronically mentally ill; and
- nursing facility level of care for individuals who are elderly, physically disabled, and/or cognitively impaired.

To be a waiver participant, an individual must be medically qualified, certified for the waiver's institutional level of care, choose to enroll in the waiver as an alternative to institutionalization, cost Medicaid no more in the community under the waiver than he or she would have cost Medicaid in an institution, and be financially eligible based on their income and assets.

Updated
July 16, 2009

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SB 250

Alaska State Legislature

Interim: (May - Dec.)
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Fax: (907) 269-0148

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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senate Health and Social Services Committee

CS for Senate Bill No. 250( )

"An Act requiring insurance coverage for autism spectrum disorders, describing the method for establishing a treatment plan for those disorders, and defining the treatment for those disorders; and providing for an effective date."

Sponsor Statement

SB 250 requires that health insurers in Alaska provide coverage for autism spectrum disorders, including the behavior therapies that after 30 years of study have shown to be the only effective treatment of these disorders. Treatment has been shown to improve the symptoms of ASD and in some cases even eliminate the need for special education services for a child with ASD. The incremental societal cost of not treating an individual with autism has been estimated by Harvard economist Michael L. Ganz, MS, Ph.D. to be approximately $3.2 million. The cost savings alone in special education to age 22 for each autistic child has been estimated at $187,000-$203,000 or $1.1 million to age 55 relative to three years Early Intensive Behavioral Treatment. The cost to policy holders to implement such coverage is estimated at less than a 1% increase in premiums, or $3.60 per member per month. (See "The Lifetime Distribution of the Incremental Societal Costs of Autism," *Archives of Pediatrics and Adolescent Medicine*, April 2007, Vol. 161, cited in "*Actuarial Cost Estimate: Alaska House Bill 187, an Act Requiring Insurance Coverage for Autism Spectrum Disorders, February 9, 2010").*

SB 250 only mandates coverage for autism spectrum disorders for about the 40% of Alaskans who are covered by insurers or insurance company plans. Self-funded health plans, often sponsored by the largest employers, including the State health care plan, or "Alaska Care" plan, usually are entirely exempt from state regulation because they are preempted by the federal ERISA law. The state historically, however, has complied with state insurance laws including mandated benefit laws, even if it is not legally required to do. The Division of Insurance to date has not enforced insurance laws on the state union health trusts, and its ability to do so is subject to legal debate.

Prevalence of ASDs

The Centers for Disease Control (CDC) reports about 1 in 110 children are affected with ASDs, and is much more prevalent among boys, about 1 in 58. This is a dramatic increase from just a decade ago. It is unclear how much of this increase is due to a broader definition of ASDs, better diagnoses, or a combination of both. Despite being treatable, many children diagnosed with an Autism Spectrum Disorder (ASD) never receive the treatment they need. Families can go bankrupt or mortgage their future, trying to provide their children with the treatment to ameliorate their condition. Families are forced to dig into their savings, retirement funds, and their other children's college savings because ASD is not covered by insurance plans. Although some insurers may already cover some types of autism, most insurance plans explicitly exclude the treatment of ASD, even when the service would otherwise be covered by the health plan as a regular medical condition.

What are Autism Spectrum Disorders?

The National Institute of Mental Health reports that Autism Spectrum Disorders (ASD), also known as Pervasive Developmental Disorders (PDDs), cause severe and pervasive impairment in thinking, feeling, language, and the ability to relate to others. These disorders are usually first diagnosed in early childhood and range from a severe form, called autistic disorder, through pervasive development disorder not otherwise specified (PDD-NOS), to a much milder form, Asperger syndrome. They also include two rare disorders, Rett syndrome and childhood disintegrative disorder. All of these can be debilitating to families emotionally, physically, and financially. Societal rewards of early detection and proper treatment include stronger families, healthier children, and savings in health transfer costs later in life.

National and State Coverage

President Obama has stated the coverage of treatment and other types of funding for ASD would be a priority of his administration. Sens. Durbin, Casey and Menendez introduced the Autism Treatment Acceleration Act of 2009, mandating the insurance coverage of ASD. Implementing SB 250 while a federal mandate is pending allows insurers and the state needed time to adjust to the requirements of such a law. It also would bring healthcare professionals and jobs to the state.

Since March of 2009, 11 states have passed legislation regarding mandatory insurance coverage of treatment for ASD, with 8 states having enacted legislation prior to March of 2009. The District of Columbia, Puerto Rico and 19 additional states currently have similar legislation pending. These enacted and pending bills, including the Autism Treatment Acceleration Act, demonstrate the nationwide need for relief for families of autistic individuals. Autism is not a state- or region-specific condition. Families burdened with the costs of autism are unlikely to relocate to one of those 11 states that require insurance companies to cover the cost of ASD treatment. On the other hand, families of any state should not be burdened alone with the great cost of treating a disorder they could not prevent or predict. Moreover, they should not find themselves victims of unwarranted discrimination by health insurance companies. Although there is no cure for ASD, SB 250 will help significantly to treat hundreds of Alaskans suffering from these disorders.

26-LS1400\R
Bailey
3/11/10

CS FOR SENATE BILL NO. 250( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

A BILL

FOR AN ACT ENTITLED

"An Act requiring insurance coverage for autism spectrum disorders, describing the method for establishing a treatment plan for those disorders, and defining the treatment for those disorders; and providing for an effective date."

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

* **Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.397. Coverage for autism spectrum disorders. (a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in this state shall provide coverage for the costs of the diagnosis and treatment of autism spectrum disorders. Coverage required by this subsection must include treatment prescribed by a licensed physician or psychologist, provided by or supervised by an autism service provider, and as identified in a treatment plan developed following a comprehensive evaluation. Covered treatment may include medically necessary pharmacy care, psychiatric care, psychological care, habilitative or rehabilitative care, and therapeutic care. In this subsection,

(1) "habilitative or rehabilitative care" means professional counseling, guidance services, and treatment programs, including applied behavior analysis or other structured behavioral therapies necessary to develop, restore, and maintain the functioning of an individual to the maximum extent practicable; in this paragraph, "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement, and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function;

(2) "therapeutic care" means services provided by or under the supervision of a speech-language pathologist licensed under AS 08.11 or an occupational therapist or physical therapist licensed under AS 08.84.

(b) Coverage under this section

(1) is required to be provided only to individuals under 21 years of age;

(2) must provide a maximum benefit of $36,000 a year, adjusted annually, beginning January 1, 2012, by the percentage change in the Consumer Price Index for all urban consumers compiled by the United States Department of Labor, Bureau of Labor Statistics; payments made by an insurer on behalf of a covered individual for treatment of a medical condition unrelated to the individual's autism spectrum disorder may not be applied toward the maximum benefit established in this paragraph;

(3) may not limit the number of visits to an autism service provider for treatment;

(4) is subject to copayment, deductible, and coinsurance provisions, and other general exclusions or limitations included in a health insurance policy to the same extent as other health care services covered by the policy; and

(5) must cover medically necessary treatment that is coordinated with an education program, but may not be contingent on the coordination of treatment with an education program.

(c) This section does not limit benefits that are otherwise available to an

individual under a health care insurance plan.

(d) A health care insurer may not refuse to deliver, execute, issue, amend, or renew coverage to an individual or terminate coverage because the individual is diagnosed with or received treatment for autism spectrum disorders.

(e) In this section,

(1) "autism service provider" means an individual who is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized certifying organization and who provides direct services to an individual with an autism spectrum disorder;

(2) "autism spectrum disorders" means pervasive developmental disorders, or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-IV-TR, as amended or reissued from time to time;

(3) "health care insurance plan" has the meaning given in AS 21.54.500;

(4) "health care insurer" has the meaning given in AS 21.54.500;

(5) "medically necessary" means any care, treatment, intervention, service, or item prescribed by a licensed physician or psychologist in accordance with accepted standards of practice that will, or is reasonably expected to,

(A) prevent the onset of an illness, condition, injury, or disability;

(B) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability;

(C) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacity of other persons of the individual's age.

*** Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 21.42.397, enacted by sec. 1 of this Act, applies to a health

insurance policy that is offered, issued for delivery, delivered, or renewed on or after January 1, 2011.

* **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB 250**
() Publish Date:

Identifier (file name): SB250-CED-INS-3-8-10
Dept. Affected: DCCED
Title: Ins. Coverage: Autism Spectrum Disorder
RDU: Insurance
Component: Insurance
Sponsor: Health & Social Services Committee
Requester: Health & Social Services Committee
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill mandates coverage for the diagnosis and treatment of autism spectrum disorders in any plan offered by health care insurer.

The department does not expect a fiscal impact as a result of this legislation

Prepared by: Linda Hall, Director
Phone 907-269-7900
Division: Insurance
Date/Time 3/8/10 1:50 PM
Approved by: Emil Notti, Commissioner
Department of Commerce, Community and Economic Development
Date 3/8/2010

(Revised 11/6/2009 OMB)

5241

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 11, 2010

SUBJECT: Coverage for autism spectrum disorders; sectional summary (SB 250, 26-LS1400\A; CSSB 250( ), 26-LS1400\R)

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Thomas Obermeyer

FROM: Dennis C. Bailey
Legislative Counsel

You have requested a sectional summary that compares SB 250, ver. A, with CSSB 250( ), ver. R.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

VERSION A.

Section 1, ver. A.
Sec. 21.42.397(a) requires a health care insurer to provide coverage for the cost of diagnosis and treatment of autism spectrum disorder, including treatment prescribed by a physician or psychologist and provided by an autism service provider under a treatment plan that must identify pharmacy, psychiatric, psychological care, rehabilitative care, and therapeutic care; defines "rehabilitative care" and "therapeutic care".

Sec. 21.42.397(b) requires that coverage (1) only applies for individuals under 21 years of age; (2) is limited to $36,000 per year; (3) may not limit the number of visits for treatment; (4) is subject to copayment, deducible, coinsurance, general exclusions or limitations to the same extent as other health care services covered under the policy; (5) must cover treatment coordinated with an education program but may not be contingent on coordination of treatment with an education program.

Sec. 21.42.397(c) states that the section does not limit benefits otherwise available to an individual under a health care insurance plan.

Sec. 21.42.397(d) prohibits an insurer from refusing to provide coverage or terminating coverage because an individual is diagnosed with autism spectrum disorders.

Sec. 21.42.397(e)(1) defines an "autism service provider" as a licensed, certified or registered individual with (A) a doctoral degree with a specialty in psychiatry, medicine, clinical psychology, and behavioral or health science with one year of experience with people with autism spectrum disorder, (B) with a master's degree and board certification as a behavior analyst, (C) and (D) with a master's degree or higher in behavior or health science, licensed as a physical therapist, occupational therapist, or speech language pathologist, and with one year of directly supervised experience in behavioral therapies for people with autism spectrum disorder, (E) with a baccalaureate degree or higher and is a board certified associate behavior analyst.

Sec. 21.42.397(e)(2) defines "autism spectrum disorder" using the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders including autistic disorder, Asperger's disorder, and pervasive developmental disorders not otherwise specified.

Sec. 21.42.397(3) defines a "health care insurance plan."

Sec. 21. 42.397(4) defines a "health care insurer."

Sec. 21.42.397(5) defines "medically necessary" to mean care, treatment, intervention, service or item prescribed by a physician or psychologist in accordance with accepted standards of practice that will, or is expected to (A) prevent the onset of an illness, condition, injury, or disability, (B) reduce the physical, mental, or developmental effects of an illness, condition, injury or disability, or (C) assists in achieving or maintaining maximum functional capacity in performing daily activities.

Section 2, ver. A. Makes the changes in the Act applicable to policies issued after January 1, 2011.

Section 3, ver. A. Sets an immediate effective date.

VERSION R.

Section 1, ver. R.
Sec. 21.42.397(a) requires a health care insurer to provide coverage for the cost of diagnosis and treatment of autism spectrum disorder, including treatment prescribed by a physician or psychologist and provided by or supervised by an autism service provider under a treatment plan that must identify pharmacy, psychiatric, psychological care, habilitative or rehabilitative care, and therapeutic care; defines "habilitative or rehabilitative care" and "therapeutic care".

Sec. 21.42.397(b) requires that coverage (1) only applies for individuals under 21 years of age; (2) is limited to $36,000 per year; (3) may not limit the number of visits for treatment; (4) is subject to copayment, deducible, coinsurance, general exclusions or limitations to the same extent as other health care services covered under the policy; (5)

must cover treatment coordinated with an education program but may not be contingent on coordination of treatment with an education program.

Sec. 21.42.397(c) states that the section does not limit benefits otherwise available to an individual under a health care insurance plan.

Sec. 21.42.397(d) prohibits an insurer from refusing to provide coverage or terminating coverage because an individual is diagnosed with autism spectrum disorders.

Sec. 21.42.397(e)(1) defines an "autism service provider" as a licensed, certified, or registered individual who provides direct services to an individual with an autism spectrum disorder.

Sec. 21.42.397(e)(2) defines "autism spectrum disorder" using the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders including autistic disorder, Asperger's disorder, and pervasive developmental disorders not otherwise specified.

Sec. 21.42.397(3) defines a "health care insurance plan."

Sec. 21.42.397(4) defines a "health care insurer."

Sec. 21.42.397(5) defines "medically necessary" to mean care, treatment, intervention, service or item prescribed by a physician or psychologist in accordance with accepted standards of practice that will, or is expected to (A) prevent the onset of an illness, condition, injury, or disability, (B) reduce the physical, mental, or developmental effects of an illness, condition, injury or disability, or (C) assists in achieving or maintaining maximum functional capacity in performing daily activities.

Section 2, ver. R. Makes the changes in the Act applicable to policies issued after January 1, 2011.

Section 3, ver. R. Sets an immediate effective date.

If I may be of further assistance, please advise.

DCB:ljw
10-162.ljw

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senate Health and Social Services Committee

CS for Senate Bill No. 250( )

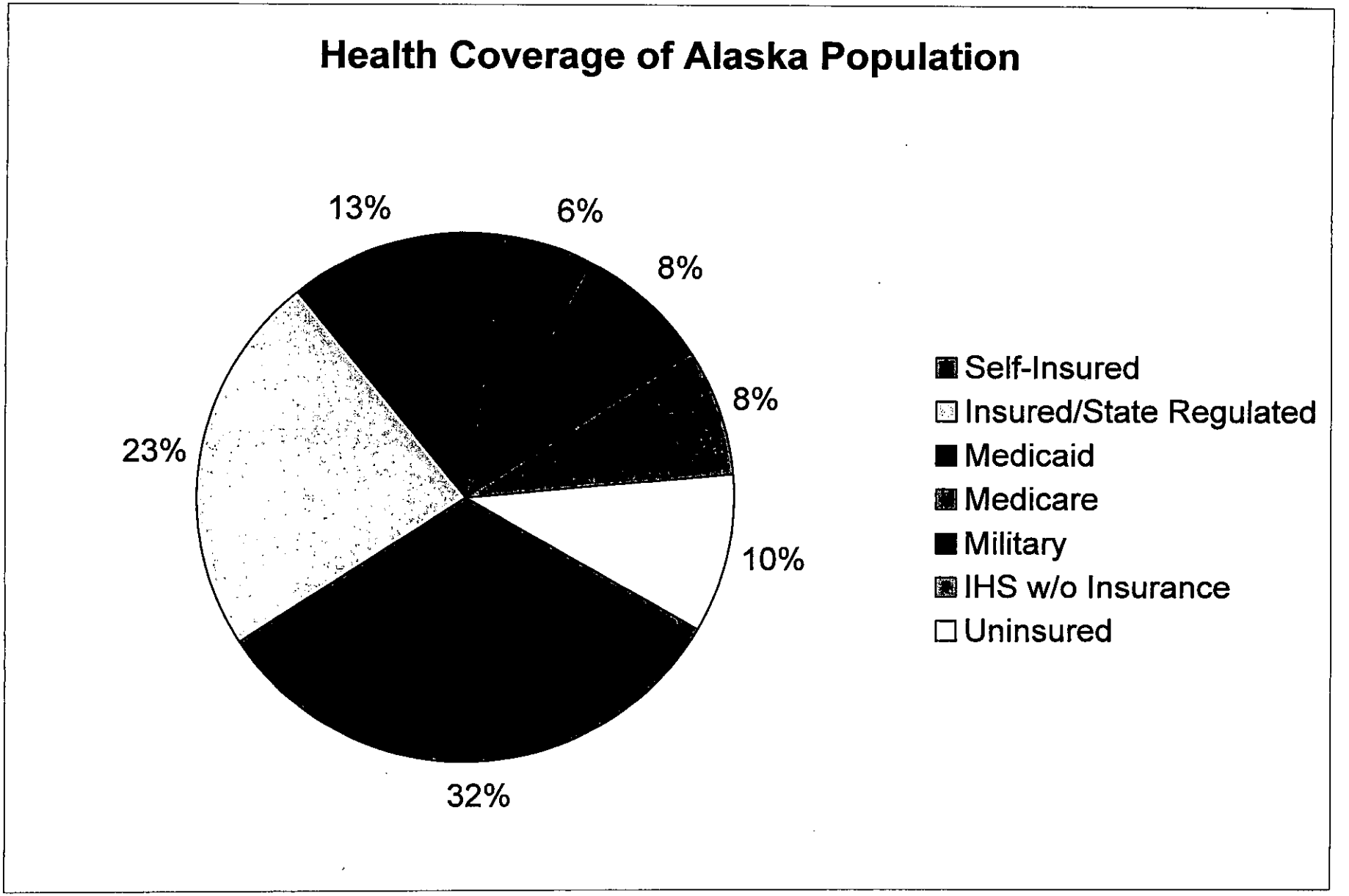
"An Act requiring insurance coverage for autism spectrum disorders, describing the method for establishing a treatment plan for those disorders, and defining the treatment for those disorders; and providing for an effective date."

BULLET POINTS

- The cost savings in special education alone would amount to approximately $208,500 per capita during the school years. This number rises to over $1.08 million over the autistic person's lifespan.
- The incremental societal cost of not treating autism has been estimated by Michael Ganz, a Harvard economist, to be approximately $3.2 million per capita.
- Since the House version of this bill, HB 187, was introduced in March of 2009, 11 states have passed legislation regarding mandatory insurance coverage of treatment for ASD, with 8 states having enacted legislation prior to March of 2009. The District of Columbia, Puerto Rico and 19 additional states currently have similar legislation pending
- The majority of children with autism who receive appropriate intervention and treatment experience marked improvement – 47% recover "typical" function, 40% make significant improvement, and the remaining 13% make little progress.
- The potential pool of beneficiaries between ages 2 and 20 is 48,425, which includes the 54.6% of private sector enrollees working in Alaska who are enrolled in self-insured plans, and after excluding the uninsured and those federal employees in Alaska covered by the ERISA preemption.

- With treatment, Alaska will see savings of $208,500 per capita in avoided special education costs and lifetime savings of $1.08 million per capita. WITHOUT treatment, estimated cost to the state of $3.2 million per capita in state funds.

- SB 250 would affect approximately 23% of all insurance plans in Alaska, providing a maximum annual coverage of $36,000 for diagnosis and treatment of ASD, including, but not limited to, applied behavior analysis.


Health Coverage of Alaska Population
13%
6%
8%
8%
23%
10%
32%
Self-Insured
Insured/State Regulated
Medicaid
Medicare
Military
IHS w/o Insurance
Uninsured

SB 250 Autism Insurance Coverage
Used in (S)HSS hearing 3/15/2010

January 25, 2010

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Representative Wes Keller
Alaska State Capitol – Room 13
Juneau, AK 99801

Jack C. McRae
Senior Vice President

Dear Representative Keller:

On behalf of Premera Blue Cross Blue Shield of Alaska, I am writing to you to express our concerns with HB 187 which mandates coverage for autism spectrum disorders (ASD).

We, too, are concerned with the challenges faced by children with autism and their families. We want to approach this issue in a manner that is in their best interest as well as all of the members we serve.

Of serious concern to us is the cost impact for employers and families already struggling to afford healthcare coverage. Our analysis of this mandate projects a rate increase of at least 3 % to our Alaska members.

Every benefit mandate adds to the overall cost of healthcare and insurance premiums. And, during a time when we are collectively looking to make healthcare more affordable, we believe employers should be able to determine their own benefit plans without additional state mandates. Financial impacts must be strongly considered for any benefit mandate proposal, especially given the current economic conditions, and the fact that many families and employers already face difficulties in affording coverage. Furthermore, this mandate will not impact self-funded plans in Alaska, which are not regulated by the state.

While the proposed mandate would provide some financial relief to families impacted by ASD whose employers can continue to afford coverage, there will be an unfortunate tradeoff for those families who would no longer be able to afford medical coverage at all, including families with ASD affected children. With an increasing load of mandates, employers may be forced to drop health insurance benefits altogether.

Also of particular concern is potentially requiring medical plan coverage for services that are essentially educational in nature, such as Applied Behavior Analysis (ABA) therapy. These services are provided by individuals with backgrounds and training in the field of education, not medical or mental health. We also question the appropriateness of mandating educational services, designed to assist with behaviors such as getting dressed, eating meals, brushing teeth, or sitting still during classes, to be included as part of medical program coverage. This would establish an inappropriate precedence. In addition, numerous reviews of ABA therapy by objective parties have concluded that evidence for the effectiveness of ABA therapy is contradictory, and at best, modest. We would recommend not mandating this therapy in the benefit.

To ensure quality treatment and patient safety, it is important that any person or entity providing treatment of ASD be licensed or certified. The definition of an ASD provider included in HB 187 is overly broad to include any person, entity, or group that provides treatment of ASD. We would recommend that providers treating ASD demonstrate specific training and experience, and that ABA therapy be provided by behavior specialists who are board certified, such as by the Behavior Analyst Certification Board.

Thank you for considering our concerns on this issue.

Sincerely,

Jack C. McRae
Senior Vice President

P.O. Box 327
Seattle, WA 98111

tel 425 918 5757
fax 425.918.5635
jack.mcrae@premera.com

www.premera.com

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The Voice of Small Business®

ALASKA

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FEB 02 2010

February 1, 2010

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
State Capitol Building
Juneau, Alaska 99801-1182

Dear Senator Davis:

RE: SB 250

On behalf of the National Federation of Independent Business/Alaska, I wish to respectfully share our opposition to Senate Bill 250. The National Federation of Independent Business is the largest small-business advocacy group in Alaska.

Senate Bill 250 proposes to lay an expensive new burden on small businesses already struggling to provide health care. SB 250 mandates coverage for Autism Spectrum Disorder and requires small businesses to cover the costs. The bill does not include the state or most local governmental agencies. Federal law already exempts most large firms and union health plans from the state mandate.

It is understandable that legislators consider the autism mandate too expensive for the state, but it is puzzling that, at a time when the ranks of the uninsured swell, they expect Alaska's small businesses to shoulder a burden that government itself is unwilling to address.

The unfairness of SB 250 is compounded by federal law, which prohibits states, including Alaska, from placing such mandates on large employers who self-insure such as major oil companies and most big box stores. So if you are a larger business, you can operate under one lower-cost, lower-mandate set of federal rules; however, if you are an Alaska small business, you must comply with 28 mandates (29 if SB 250 becomes law) that drive up the costs.

In addition to the economic implications, lawmakers are also sending a highly contradictory message to their constituents. If this legislation is important, why shouldn't state workers and the thousands employees covered by ERISA plans and union health plans have access to this benefit.

American small businesses, which employ 80 percent of the nation's workers, are at the dead center of the health-care crisis in the country. Whereas 99 percent of big companies and corporations provide health care for their employees, less than half (47 percent) of small business owners can afford to do so, according to studies by the National Association of Insurance Commissioners and the Kaiser Family Foundation. Small business that do struggle to provide health care for their employees also pay 18 percent more in premiums than the largest firms do --

for the same benefits -- according to a Commonwealth Fund-supported study.

If Senate Bill 250 becomes law, its first and most lasting effect will be to increase the cost of health insurance and contribute to driving more Alaska workers into the ranks of the uninsured. No one should get trapped into an argument over whether or not it is important to include Autism Spectrum Disorder in health coverage. What small businesses have been asking for is the ability to work with health insurers to individually tailor health plans that fit the needs of their particular businesses and their employees -- which might or might not include autism coverage -- rather than be forced to operate under the one-size-fits-all, legal straightjacket of mandates.

If the legislature intends that it is public policy that Autism Spectrum Disorder be insured, it should make payment also a public responsibility. Since the savings identified by proponents are found in state funded programs, logic would suggest that the state should fund the benefit. Making Autism Spectrum Disorder a diagnosis eligible benefit for the state's Medicaid program could accomplish that goal.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

Cc: NFIB/AK Leadership Council

[redacted]
SB 250 Autism Insurance Coverage
Used in (S)HSS hearing 3/15/2010

Mercedes Theuer

From: Hall, Linda S (CED) [linda.hall@alaska.gov]
Sent: Wednesday, January 27, 2010 5:38 PM
To: Mercedes Theuer; Rep. Pete Petersen
Subject: FW: Mental Health Parity

Following is the information from the Division Life & Health supervisor and actuary regarding the questions we discussed yesterday. My apologies for getting this to you so late. Please do not hesitate to contact me should you have any questions.

Thanks

Linda S Hall
Director
Alaska Division of Insurance
907-269-7900

From: Campbell, Katie S (CED)
Sent: Wednesday, January 27, 2010 8:57 AM
To: Hall, Linda S (CED)
Subject: Mental Health Parity

Mental health parity only applies to employer groups with 50+ employees.

Mental health is defined as "benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law. Our definition is "benefits provided for mental health services as defined under the terms of the health care insurance plan; but does not include benefits for the treatment of substance abuse or chemical dependency".

Financial requirements may not be more restrictive than for medical and surgical benefits. Financial requirements are defined to include deductibles, copays, coinsurance and out of pocket expenses. I don't believe travel benefits were intended to be covered by this definition but I suppose one could argue that travel is an out of pocket expense and if it is covered for medical and surgical it must be covered for mental health as well. If the desire is to cover travel it should be specifically required.

Because the law doesn't mandate benefits it doesn't address the offer of mental health benefits in terms of whether an insurer can offer coverage only for specific types of mental health conditions. The law allows the plan to define what constitutes mental health benefits.

From: **AUTISM SPEAKS**

AUTISM SPEAKS

Rebecca Shaffer Stelzner -- 202.955.3114; rshaffer@autismspeaks.org

Rubenstein Communications, Inc.
Adam Pockriss – 212.843.8286; apockriss@rubenstein.com

FOR IMMEDIATE RELEASE

AUTISM SPEAKS ENDORSES ALASKA AUTISM INSURANCE REFORM BILL

House Bill 187 Would End Health Care Discrimination Against Children with Autism by Requiring Coverage of Diagnosis and Treatment

Juneau, AK (March 19, 2009) – Autism Speaks, the nation's largest autism advocacy organization, today announced its support for House Bill 187, also known as the autism insurance reform bill. The legislation would require private health insurance companies to cover the diagnosis, testing and treatment of autism spectrum disorder (ASD). The maximum benefit would be $36,000 per year.

Sponsored in the Alaska State House of Representatives by State Representative Pete Petersen (D-19) HB 187 includes coverage of Applied Behavior Analysis (ABA), an evidence-based, medically-necessary autism therapy.

"We applaud and thank Representative Petersen for his leadership on this issue of critical concern to thousands of Alaska families," said Elizabeth Emken, Autism Speaks Vice President of Government Relations. "Autism Speaks joins Alaska's autism community in calling on the legislature to pass HB 187 and join the growing number of states that have ended healthcare discrimination against children with autism."

Most states do not require private insurance companies to cover even essential autism treatments and services. In the absence of coverage, families often pay as much as they can out-of-pocket for services that can cost upwards of $50,000 per year. In the process, many risk their homes and the educations of their unaffected children – essentially mortgaging their entire futures.

Eight states – Arizona, Florida, Louisiana, Illinois, Indiana, Pennsylvania, South Carolina and Texas -- have enacted autism insurance reform legislation. Several other state legislatures will vote on similar legislation during the current session.

To learn more about Autism Votes, an initiative of Autism Speaks focused on federal and state legislative advocacy, please visit **www.autismvotes.org**.

About Autism

Autism is a complex brain disorder that inhibits a person's ability to communicate and develop social relationships, and is often accompanied by behavioral challenges. Autism spectrum disorders are diagnosed in one in 150 children in the United States, affecting four times as many boys as girls. The prevalence of autism has increased tenfold in the last decade. The Centers for Disease Control and Prevention have called autism a national public health crisis whose cause and cure remain unknown.

About Autism Speaks

Autism Speaks is dedicated to increasing awareness of autism spectrum disorders, to funding research into the causes, prevention and treatments for autism, and to advocating for the needs of individuals with autism and their families. It was founded in February 2005 by Suzanne and Bob Wright, the grandparents of a child with autism. Bob Wright is Senior Advisor at Lee Equity Partners and served as vice chairman, General Electric, and chief executive officer of NBC and NBC Universal for more than twenty years. Autism Speaks merged with both the National Alliance for Autism Research (NAAR) and Cure Autism Now (CAN), bringing together the nation's three leading autism advocacy organizations. To learn more about Autism Speaks, please visit www.autismspeaks.org

###

HB 187 Questions

Note: Answers provided by the Governor's Council on Disabilities & Special Education with assistance from the Division of Public Health, Section on Women, Children and Family Health, the Center for Human Development at the University of Alaska Anchorage and Jim Bouder

1. **Who will do the recruitment, training and deployment? What has been done to date? Are there any specific strategies for recruitment, training, deployment?**

   Presently, there are four coordinated initiatives to prepare personnel to more effectively serve infant, toddlers, children and youth with Autism. The first 3 are being conducted through one state funded project – Capacity Building for Autism Interventions Project, through the UAA Center for Human Development (CHD). They also directly relate to services provided through insurance funding. The fourth, more targeted, is being funded through the AK Part C Program.

   (1) A total of 15 **Autism Specialists**, (i.e., advanced graduate professional responsible for planning, implementation and monitoring of intensive services), are being trained though a 2-year program of study. Eight are beginning their studies through the CHD project, cooperatively delivered with Northern Arizona University. Seven others are at least ½-way through their programs and are closing on the required 1500 clock hours of supervised field work. One Alaskan professional is currently nationally credentialed in this manner (i.e., Board Certified Applied Behavior Analysts – BCBA- through the through the international division of A.B. A., of the American Psychological Association), though she soon will be retiring. Based on the current population size, Alaska has need for at least 30 of these BCBA specialists.

   It is anticipated that a new cohort of at least 6 graduate students will begin their 2-year studies fall 2010. Students who already have Master's degrees must take the 5 graduate courses, complete the intensive 1500 hr field experience, and pass the national examination before becoming certified. Recruitment takes place through the numerous professional and parent Autism groups (e.g., CAII, Autism Alliance, state/local chapters of Autism Speaks and ASA) along with state and private Behavioral Health, Developmental Disability, Education and Infant Learning agencies.

   (2) **Certified direct service personnel**, both on an undergraduate degree and paraprofessional basis, are needed to implement the services designed by the Autism Specialist. An Occupational Endorsement certificate program is currently being designed and submitted for approval by the Capacity Building for Autism Interventions Project of CHD, in cooperation with the UAA Department of Human Services. This 6 course, 18-credit program is being designed to (a) stand alone as an Occupational Endorsement, or

(b) partially fulfill A.A. or B.A. degree requirements. Initial recruitment will be through similar markets as the Autism Specialist training, as well as conventional UAA channels, with the program anticipated in starting by fall 2010.

(3) **Ongoing Autism professional and paraprofessional training** through a regular week-long Summer Institute was begun by the Capacity Building for Autism Interventions Project the summer of 2009. A total of 42 professionals and paraprofessionals from state and private DD and Infant Learning Program agencies participated. Topics are limited to specific interventions directly relevant to the provision of intensive intervention services. The 2009 Institute focused solely on the needs of infants, toddlers and young children. Plans for 2010 training are to broaden the scope to include strategies for serving teens and young adults with ASD, with special relevance to those youth with Autism, targeted by BTKH for return to Alaska.

(4) **Training of Infant Learning Provider staff**. Beginning the summer of 2010, specialized training is being provided by the Part C Program to ILP staff. This 3-day training will take place in Fairbanks and will focus on the evidenced-based strategies to promote social and communication skill acquisition by very young children.

2. **Have there been any projections of how much money would be spent for travel and lodging compared to how much would be spent for actual treatment?**

At this time, the only travel and lodging associated with the ASD services from the bill potentially relate to those costs associated obtaining a diagnosis when parents chose out-of-state services, as opposed to obtaining that determination here in Alaska. It is anticipated however that most families will already have a diagnosis and not need special travel. Workers who are being prepared to serve with these youth are receiving training primarily either via distance-based delivery systems or coordinated Institutes or Conferences here in Alaska.

Insurance companies do not generally cover the cost of travel and lodging although individual providers who travel to deliver services may build these costs into their indirect rate.

3. **What is the projected cost per insured at a prevalence of 1:100?**

- With an average of 11,000 births in Alaska a year (2) an estimated 111 children (1) will receive an autism diagnosis this year.
- Direct annual average costs related to the medical/behavioral interventions for an autism diagnosis is approximately $48,000
- These 111 children will cost the State of Alaska $3.3 million annually for each year of their life [*if they do not receive treatment that provides them a reasonable independent lifestyle*] (3)

(1) American Academy of Pediatrics (2009)
(2) State of Alaska Bureau of Vital Statistics (2008)
(3) Ganz, M Understanding autism: from basic neuroscience to treatment

According to a recent report (Brief Report: Quantifying the Impact of Autism Coverage on Private Insurance Premiums by James N. Bouder, Stuart Spielman,David S. Mandell), **"Our analyses imply that the percentage increases in healthcare premiums changed linearly based on changes in assumptions in annual costs and treated prevalence. It is important to note, however that the treated prevalence and the per-child expenditures may interact. That is, as treated prevalence increases, the proportion of children with less intensive medical needs may increase, thereby reducing the average per-child expenditure."** (Page 4, column 2, paragraph 2).

Only about 10% of children with ASD diagnoses in the Pennsylvania Medicaid system expend more than $36,000 per year (**Note:** $36,000 is the private insurance cap in Pennsylvania). Given the higher cost of health services in Alaska, it may make sense to bump the cap to $50,000 because the additional impact on premiums will be negligible.

4. **How much actual total premium increases are we talking about in Alaska? How many children total and how many of them would require coverage?**

The total premium increase is estimated to be no more than $3.60 per member per month. This estimate is consistent with findings in other states. Alaska currently has 1,512 children and youth under the age of 21 who have autism; approximately 454 or 30.2% need significant clinical treatment.

5. **Please describe the "Applied Behavior Analysis Treatment." Is any physician or psychologist qualified to administer this treatment?**

Applied Behavioral Analysis (ABA) describes a number of empirically validated strategies and interventions that are used to promote learning and/or change or reduction of behavior. These methods have been authenticated through hundreds of empirical studies that have demonstrated that new behaviors will happen more frequently if they are regularly reinforced, while previously demonstrated behaviors or skills will diminish if they are not. These ABA interventions achieve these outcomes by systematically responding to a child's needs through a process of rigorous data collection and analysis. Recently, the 30 member team of National Autism Standards Project (National Autism Center, http://www.nationalautismcenter.org/) developed criteria and resource lists of evidence-based interventions, suggested from over 950 studies conducted with child, youth and adults with autism. All of those assessed by this national body as being "established" empirically validated treatments were ones that were ABA-based interventions.

Applied Behavior Analysis is often employed within a highly structured context and in an intensive manner (i.e., 1:1 or small group), relying heavily on the determination of the function of behaviors or skills as a first step to selection of a specific package of interventions. Key to the child's success is s/he developing the ability to recognize (discriminate) when and how to behave (respond). For a young child with Autism, this typically first means responding consistently, correctly and quickly to simple prompts, cues or directions given by an adult. It requires teaching the child, on a 1:1 basis, to attend or jointly attend with the adult, to specific objects or actions. The interventionist chooses and delivers cues, directions or actions precisely, and consistently uses positive reinforcement to strengthen and shape the child's correct responses. Doing so increases the child's ability to participate in typical social, home, and school settings as a function of his/her regular demonstration of those skills or behaviors that are contextually applicable or appropriate there. Progress is monitored through data collected on each target skill or behavior, with performance graphed over time.

There are a large number of tested interventions based on the principles of Applied Behavioral Analysis. While many have been validated for use with children with challenging behaviors and/or autism, others have been developed for behavior change by different populations, such as for parenting, weight loss, cessation of smoking, and other major life issues or behaviors. An effective Behavior Analyst systematically selects from different ABA assessment, data analysis, and planning methods as tools in the delivery of services, so as to ensure that the match between the interventions, schedule of service activities, the delivery of services and the child's home, school and community environments are optimal for learning. While many practitioners employ ABA methods, quality is controlled through a national process of certification, through the Behavior Analyst Certification Board, Inc, (BACB), an organization with roots within the Association for Behavior Analysis, International. The graduate level certification standards and credentialing from BACB is endorsed by the Association of Professional Behavior Analysts, the Association for Behavior Analysis International and Division 25 (Behavior Analysis) of the American Psychological Association.

Typically, ABA is provided by OT/PT staff or other master-prepared staff. Physicians and psychologists do NOT typically provide this intensive therapeutic intervention.

6. **Please describe the approved screening process/practice. (no biological markers)**

A flow chart that outlines the screening process/practice used in Alaska is attached.

In FY09, 105 children were referred to the pediatric neurodevelopmental outreach clinics for screenings; 85 were actually scheduled for appointments 34 of whom were presenting autism symptoms. 17 of the 34 (50%) were referred for a full diagnostic workup at Providence Autism Diagnostic Network; 9 were placed in a "watchful waiting" status.

Additionally, 128 children received a full diagnostic workup at the Providence Autism Diagnostic Network. Of the 128 children, 57 (44.3%) were diagnosed with an Autism Spectrum Disorder and an additional 5 (3.9%) were diagnosed with Asperger's Syndrome. 9 (7%) were diagnosed with a mental health diagnosis and 57 (44.3%) were diagnosed with other neurological disorders.

During the most recent quarter (10/1-12/31/09), 97% of children referred were referred suspecting Autism Spectrum Disorder or Asperger's Syndrome. 56% received a final diagnosis of autism or Asperger's; 44% have a diagnosis of another neurological disorder or mental health condition.

A word of caution: these numbers should not be used as a proctor to calculate prevalence or incidence. They are only what the outreach clinics and the Providence Autism Diagnostic Network are experiencing. Many kids referred with a suspected autism diagnosis or "looking like autism" are not screening positive definitely and some of the younger kids screened at the outreach clinics are placed in a "watchful waiting" status – a conservative approach but in their best interests.

Additionally, without a surveillance system, we do not know how many children are being diagnoses by other providers in-state nor the number who move to the state of Alaska who were diagnosed in other states.

7. **How does the education mandate apply? What percentage of children with autism qualify as special education students – intensive needs students? Would there be a duplication of services?**

Special education services and related services (e.g., occupational therapy, speech therapy) are provided to children with a disability whose disability is interfering with their ability to receive an education. The presence of a disability is not sufficient to establish eligibility for special education. The disability must result in an educational deficit that requires specially designed instruction (special education). Special education services are provided according to each student's Individualized Education Plan during the child's school day.

On October 1, 2008, 607 children were receiving specialized education services based on a diagnosis of autism. Because the current definition of autism is restrictive, the majority of these children is on the severe end of the autism spectrum and most likely qualifies as special education intensive needs students. Children with less severe autism often receive special education services based on other categories (e.g., multiple disabilities, other health impaired, emotional disturbances, learning disabilities).

Many children with autism, particularly those who need significant clinical intervention, require services beyond the school day; these are the services that would be covered through health insurance. Ideally, both education and health insurance services are coordinated so that they are complementary of one another, build upon what each system covers, are not duplicative and ensure that the individualized needs of each child are met.

The goals of special education and the goals of health care are not one and the same. The goal of special education is to enable a child with a disability to access the regular education curriculum to the maximum extent appropriate. The goals of health care are to relieve pain, cure disease, and improve functioning. There is no Federal mandate (or state mandate I'm aware of) that requires schools to treat the symptoms of a child's disability – this remains the domain of health care. In the case of children with autism, educational benefit can be realized as a result of treating and ameliorating the varied symptoms of autism. For the most part, clinicians are generally better trained to address the clinical needs of children with autism than special educators. This is not to say that quality special education programs are not important or beneficial – but clinical services delivered under a medical model of care are necessary for many children with autism and, especially when delivered in cooperation with special education, will improve the child's overall outcome.

To sum up, clinical applications of ABA are aimed at improving the functioning of people with autism, whereas special education aims at enabling the child to make meaningful educational progress. I believe these are distinct goals, but the first certainly effects the second. Also, ABA is a psychological discipline with a broad array of applications, including (not surprisingly) clinical applications.

Provided By: Millie Ryan 5 April 2009
The Governor's Council on Disabilities and Special Education

Diagnosis of Autism Spectrum Disorders

Autism Spectrum Disorders (ASD) covers a wide range of symptoms from very mild to severe. ASD affects social skills, communication and cognitive development. ASD affects the individual's ability to convey or interpret others' emotions. Children may engage in restricted and/or repetitive play and have unusual attachments to objects. People with ASD might not seem interested in other people and prefer to be alone. People with ASD might not seem interested in other people and prefer to be alone. Some children with ASD do not like to be held or cuddled, and many do not make eye contact with others. Individuals with ASD also show varied degrees in impairment in their verbal and nonverbal communication. Some individuals with ASD may be nonverbal, while others may not have any difficulty speaking. Some repeat something previously heard or use stock phrases or learned scripts to communicate. Cognitively, individuals with ASD develop differently from others. Many people with ASD have difficulty processing sensory stimuli and verbal input, and this affects their understanding of the world around them.

It is important to note that some people without an ASD might also have some of these symptoms. But for people with an ASD, the impairment is bad enough to make life very challenging in terms of interacting with others, communicating, learning or holding down a job.

The Governor's Council on Disabilities recommended that the state establish universal screening for ASD during well-child exams to identify children who have behaviors that could indicate a disorder. The American Academy of Neurology recommends immediate referral for a diagnostic evaluation for any of the following:

- No babbling by 12 months
- No gesturing by 12 months
- No single words by 16 months
- No 2 work spontaneous phrases by 24 months
- Any loss of any language or social skills at any age

ASD screenings identify those children who require a comprehensive assessment across developmental and physical domains. Professionals from multiple disciplines then conduct a complete assessment (i.e. neurodevelopmental pediatrics, psychology, speech, occupational and physical therapy, ophthalmology, audiology). For young children, it is especially critical to conduct a differential diagnosis to rule out any other possible genetic or medical disorders.

The diagnosis focuses on determining to what extent the child has:

- Irregularities and impairments in communication
- Engagement in repetitive activities and stereotyped movements
- Resistance to environmental change or change in daily routines

- Unusual responses to sensory experiences

In order to receive a diagnosis of ASD, the child must show qualitative impairment in reciprocal social interaction, qualitative impairment in communication and repetitive, stereotypical behaviors that interfere with his or her ability to develop, communicate and learn compared to typically developing peers.

In order to qualify for special education with an ASD, a child must

- exhibit a developmental disability significantly affecting verbal and non-verbal communication and social interaction, generally evident before age three, that adversely affects educational performance; and
- require special facilities, equipment, or methods to make the child's educational programs effective; and
- be diagnosed as having an autism spectrum disorder by a psychiatrist, physician, licensed psychologist or advanced nurse practitioner; and
- be certified by a group consisting of qualified professional and a parent of the child as qualifying for and needing special education services

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

HB 187 – Autism Insurance Reform

[redacted]

WHAT: **SB 250 Autism Insurance Coverage**

Used in (S)HSS hearing 3/15/2010

- **HB 187 will require insurance coverage for autism spectrum disorders.**
- **Autism is a disorder affecting at least 1 in 150 children with approximately 1 in 500 requiring significant clinical treatment.** Alaska currently has 1,512 children and youth under the age of 21 who have autism; approximately 454 need significant clinical treatment.

WHY:

- **Because Alaska law does not require insurance coverage for autism services, families that do not qualify for DHSS services pay out of pocket, often as much as $50,000 per year or more; in some instances, bearing this burden results in divorce or bankruptcy.** Families that cannot afford to do so, go without crucial intervention.
- **Autism is treatable.** 30 years of research shows that with treatment, many children overcome the severe symptoms of their disorder.

  - ✓ About half the children who receive intensive early intervention achieve normal functioning after 2-3 years of treatment.
  - ✓ There is an average gain of 22 IQ points.
  - ✓ 1/3 gained 45 IQ points.
  - ✓ Nearly 50% of those receiving intensive early intervention do not require lifelong services and supports.

- **The earlier the diagnosis, the more effective treatment is.** The diagnostic process involves a comprehensive assessment (neurodevelopmental pediatrics, psychology, speech, occupational and physical therapy, ophthalmology, audiology) by a multidisciplinary team. Only those children who meet specific medical criteria are diagnosed with autism.
- **Treatment equals savings.** With treatment, Alaska will see savings of $208,500 per capita in avoided special education costs and lifetime savings of $1.08 million per capita. Treatment may include the following medically necessary services.

  - ✓ Pharmacy, psychiatric, psychological, rehabilitative and therapeutic care.
  - ✓ Rehabilitative care includes applied behavior analysis (the design, implementation and evaluation of environmental modifications to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.

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GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

HB 187 – Autism Insurance Reform

- **Without treatment it is estimated that it will cost the state $3.2 million per capita.** (Michael Ganz, Harvard economist)
- **Coverage of medically necessary autism treatment in Alaska will enable many children to access the services they need and live more productive lives.**
- **Most private insurance policies specifically exclude coverage for treating autism, even when the services are otherwise covered by the health plan.**
- **HB 187 requires private insurance policies (approximately 23% of all insurance plans) to provide a maximum coverage of $36,000 a year for the diagnosis and treatment of autism spectrum disorders, including but not limited to applied behavior analysis.**

  - ✓ Must be prescribed by a licensed physician, psychologist or advanced nurse practitioner.
  - ✓ Must be provided by an autism service provider as identified in a treatment plan developed following a comprehensive evaluation.
  - ✓ Must identify the medically necessary pharmacy care, psychiatric care, psychological care, rehabilitative care and therapeutic care.

- **The maximum likely cost of such coverage to the private insurance ratepayer is approximately 0.92% or $3.60 per policyholder per month.**

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Autism Issues and Needs

The Governor's Council on Disabilities & Special Education

SB 250 Autism Insurance Coverage
Used in (S)HSS hearing 3/15/2010

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Preliminary Report of the Ad Hoc Committee on Autism: Findings and Recommendations

Governor's Council on Disabilities and Special Education

2006

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Millie Ryan, Executive Director

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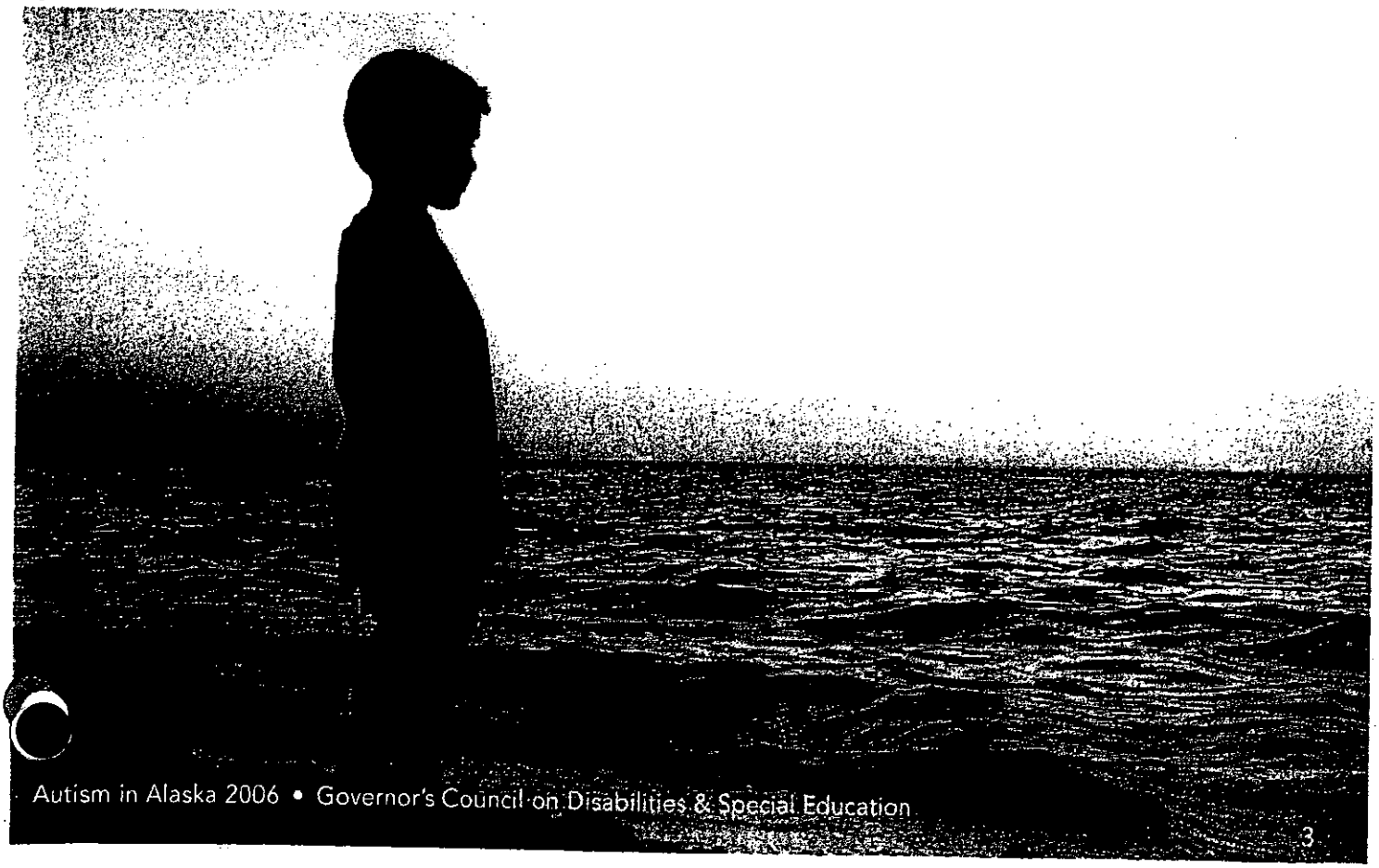

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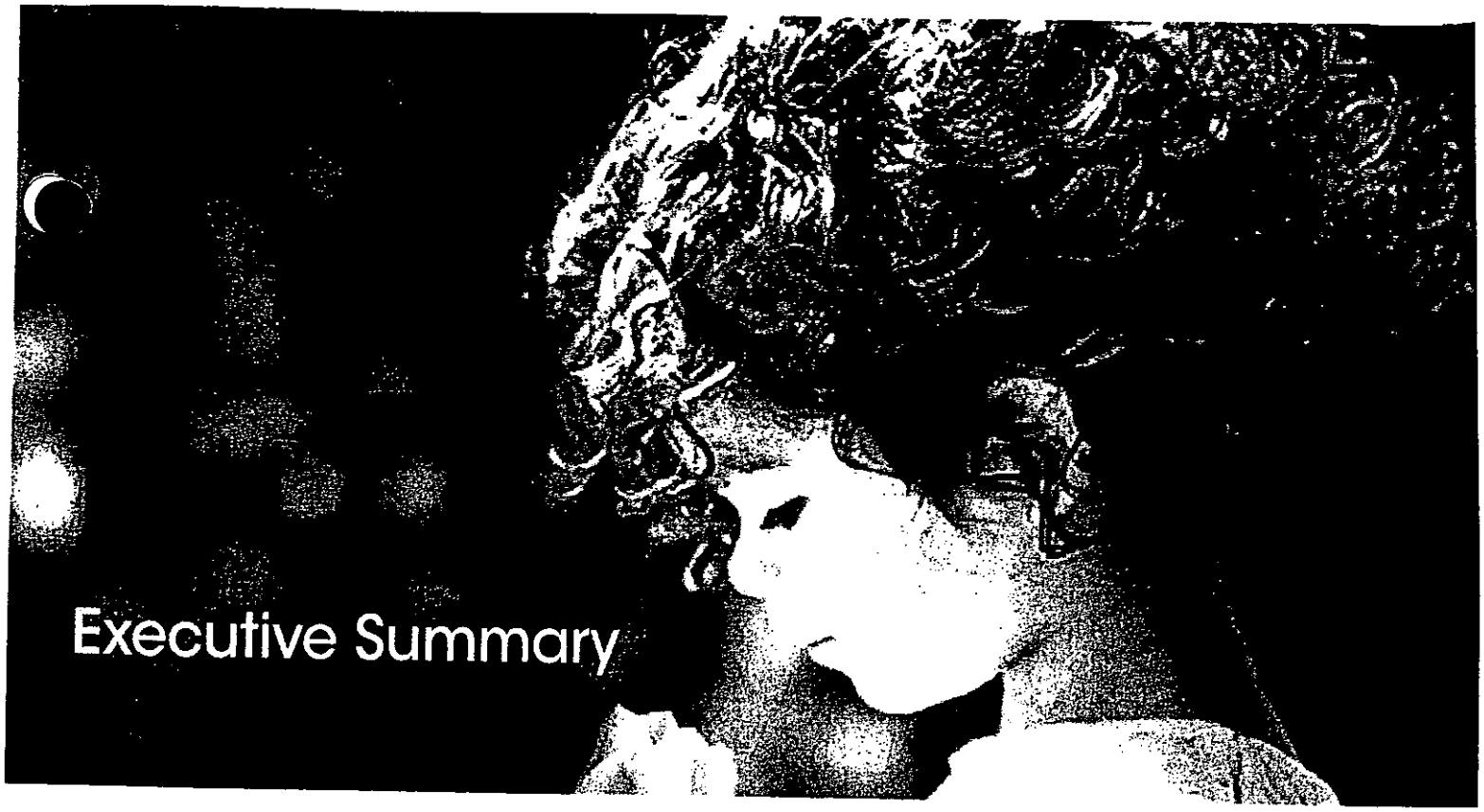


Executive Summary

Experts agree that early identification and diagnosis of ASD is important.

Although incremental changes have occurred on behalf of children and adults with Autistic Spectrum Disorders (ASD) in Alaska, the pace and amount of change has been inadequate to meet needs. Alaska does not have a system to capture the prevalence of ASD, but as in other states, the educational and service delivery systems have experienced an increased demand for ASD-specific intervention in recent years.

Experts agree that early identification and diagnosis of ASD is important. Screening identifies those in need of a comprehensive evaluation and assessment, and a diagnosis leads to appropriate interventions. Research has documented the efficacy of early, intensive intervention (Sheinkopf and Siegel, 1998, Dawson and Osterling, 1997). ASD specific interventions may speed the child's development, ameliorate inappropriate behaviors, and improve functioning over their lifetime. While not all children with ASD experience dramatic improvement with intervention, many do.

The overall cost of caring for a person with autism over his or her lifetime is estimated to be $3.2 million (Ganz, 2006). Applying national prevalence rates of 1/166 to Alaska's 10,000 births annually results in about 60 babies born each year who will likely develop ASD. The lifetime cost for the 60 Alaskan babies born this year would total $192 million, as well as for the 60 babies born every subsequent year.

When children do not receive early intervention, the cost of caring for them over their lifetime exerts a substantial economic burden on society. Behavioral

therapies represent only 6.5% of the total cost of caring for an individual with ASD. By contrast, adult care represents 21% and lost productivity is nearly 31% of the total annual expense involved in caring for an individual with ASD.

The Governor's Council on Disabilities and Special Education, with the concurrence of the Alaska Mental Health Trust Authority, convened an Ad Hoc Committee on Autism to develop recommendations to present to the Alaska Legislature and Administration. The group organized their 21 recommendations around identification, diagnosis, and treatment. Recommendations were prioritized by the Committee, and submitted to the Council's Executive Committee for final approval.

The following four recommendations were ranked as the Committee's highest priorities. Although each is a separate recommendation, their interdependent nature requires they be considered as a package. One recommendation is to increase screening of children for ASD. Screening is a quick process used to differentiate children who may experience ASD, and identifies those who need a complete developmental and medical assessment. Without enhancing the capacity for comprehensive assessment and diagnosis, screening would be a disservice, leaving families concerned but experiencing a very lengthy wai· before confirming or ruling out a diagnosis of ASD. Similarly, because the value of early diagnosis is in the potential for amelioration; diagnosing more children with ASD will make the existing shortage of services even more critical. To provide an adequate level of services, training for families, teachers, and direct service providers is essential to increase the size and quality of the workforce. Finally, the need for family support will intensify as more children are identified with ASDs.

Research has documented the efficacy of early, intensive intervention (Sheinkopf and Siegel, 1998, Dawson and Osterling, 1997).

1. **Greatly expand autism resources and referral services** so that the program is well funded, independent, and highly visible with a long-range plan for satellite programs throughout the state.

   Several activities are envisioned to expand the functions of an autism resource center. These include:

   - An annual comprehensive fair/institute for families to provide up-to-date medical information, guidance in navigating the system, and other topics. Disseminate the institute through a CD or a webcast for people who cannot attend in person.
   - The establishment of local resource centers across Alaska that are independent in nature, but collaborative with other providers, and state/local/national experts;

- Regional, technical assistance traveling teams with professional oversight; and
- Comprehensive parent training in education, systems and political advocacy, guardianship, medical services, and other topics as needed.

2. **Establish universal screening for autism spectrum disorders**, using a tool such as the parent-completed Modified Checklist for Autism in Toddlers (M-CHAT), and provide systematic referral for comprehensive assessment for children with risk factors for ASD.

   Screening is a quick, simple and inexpensive process to identify children who have symptoms that could indicate a disorder. Like hearing or vision problems, early identification and diagnosis of ASD can lead to a better response to treatment and lifelong outcome for children. Universal screening of children at well-child exams is recommended to ensure that children with ASD are identified as early as possible in life. The M-CHAT is a 23-question, parent-completed survey that can be used at well-child check-ups and is valid for children between the ages of 16 and 36 months.

   Screening does not take the place of a comprehensive assessment; rather it identifies those children who would benefit from a complete evaluation. The next step for children who show possible signs of an ASD is to refer them to early intervention or the school district where the process of a developmental assessment can begin. A protocol for children with risk factors for ASD should be developed to ensure they are referred for further testing and a comprehensive developmental assessment.

Early identification and diagnosis of ASD can lead to a better response to treatment and lifelong outcome for children.

3. **Increase the capacity for comprehensive, timely assessments and diagnosis** of Autism Spectrum Disorders using a multidisciplinary team that is embedded with a system for referral to appropriate services (i.e. Early Intervention/Infant Learning Program, school districts, medical and other clinical providers).

   Screening for ASD will identify those children who require a comprehensive assessment across developmental and physical domains. Professionals from multiple disciplines are needed to conduct a complete assessment (i.e. neurodevelopmental pediatrics, psychology, speech, occupational and physical therapy, opthamology, audiology). For young children it is especially critical to perform a differential diagnosis to rule out any other possible genetic or medical disorders.

Assessment leads not only to diagnosis, but to a plan of intervention and services for the child and family.

Currently few clinicians and specialists are skilled and trained in performing ASD assessments. Investing in training and developing specialists in ASD will reduce the time between screening and a comprehensive assessment, as all testing needs to occur before a definitive diagnosis can be made.

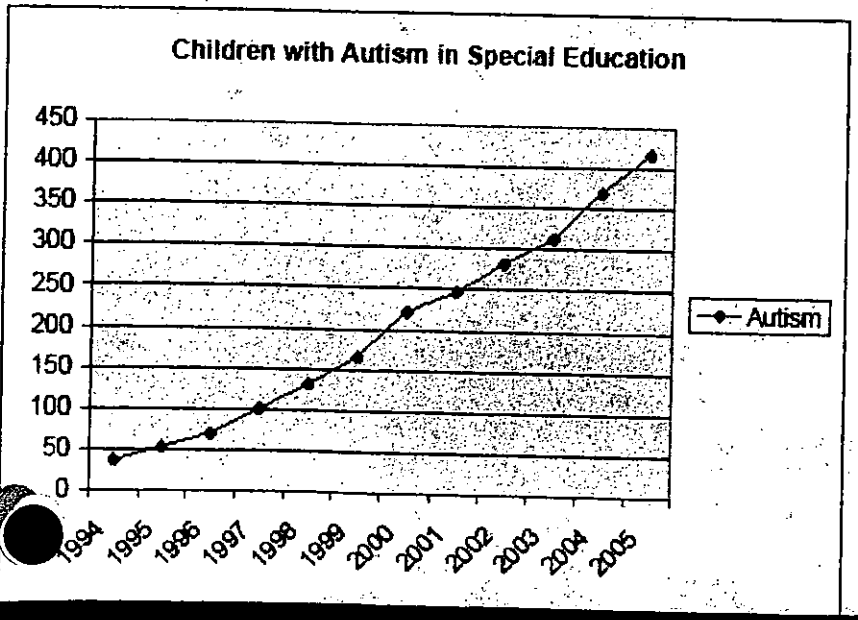
The comprehensive assessment leads not only to diagnosis, but to a plan of intervention and services for the child and family. Families need information and active referral to link up with needed health, educational, financial and family support resources.

4. **Change Medicaid to ensure that children with ASD are able to receive time-limited, intensive intervention services.**

The Deficit Reduction Act permits flexibility within state Medicaid plans. It is recommended that the Medicaid State Plan be modified to include time-limited autism intervention services. If modifying the Alaska Medicaid Plan is not feasible, the Committee recommends that the state develop an Autism waiver modeled after Minnesota or Wisconsin. A third alternative would be to change eligibility within the Home and Community Based Waiver to ensure children with ASD receive time-limited intensive services.

Introduction
Autism Spectrum Disorder

Autism is a complex developmental disability that is the result of a neurological disorder affecting the functioning of the brain (Autism Society of America). Autism Spectrum Disorders (ASD) includes Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder – Not Otherwise Specified, and Childhood Disintegrative Disorder. Studies have produced varying prevalence rates, in part due to method of diagnosis and size of the sample; however, 1 in 166 children are thought to have an Autism Spectrum Disorder (Centers for Disease Control and Prevention, n.d.),. Each year about 10,000 babies are born in Alaska, suggesting that 60 of those babies will be identified in their early childhood as having an ASD. Another indicator that Autism is climbing in Alaska comes from the public school system. The number of children with autism in the Alaskan School system has risen each year for the past 13 years. These trends are similar in other states.



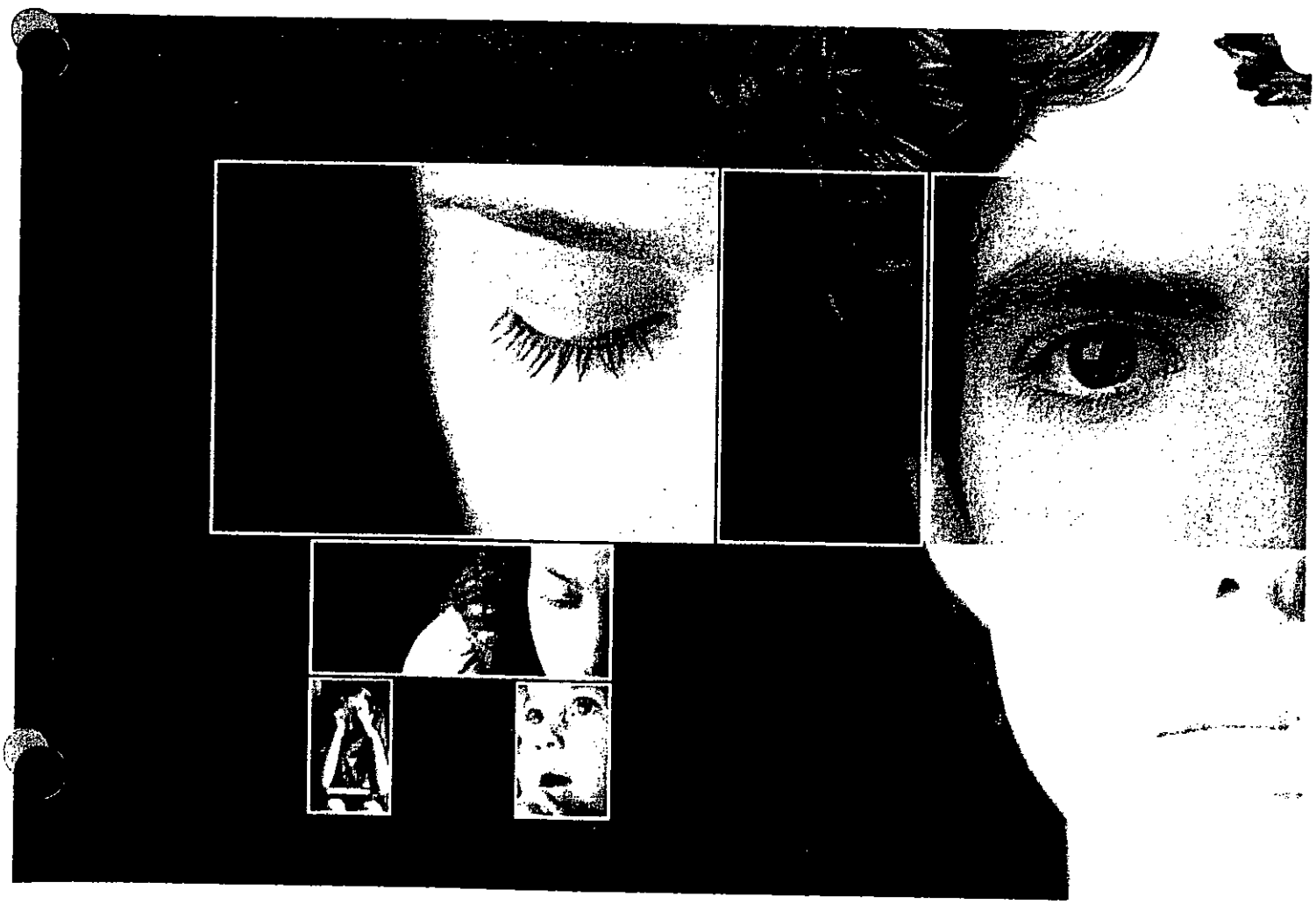
Growth of the Number of Cases of Autism in Alaskan Schools

ASD covers a wide range of symptoms, from very mild to severe. ASD affects social skills, communication, and cognitive development. ASD affects the individuals' ability to convey or interpret others emotions. Children may engage in restricted and/or repetitive play and have

Introduction Cont...

Some individuals with ASD may be nonverbal, while others may not have any difficulty speaking.

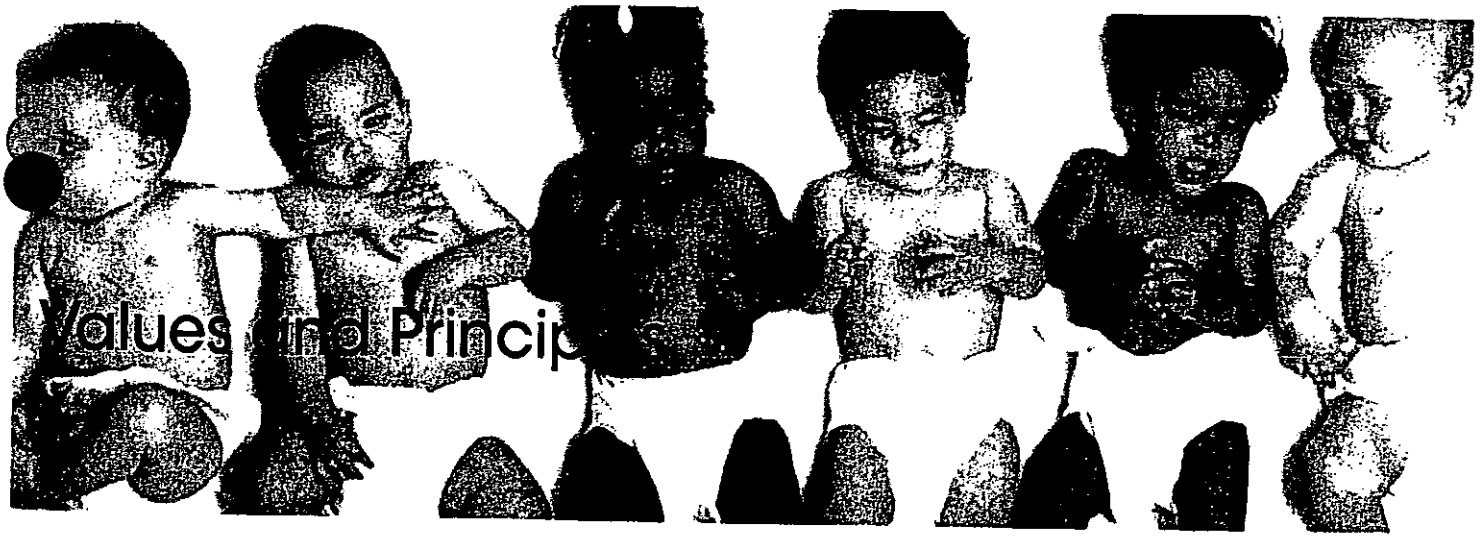
unusual attachments to objects. People with ASD might not seem interested in other people and prefer to be alone. Some children with ASD do not like to be held or cuddled, and many do not make eye contact with others. Individuals with ASD also show varied degrees of impairment in their verbal and nonverbal communication. Some individuals with ASD may be nonverbal, while others may not have any difficulty speaking. Some repeat something previously heard or use stock phrases or learned scripts to communicate. Cognitively, individuals with ASD develop differently from others. Many people with ASD have difficulty processing sensory stimuli and verbal input, and this affects their understanding of the world around them.



Ad hoc Committee on

On December 6th 2005, the Governor's Council on Disabilities and Special Education's convened an Ad Hoc Committee on Autism. The purpose of this group was to examine the current status of services needed by people with ASD and their families and make recommendations to the Legislature and state policymakers. The 17 member committee consists of parents of children with ASD, Governor's Council members, and representatives from the Department of Health & Social Services, Division of Senior and Disability Services, Division of Behavioral Health, Department of Education & Early Intervention, Office of Children Services, and the University of Alaska Anchorage. The Committee met monthly over the course of five months. This report contains the recommendations of the Governor's Council and the Ad hoc Committee on Autism.

The report is organized around the following three major areas: Values and Principles, Identification/Screening/Diagnosis, and Services. Topics are prefaced with a summary of the Committee's evaluation of Alaska's current status and followed by recommendations.



Values and Principles

The following statements articulate the values that guided the Committee's work and recommendations.

Early intervention works, is cost-effective and fiscally responsible.

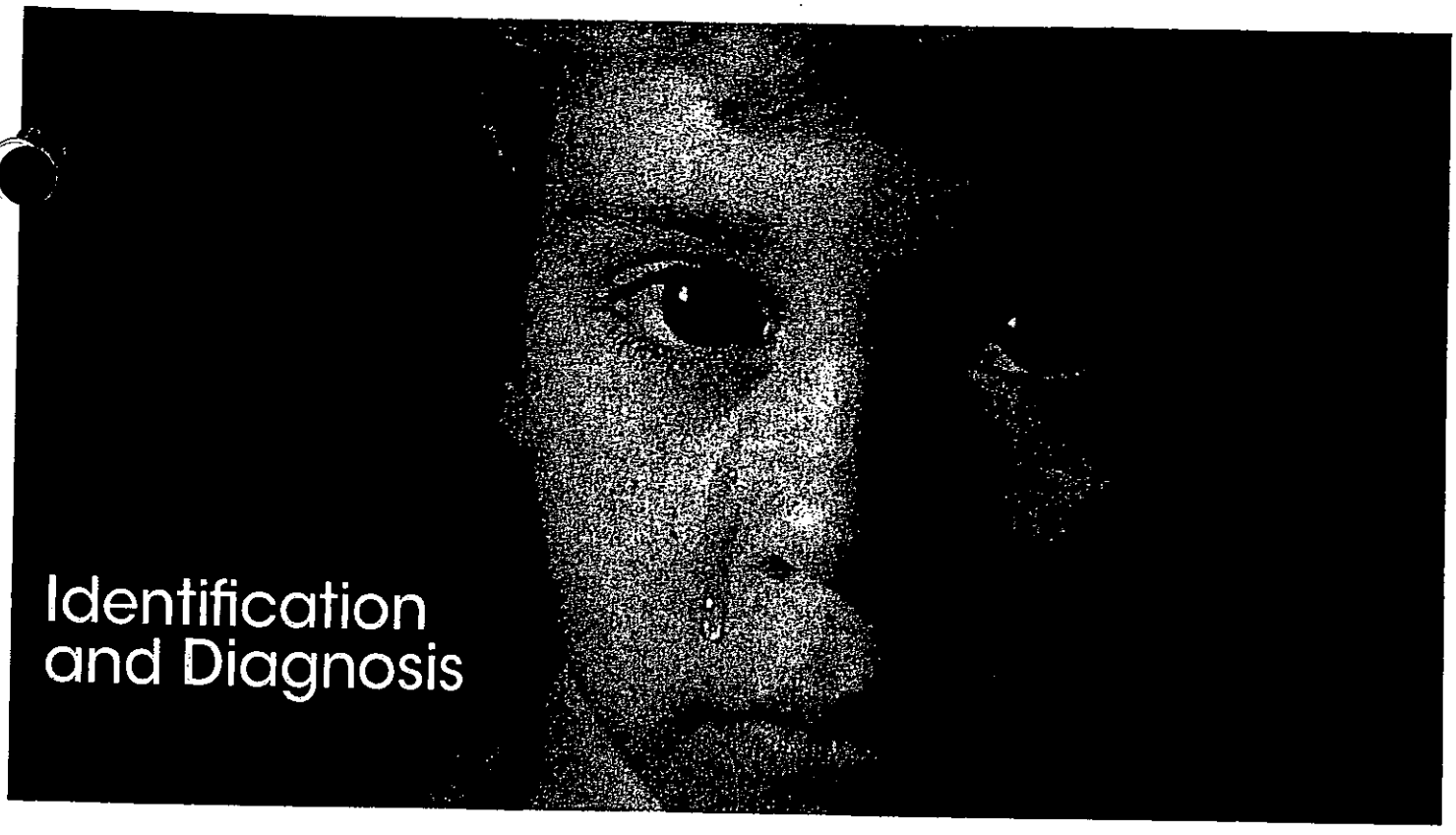
People with Autistic Spectrum Disorders:

- Have great promise, gifts and potential;
- Deserve the opportunity to engage actively in the community, with friends and family and in work and volunteer positions;
- Contribute to their families, communities, and Alaska;
- Represent ethnic, socioeconomic, racial, and religious groups, speak many languages and live in urban, rural and remote areas of the state; and
- Are people first – ASD is only a part of who they are.

Early intervention works, is cost-effective and fiscally responsible.

Services for people with ASD need to be:

- Individualized, based on family choice and need;
- Family directed, and based on principles of self-determination;
- Evidence-based;
- Provided as soon as possible after identification and diagnosis;
- Culturally appropriate and relevant, available in urban and rural areas;
- Coordinated, comprehensive and collaborative across all disciplines and state service systems;
- Available across the lifespan, and the full spectrum of autistic disorders;
- Delivered in a manner that maximizes independence by providing the supports and services needed; and
- Built on and honoring of individual strengths.



Identification and Diagnosis

The importance of early identification and diagnosis of individuals with autism cannot be overstated.

The importance of early identification and diagnosis of individuals with autism cannot be overstated. Early identification and diagnosis of autism leads to early intervention. Children with autism identified early and enrolled in early intervention programs show significant improvements in their language, cognitive, social, and motor skills, as well as in their future educational placement (National Research Council, 2001). There is also empirical evidence that shows children who enter early intervention at younger ages show greater results than children who enter intervention programs at an older age (Harris & Handleman, 2000; Sheinkopf & Siegal, 1998). There is also a financial incentive for the early identification, diagnosis, and intervention for children with autism. Ninety percent of children with autism who do not receive effective early intervention will require special or custodial care throughout their lives, and this is estimated to cost the United States $35 billion dollars a year (Ganz, 2006).

Where we are now

For the past 14 years, the Children's Hospital at Providence has supported the Center for Children with Special Needs, staffed with a neurodevelopmental pediatrician skilled in the diagnosis of children with ASD and other developmental disabilities. In addition, the State of Alaska sponsors neurodevelopmental screening clinics in locations around the state. However, despite Child Find efforts on the part of early intervention and school districts, not all children with significant developmental delays

Identification and Diagnosis Cont...

are referred for a neurodevelopmental evaluation prior to entering school. Children residing in more remote, rural locations may be identified later than children in communities in more urban settings. Accurate identification of the child's pattern of development/learning style and behavior (i.e. autism diagnosis) leads to an appropriate school certification and program as well as an approach to solving behavior problems. Families living outside of Anchorage with children who are suspected of having autism frequently must wait for an appointment and then travel to Anchorage for a medical work-up and diagnosis.

The current definition used by Alaska's Department of Education & Early Development to determine eligibility is also an obstacle for the provision of special education services for students with ASD. This definition includes Autism, but not the other disorders in the spectrum. This committee proposes a definition that includes Pervasive Development Disorder, Asperger's Syndrome, and Childhood Disintegrative Disorder.

Currently there is not an accurate count of persons with ASD in the state. This adds to the difficulty of planning and securing resources for statewide autism services. This affects people with autism, their families, state and local governments, school districts, and federal agencies. Having hard data on autism in the state will provide a comprehensive information resource that can direct state policies and service decisions that will improve the lives of people with ASD and their families. Autism registries have already been shown to be effective for planning and providing services in the states of Missouri, Virginia, West Virginia, Florida, and Delaware. An autism registry will also facilitate early detection and diagnosis of people with autism.

Identification and Diagnosis Recommendations

1. **Establish universal screening for autism spectrum disorders, using a tool such as the parent-completed Modified Checklist for Autism in Toddlers (M-CHAT), and provide systematic referral for a comprehensive assessment for children with positive screens.**

   Screening is a quick, simple and inexpensive process to identify children who have symptoms that could indicate a disorder. Like hearing or vision problems, early identification and diagnosis of ASD can lead to a better response to treatment and lifelong outcome for children. Universal screening of children at well-child exams is

Recommendations Cont...

recommended to ensure that children with ASD are identified as early as possible in life. The M-CHAT is a 23-question, parent-completed survey that can be used at well-child check-ups and is valid for children between the ages of 16 and 36 months.

Screening does not take the place of a comprehensive assessment; rather it identifies those children who would benefit from a complete evaluation. The next step for children who show possible signs of an ASD is to refer them to early intervention or the school district where the process of a developmental assessment can begin. A protocol for children with risk factors for ASD should be developed to ensure they are referred for further testing and a comprehensive developmental assessment.

Children who appear at risk of having an ASD require a comprehensive assessment across developmental and physical domains.

2. **Increase the diagnostic capacity throughout the state by developing a system to provide timely, comprehensive diagnosis of Autism Spectrum Disorders using a multidisciplinary team and systematic referral to appropriate services (i.e. Early Intervention/Infant Learning Program, school districts, medical and other clinical providers).**

Children who appear at risk of having an ASD require a comprehensive assessment across developmental and physical domains. Professionals from multiple disciplines are needed to conduct a complete assessment (i.e. neurodevelopmental pediatrics, psychology, speech, occupational and physical therapy, opthamology, audiology). For young children it is especially critical to perform a differential diagnosis to rule out any other possible genetic or medical disorders.

Currently few clinicians and specialists are skilled and trained in performing ASD assessments. Investing in training and developing specialists in ASD will reduce the time between screening and a comprehensive assessment, as all testing needs to occur before a definitive diagnosis can be made.

The comprehensive assessment leads not only to diagnosis, but to a plan of intervention and services for the child and family. Families need information and active referral to link up with needed health, educational, financial and family support resources.

3. **Expand the educational definition of autism to include all disorders in the Autism Spectrum Disorder. See Appendix A for recommended definition language.**

The current definition of autism used by the Alaska Department of Education &

Recommendations Cont...

Early Development to determine the eligibility is restrictive, including Autism Disorder, but not other disorders in the spectrum. The Committee recommends a definition that includes Pervasive Development Disorder, Asperger's Syndrome, and Childhood Disintegrative Disorder.

It is important to define ASD broadly so that students receive an appropriate education. Some children with ASDs are incorrectly categorized as emotionally disturbed resulting in educational programs that disregard the neurological basis for the disorder, and instead treat the child as though they had a behavioral condition. Children receiving proper services are more likely to achieve better outcomes and exit the special education system earlier. A broad definition benefits the State by reducing costs, and providing more accurate data.

Children receiving proper services are more likely to achieve better outcomes.

4. **Establish and maintain a statewide autism registry or surveillance program.**

Alaska does not have a reliable way of assessing the number of individuals in the state with ASD. Having valid statistics on the prevalence of ASD in Alaska is critical to understanding trends, planning and developing programs tc meet the educational and lifelong needs of individuals with ASD, future budgeting, and ensuring adequate numbers of people trained to provide specialized services. By understanding the prevalence of autism in Alaska, we will be better prepared to garner financial support from many sources to help Alaskan children and adults with ASD. The data collected will also allow our state legislature and school districts to better plan for growing needs for Alaskan's with autism.

5. **Develop capacity to diagnose Asperger Syndrome in older children and adults.**

Unlike other ASDs, Asperger Syndrome is typically not diagnosed in early childhood, but rather when the child is in school or even as an adult. A multidisciplinary team familiar with the features of Asperger Syndrome is needed to do an adequate assessment. Components of this assessment include taking a physical and developmental history, and conducting communication and psychological evaluations. Results of the evaluation need to be translated into a coherent picture and communicated to the child's family or the adult.

Service

There is a critical shortage of services for people with ASD in the state.

There is a critical shortage of services for people with ASD in the state. Reasons for this include an inadequate workforce, lack of evidence-based intervention programs within the state, especially for young children, and a need for more training for all those who work or come into regular contact with individuals with ASD. The lack of services influences the quality of the medical, dental, educational, and treatments offered to people with autism. Without these services, especially in the early childhood years when intervention can dramatically affect long-term outcomes, individuals with ASD and their families will fail to reach their potential, be less self-sufficient and more reliant on state-funded services, and unable to fully contribute as a citizen.

Where we are now

Providing medical and dental care for individuals with autism can be complicated. The most common medical problems linked with autism are seizures, accidents and injuries, infections, dental problems, and nutritional issues (Volkmar, 2000). Pediatricians are located only in urban areas of the state or on an itinerant basis to hub communities. Smaller communities may be served by family practice physicians, nurse practitioners, or physician assistants while remote areas of the state are most commonly served by community health aides and practitioners. While pediatricians in particular are familiar with autism, many families are unable to access a medical provider who can advise them about the treatment options families may learn about. As many of these treatment options are controversial, having a

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medical provider knowledgeable about the current status of autism treatment, would guide families in making informed decisions.

There are a number of evidence-based educational interventions used throughout the country. In Alaska, educational services are provided by the Early Intervention/Early Intervention/Infant Learning Program (EI/ILP) for children birth to three, and by school districts for children from 3 to 18 or 22, depending on the student's Individual Education Plan. The EI/ILP delivers services in the family's home. An early interventionist, early childhood special education teacher, speech therapist, physical therapist, occupational therapist and/or paraprofessional supervised by an early interventionist work with families to teach them ways to enhance their child's development. School districts serve children and youth with ASD through their Individual Education Plan, which outlines the goals and services to be delivered. A statewide assessment of school districts' educational programs for students with ASD has not been conducted. However, nationally-recognized intensive intervention programs designed specifically for individuals with ASD, such as applied behavioral analysis, floor time, and TEACCH (Treatment and Education of Autistic and related Communication Handicapped Children) are largely unavailable to families unless they are able to pay for the services of a consultant outside the state. The Anchorage School District does provide some specialized classrooms for children with ASD.

Since individuals with ASD have different needs and abilities, providing a range of evidence-based treatments is extremely important.

This is a critical aspect of autism services because the major treatment for autism is early and ongoing educational intervention. Presently, there are some limited and inconsistent services provided by school districts, private and home programs. Most school districts do not have the capacity to provide intensive interventions for students with autism. Part of the problem is that in both the rural and urban parts of the state, there is difficulty in the recruitment and retention of staff experienced with autism. The intensive, one-on-one nature of many interventions is prohibitively expensive for many school districts. There is also currently a limited amount of time provided for extended school year services. These services may be provided by the school district to some children with developmental disabilities who regress when not in school and are offered during regular school breaks. When extended school year services provided by school districts, some children with autism behaviorally and cognitively regress.

Providing effective autism treatments is found to be deficient in Alaska. Since individuals with ASD have different needs and abilities, providing a range of evidence-based treatments is extremely important. Many parents are forced to go out of state and spend a lot of

money to get the services their children need. There are currently pockets of well-trained professionals providing autism related services in Alaska, but they are mostly clustered in the major urban centers. In Alaska, Medicaid does not reimburse for intensive behavioral treatment as a medical service. Intensive behavioral treatment is an important component of autism treatment.

A contributing factor to the lack of treatment and services for individuals with Autism Spectrum Disorders, is an inadequate level of training, resources and support for professionals and parents. More in-state training is needed, especially due to the high turnover rate in the direct service field and in school districts throughout Alaska.

More in-state training is needed.

Service Recommendations

Medical Services

1. **Expand specialty clinics at hospitals for individuals with autism.**

   Medical services are critical because children with ASD are more likely to develop certain medical conditions such as seizures, accidents and injuries, infections, and dental and nutritional problems. This committee recommends that medical services be expanded to include consultation with the child's or adolescent's primary care provider and other service providers. Families and providers often need advice on such issues as medication, toileting, sleep disturbances, behavior and aggression, self-injurious behaviors, motor tics, social skills, and others.

2. **Amend Medicaid regulations to ensure reimbursement for evidence-based medical interventions and psychological assessments and interventions. Currently only psychologists working in mental health clinics or under the supervision of a psychiatrist are allowed to bill Medicaid.**

   School districts perform psychological evaluations every three years. Because children develop rapidly in the early years, a new evaluation is typically needed to complete an assessment. Child psychologists are uniquely qualified to perform cognitive and adaptive behavior skills, and this is an important element of the diagnostic process. Adding psychology services for Medicaid recipients would alleviate this problem.

Service Recommendations Cont...

3. **Develop the capacity of medical providers to work successfully with individuals with ASD.**

   Increasing the capacity of medical providers to work with individuals with ASD is essential to providing quality health and dental care for the ASD population. Communication and behavior problems as well as unusual and unpredictable response to stimuli complicate medical and dental care. Specialized training and skills will help medical and dental professionals provide quality care for those with ASD in Alaska.

   The Committee recommends that training on ASD be provided at medical conferences in Alaska.

There is strong evidence supporting the validity of intensive early intervention beginning as early as possible after diagnosis.

Educational Services

1. **Adopt best practice guidelines and set measures of effectiveness of educational services for children with ASD.**

   The National Autism Center is developing national standards for the treatment of ASD. Using evidence-rating criteria the Center will produce a set of national research-based standards for education and behavioral intervention for children with autism. The Committee recommends that Alaska adopt best practice standards, based on national standards, for interventions and educational services provided to individuals with ASD in Alaska.

2. **Provide adequate funding to establish intensive early intervention services for children with autism through the Early Intervention/Early Intervention/Infant Learning Program, Head Start and school district preschool programs.**

   Intensive early intervention has been documented to be an effective intervention for children with ASD (Dawson & Osterling, 1997; Green, 1996). Although the specific intervention models are a source of controversy, there is strong evidence supporting the validity of intensive early intervention beginning as early as possible after diagnosis (Sheinkopf & Siegel, 1998).

   Children under three with developmental delays are served by the Early Intervention/Infant Learning Program. Some children receive a diagnosis of ASD before their third birthday and will begin receiving services through this program. Families receive periodic home visits

Service Recommendations Cont...

from an early intervention specialist, based on the child and family needs. Eligible three to five year old children attend public preschool or Head Start programs.

3. **Adequately fund and provide appropriate intensive interventions based on best practices to children with ASD in the educational system.**

   Currently, schools provide either limited or no ASD-specific intervention programs for children qualified to receive special education. Rather than endorsing a specific model, the Committee recommends that evidence-based models for ASD intervention become available in the educational system. Families need to be provided a choice of models and an opportunity to decide which approach will best meet their child and family's needs. Interventions require a time and lifestyle commitment from the families.

Research has documented the efficacy of early, intensive intervention (Sheinkopf and Siegel, 1998, Dawson and Osterling, 1997).

4. **Enlist Alaska's universities' support and collaboration in developing certification and degree programs for students interested in specializing in autism interventions.**

   The University of Alaska system and the small number of private colleges in the state are a resource that can be used to help develop the workforce needed to provide effective services for individual with ASD. Education, Special Education, Social Work, and Psychology degree programs, with a certification in autism interventions can help alleviate the current shortage of qualified personnel. The University of Alaska Anchorage also has the Washington, Wyoming, Alaska, Montano, and Idaho (WWAMI) Biomedical program affiliated with the University of Washington School of Medicine. This program can be used to increase the number of medical doctors in state who specialize in diagnosing and treating children with ASD.

5. **Build capacity for all early intervention and childcare programs, and school districts, to adopt evidence-based, non-aversive behavioral interventions, such as positive behavioral support and best practice interventions with proven outcomes.**

   Challenging behaviors often accompany ASD. When individuals are limited in their communication skills, they may use behaviors as a way to let others know what they want and need. Positive behavior support helps adults decipher the communication intent of behavior, and teaches alternative ways individuals can express themselves. Programs that serve children with ASD need training and tools for helping the adults better support the communication

Service Recommendations Cont...

and behavioral needs of students with ASD.

Children with ASD present unique and difficult needs that require specific skills from teachers and education professionals. Currently, no specific certification in ASD interventions for teachers and educational professionals exists in the state.

6. **Investigate amending Medicaid regulations to allow reimbursements to districts for school-based intensive autism interventions to Medicaid eligible students.**

   About half of Alaska's children are Medicaid eligible. Adding intensive intervention for ASD as a Medicaid service would permit the state to collect federal funds to help cover the expense. Shifting some of the cost of intervention would permit school districts to use their funding to reach non-Medicaid students as well.

Children with ASD present unique and difficult needs that require specific skills from teachers and educational professionals.

Home and Community-Based Services

1. **Change Medicaid to ensure that children with ASD are able to receive time-limited, intensive intervention services.**

   The Deficit Reduction Act permits flexibility within state Medicaid plans. It is recommended that Alaska modify their Medicaid Plan to include time-limited autism intervention services. If modifying the Alaska Medicaid Plan is not feasible, the Committee recommends that the state develop an Autism waiver modeled after Minnesota or Wisconsin. A third alternative would be to change eligibility within the Home and Community Based Waiver to ensure children with ASD receive time-limited intensive services.

2. **Provide supplemental grant funding for providers to offer treatment services for individuals with autism who are not eligible for Medicaid or meet level of care.**

   Not all individuals with ASD meet level of care requirements for a Medicaid Home and Community-based waiver or TEFRA, but would benefit from intervention. The DD grant program supports individuals with developmental disabilities who are not eligible for a waiver. Additional funding in the DD grant program would help meet the needs of children and adults with ASD.

Service Recommendations Cont...

3. **Bring training on diagnosis and interventions to Alaska.**

   Alaska faces a shortage of clinically trained personnel experienced in performing diagnostic assessments and follow-up treatment. The Committee recommends improvement in the availability and expertise of these specialists to assess and treat ASD. Very few psychologists in Alaska are experienced in administering assessment tools for autism and evaluating the results, especially for young children.

   Several University-based Autism centers provide training that, if brought to Alaska, would expand statewide capacity for timely and accurate diagnosis and appropriate intervention.

Bring training on diagnosis and interventions to Alaska.

4. **Change Medicaid regulations to provide reimbursement for autism treatments as a medical service.**

   Although research has shown promising results stemming from autism interventions for some individuals with ASD, there are significant differences in the costs, degree of family involvement required, availability, and content and structure of these programs. The Committee believes a continuum of intervention options should be available and billable through Medicaid. Such interventions may significantly reduce the lifetime cost of care for individuals with ASD.

5. **Remove licensing barriers that prevent out-of-state autism specialists from practicing in Alaska.**

   Out-of-state autism specialists would help provide quality treatment for those with ASD in Alaska. Current state licensure and billing regulations that prohibit out-of-state health providers from practicing in the state need to be reviewed and revised so they may provide services for individuals with ASD in Alaska.

Parent Training

1. **Greatly expand services offered through an autism resource center, so that it is well funded, independent, and highly visible with a long-range plan for satellite programs throughout the state.**

Service Recommendations Cont...

Several activities are envisioned to expand the functions of an autism resource center. These include:

- An annual comprehensive fair/institute for families to provide up-to-date medical information, guidance in navigating the system, and other topics. Disseminate the institute through a CD or a webcast for people who cannot attend in person;
- The establishment of local resource centers across Alaska that are independent in nature, but collaborative with other providers, and state/local/national experts;
- Training for parents in systems advocacy/political advocacy;
- Regional, technical assistance traveling teams with professional oversight; and
- Comprehensive parent training in education, systems advocacy, guardianship, medical services, and other topics as needed.

There is a critical shortage of staff to work directly with individuals with developmental disabilities.

Service Provider Development

1. **Fund and deliver training to develop qualified staff who will provide evidence-based autism treatment services in home, child care and community-based settings.**

   There is a critical shortage of staff to work directly with individuals with developmental disabilities. The failure to provide evidence-based services to children and adults with Autism Spectrum Disorders impedes their development and limits their potential over their entire lifetime. Training is inadequate for those who provide care to individuals with Autism Spectrum Disorders.

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APPENDIX A

PROPOSED DEFINITION OF AUTISM
FOR THE DEPARTMENT OF EDUCATION AND EARLY DEVELOPMENT

1. **Autism Spectrum Disorders (ASD)**

To be eligible for special education and related services as a child with ASD, a child must:

a. exhibit a developmental disability significantly affecting verbal and non-verbal communication and social interaction, generally evident before age three, that adversely affects educational performance; and

b. require special facilities, equipment, or methods to make the child's educational program effective; and

c. be diagnosed as having an autism spectrum disorder by a psychiatrist, physician, or psychologist; and

d. be certified by a group consisting of qualified professionals and a parent of the child as qualifying for and needing special education services.

Characteristics of ASD include:

- Irregularities and impairments in communication
- Engagement in repetitive activities and stereotyped movements
- Resistance to environmental change or change in daily routines
- Unusual responses to sensory experiences

A child who manifests the above characteristics after age 3 may also be diagnosed as having autism spectrum disorder.

A child who is diagnosed as having Asperger's Syndrome or Pervasive Developmental Disorder - Not Otherwise Specified (PDD-NOS) and who manifests the above characteristics may be found eligible for special education under the category of ASD.

Early Intensive Intervention Services for Alaska Children with Autism: A Policy Analysis

The Governor's Council on Disabilities & Special Education

SB 250 Autism Insurance Coverage
Used in (S)HSS hearing 3/15/2010

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Introductio

> Autism is the fastest growing developmental disorder and affects more children than those with diabetes, AIDS and cancer combined.

From the covers of Time and Newsweek magazines, to the Centers for Disease Control and Prevention's Morbidity and Mortality Weekly Report, autism is in the news (Centers for Disease Control and Prevention, 2007c; Kantrowitz & Scelfo, 2006; Nash, 2002). It is the fastest growing developmental disorder and affects more children than those with diabetes, AIDS and cancer combined (Kennedy Krieger Institute, 2007). No longer considered a rare disorder, autism impacts a wider and wider segment of our society. This pervasive developmental disorder affects communication, behavior, social skills and play, and is diagnosed in the early childhood years.

In Alaska, the growing prevalence of autism has resulted in a groundswell of advocacy for improved services for children. When a child is diagnosed, families learn there are evidence-based intervention options but quickly discover the services are not generally available and/or financially accessible, especially in Alaska. Even more disheartening is that intervention is most effective when delivered as soon as the diagnosis is made, accentuating the urgency for services.

In response to frequent public testimony about this need, the Governor's Council on Disabilities and Special Education formed an Ad Hoc Committee on Autism in 2005 to develop recommendations for the Alaska Legislature and the administration. A report of this Committee suggests

Introduction continued . . .

four high priority recommendations — universal screening for autism, enhanced diagnostic capacity, expanded resource and referral services, and time-limited intervention services (Governor's Council on Disabilities & Special Education, 2006). The Council successfully advocated for increased funding for identifying and diagnosing children with autism as well as for additional resource and referral services. Activities are underway to develop universal screening. The final recommendation — a mechanism to provide time-limited, intensive early intervention services — is the topic of this policy analysis.

Purpose

This policy paper provides the state of Alaska with an analysis of options for the provision of time-limited, early intensive intervention services for children with autism.

The following five options for developing time-limited interventions for young children were reviewed:

1) exploring the options for offering autism services under the Deficit Reduction Act;

2) applying to the Centers for Medicare and Medicaid Services for an Autism Waiver;

3) attaching intensive autism intervention services to an overhaul of the entire Medicaid system in Alaska through an 1115a waiver;

4) offering intensive early intervention as part of the existing Medicaid program, e.g., by designating treatment through the EPSDT program; and

5) mandating that insurance companies coverage for autism services.

Background

Autism is a pervasive, life-long, brain-based disorder that is present from birth or the early stages of development. It affects thinking, social interaction, communication, imagination, and relationships with others (Centers for Disease Control and Prevention, 2007d; Lord & McGee, 2001; National Institute of Mental Health, 2005). Differences in sensory processing and unusual behaviors and interests are also symptomatic of autism (Centers for Disease Control and Prevention, 2007d). Language development ranges from limited or no use of speech, to unusual speech patterns such as echolalia. About 30 percent of individuals with autism are nonverbal (Akshoomoff & Stahmer, 2006).

Intellectual functioning varies among people with autism from mental retardation to above average intelligence. Some individuals become very knowledgeable about a subject of interest to them. Play is often restricted to a narrow range of interests, such as a preoccupation or atypical attachments with objects such as trains or cars. Rather than playing with other children, a child with autism may choose to play repetitively with objects in unusual ways.

These characteristics are manifested as a spectrum in individuals with autism, ranging in severity, symptoms and age of onset. Autism is classifed as a group of pervasive developmental disorders, or Autism Spectrum Disorders (ASD). This group of disorders includes Pervasive Developmental Disabilities — Not Otherwise Specified (PDD-NOS), Autistic Disorder, and Asperger Syndrome. While each of these disorders share some characteristics, they manifest in individuals at different ages, and vary in the nature and severity of these symptoms. For example, children with Autistic Disorder are typically diagnosed in early childhood, while Asperger Syndrome is diagnosed during the school years. Some children with Autistic Disorder are essentially nonverbal, while children with Asperger Syndrome develop speech but differ in their use of language.

Prevalence

As is happening across the country, increasing numbers of children in Alaska are diagnosed with an ASD. Recently released national prevalence data reveal that one in 150 children have an ASD (Centers for Disease Control and Prevention, 2007a).

While Alaska does not track autism prevalence, in 1994, 37 children enrolled in special education were classified as having autism; in 2006 that number had grown to 477, an increase of approximately, 1200% (Alaska Department of Education & Early Development, 1994, 2006). It should be noted that autism was not used as a classification within special education until 1993 and for students to receive services under the category of autism a diagnosis of Autistic Disorder is required. Asperger Syndrome and Pervasive Developmental Disorder — Not Otherwise Specified do not qualify as autism according to the Department of Education & Early Development, although these children may be receiving special education under a different category. Previous to 1993, all children with ASD were classified in categories such as Other Health Impaired, Severely Emotionally Disturbed, Mentally Retarded, or Developmentally Delayed.

The Anchorage School District estimates that one in 80 of their students has an ASD, and that one of nine special education students in the district has an ASD (Comeau, 2007).

Literature Review

Many individuals with ASD require lifelong supports at a cost estimated at $3.2 million per person (Ganz, 2006). Governments and society often bear the cost of this care in paying for early intervention, special education, and then adult services such as habilitation, supported living and supported work. There is also an expense to society related to lost productivity of the individual with autism as well as his or her family, and behaviors that sometimes lead to involvement with the criminal justice system (Ganz, 2006).

Two studies documented similar cost-savings associated with early intensive behavioral intervention. Researchers in Texas found the state could expect a total savings of $84,300 per child in state-budgeted funds, and $208,500 per child in the actual costs (including local, state and federal), achieved over total school years when children with autism received early intensive intervention

(Chasson, Harris, & Neely, 2007). In Pennsylvania, the average savings to the educational system per child ranged from $274,700 to $282,690 with inflation (Jacobson, Mulick, & Green, 1998). This study projected cost savings to age 55 with inflation ranging from approximately $2,439,700 to $2,816,500 per person.

Although there is a body of evidence supporting the effectiveness of early intervention, no single treatment approach has gained acceptance as the best-practice model for all children with ASD (Canadian Paediatric Society, 2004; Dawson & Osterling, 1997; Feinberg & Vacca, 2000; Lord & McGee, 2001; Steuernagel, 2005). However, the essential elements of successful intervention models have been defined (Dawson & Osterling, 1997; Lord & McGee, 2001).

- Intervention begins early and is intensive in hours.
- Families are active participants in their child's intervention.
- Staff are well-trained and knowledgeable about autism.
- There is objective evaluation of the child's progress.
- The curricula is highly structured resulting in a predictable daily routine and is focused on developing communication skills as well as other developmental skill areas.
- Teaching procedures emphasize generalization and maintenance of skills.
- Transitions to school are carefully planned and well supported.

Autism has significant impacts on the family (Hastings et al., 2005; Lord & McGee, 2001). Beyond typical parenting roles, children with autism may demand hypervigilance from their caregivers to ensure their safety. Other behavioral issues, such as smearing feces, limited tolerances for food and impaired communication are challenges most parents do not have to face. These behaviors make it very difficult for family members to engage in ordinary, day-to-day activities such as grocery shopping, visiting friends, working, sleeping, eating out and even taking a shower. The additional burden on families raising a child with autism is important in policy discussions. Families need to be able to choose an intervention program that fits with their values, lifestyle and available time.

Options for Financing Early Intensive Intervention

Currently there are four ways families typically receive services:

1) through the Early Intervention/Infant Learning Program up to age three;
2) through the school district from ages 3-21;
3) through Senior and Disabilities Services for home and community based Medicaid waiver or grant funded services; and
4) through private therapists and/or paraprofessionals.

Recommended intervention models for autism involve intensive instruction requiring active engagement with the child for a minimum of 25 hours a week, 12 months per year (Lord & McGee, 2001). These interventions are generally not available at that level of intensity in Alaska. The following options suggest ways to finance additional services to supplement what is already provided to children with autism.

Deficit Reduction Act (DRA). Section 6086 of the DRA contains provisions for expanding home and community-based services typically offered under a waiver to individuals with disabilities. States may adopt these services through a State Plan Amendment. There are several new options for states under the DRA.

First, states may offer home-and-community-based services, without applying for a waiver, to eligible individuals who meet Medicaid financial guidelines (currently at 150 percent of the federal poverty level). Currently only individuals receiving services under a Medicaid waiver are eligible for these services.

Second, a less stringent disability standard is required for home-and-community-based services under the DRA, broadening the group of individuals who may access these services. Recipients do not need to demonstrate that an institutional level of care would otherwise be needed. Rather, states must adopt criteria that are more restrictive for waivers than for services through the DRA.

Third, services now available through Medicaid waivers are allowed under the DRA, but states may set limits. These services include case management, homemaker, personal care, adult day health, habilitation, respite care and day treatment (Mollica, 2006).

In addition to the changes to services, there are numerous other provisions of Section 6086 of the DRA that need to be considered. States can set caps on enrollment and establish waiting lists. They may also change the criteria by which level of need is established. This means that individuals may begin receiving services, but when

criteria are modified, would no longer qualify. If this were to occur, individuals continue to receive services for at least 12 months from the date services began, not from the date the criteria changed.

The primary advantage to the DRA option is the ability to extend services to individuals with less severe disabilities. The state is offered more flexibility and may change eligibility and eliminate or reduce services without seeking approval from the Centers for Medicare and Medicaid Services. The state may also impose waiting lists and caps on services. Financial eligibility is more restrictive, meaning those with income above 150 percent of the federal poverty level would not qualify.

Medicaid 1915(c) Waiver. Another option is to apply for a Medicaid waiver specific to children with autism. This would allow children to receive time-limited services (typically for three years). An autism waiver requires that individuals meet an institutional level of care and therefore would be targeted to those with more severe forms of autism. As with other waivers, the state will set a cap on the number of individuals to be served, maintain a waiting list, and must prove that the cost of service is less than what would be incurred in an institutional setting.

With waivers, states must seek approval for changes in the number of individuals to be served, eligibility and changes in services. While this is more cumbersome administratively, it also offers recipients a greater level of assurance that if changes are to occur, there will be a review from the federal government. More individuals would meet financial eligibility standards as they are higher than for the DRA.

The state would need to make decisions regarding eligible diagnoses, qualifying ages, qualifications of interventionists, number of waiver slots, caps on services, as well as determine which intervention models will be reimbursable.

Medicaid 1115a waiver. The Pacific Health Policy Group recommended the state consider applying for an 1115a waiver as part of overall Medicaid reform. More study is needed before a decision will be made about applying for this waiver, but autism services could be included in preliminary, exploratory activities.

The primary disadvantage to the state with an 1115a waiver is the assumption of financial risk. The state would need to negotiate an overall cap on all Medicaid spending, and should the state exceed that cap, it would not receive matching funds for any expenses

Options for Financing continued . . .

over the negotiated amount. However, in adopting a managed care model, the state would essentially become a managed care provider and thus pay itself a premium for every enrolled person. These funds can be used flexibly for other health-related activities, and might present an opportunity to provide autism services for a broader group.

Medicaid and Early Periodic Screening, Diagnosis and Treatment. Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program entitles children under 21 to well child checks, hearing, vision, and dental screening as well as services to ameliorate any conditions discovered during screening and/or diagnosis. Providers may treat the condition, refer families to another provider, or recommend they seek treatment from a qualified provider.

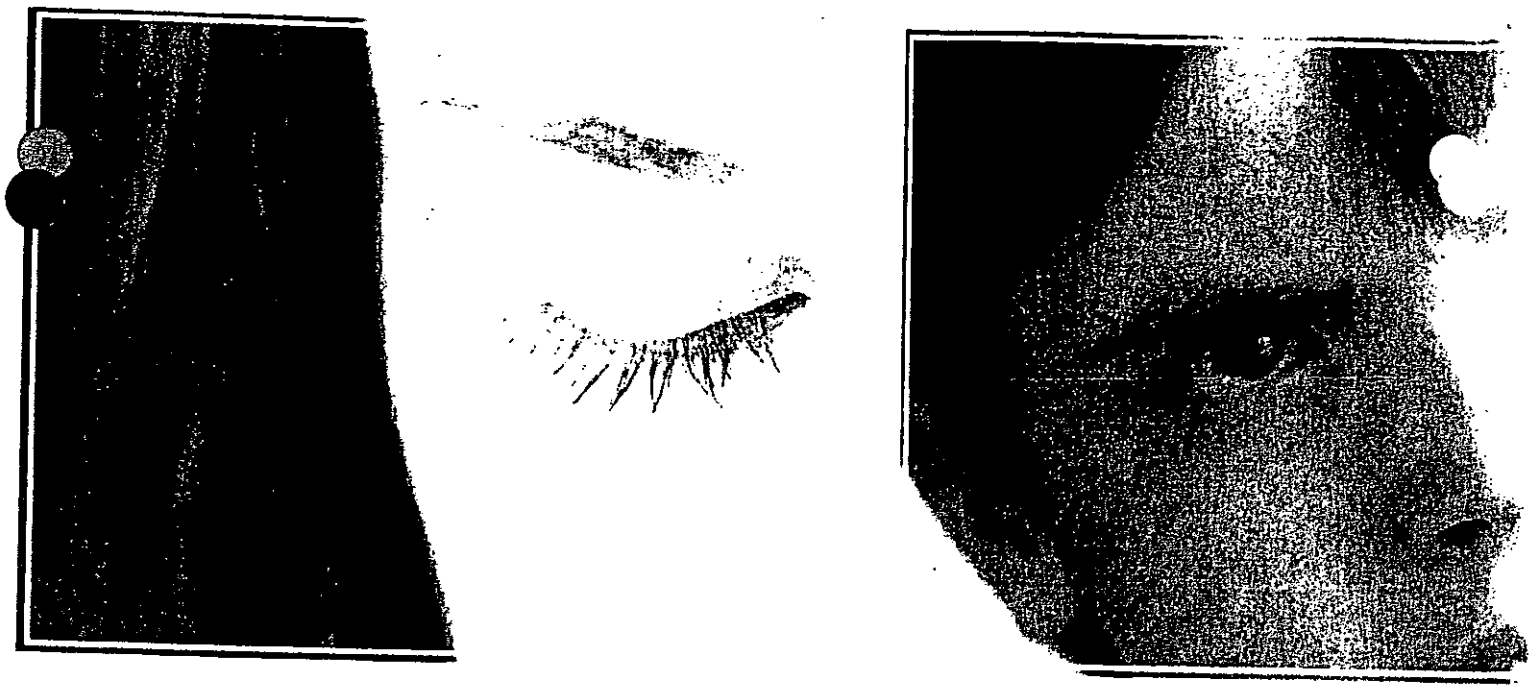
EPSDT is intentionally broad and states that Medicaid

> "requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
>
> "It also enables them to assess the child's health needs through initial and periodic examinations and evaluations, and also to assure that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly" (Centers for Medicare and Medicaid Services).

At first glance, this appears to be a mechanism by which children with autism could receive intensive intervention services. However, there is controversy over whether autism intensive intervention services are permitted. EPSDT does not cover some services, such as respite care, and targeted case management. It also does not cover habilitation services — those services that help an individual acquire and or improve skills. EPSDT does, however, cover rehabilitation under mental health codes. [Autism may be perceived to fall into an abyss between the two, with no coverage under either category. In fact, lawsuits seem to be the avenue by which a determination is made on a state-by-state basis.]

Insurance Mandates. Sixteen states have enacted some form of autism insurance legislation. [This ranges from designating autism as a mental health disorder or a neurological disorder, so that autism is reimbursed according to the same caps and co-pays applied to these conditions generally, to mandating coverage for autism intervention.]

There is an emerging trend toward state legislative action around insurance for individuals with autism. More study is needed to determine whether services would be reimbursed at a higher rate if designated a neurological condition versus a mental health condition, which generally reimburses at 50 percent of the usual and customary charge.



Conclusion

> is in the best interests of the state as well as families to work quickly to establish a mechanism for providing care

While Infant Learning and School District providers in Alaska use a variety of treatment approaches, there is evidence that many providers are not offering services at the recommended level. This is expected given the level of financial support provided to districts and the Infant Learning Program, as well as the lack of Medicaid services for autism that potentially could supplement educational programming.

However, it is obvious that the responsibility for payment of services cannot be borne by a single service system. Blended or coordinated funding from Medicaid, Infant Learning, and special education is needed to provide intensive services. Due to the high cost of providing intensive intervention services, if one service system were to assume the entire expense, funding would be directed away from children with other disabilities who also need early intervention, educational, and Medicaid services.

New funding for enhanced resource and referral as well as diagnostic and screening for autism which was obtained through the advocacy of the Governor's Council will generate an even greater demand for services. It is in the best interests of the state as well as families to work quickly to establish a mechanism for providing care that is coordinated across the medical, early intervention and educational systems. The return on this investment will become apparent in future years, but will require an up-front infusion of funds.

Alaska has an opportunity to learn from other states with autism services, and to use the experiences of these states to develop a model that builds on lessons learned. In particular, it can be expected that workforce development will be a barrier, especially in rural Alaska. Setting provider standards to ensure quality

and availability of personnel will be especially challenging in Alaska.

Some options open up more risk than others. With Medicaid costs rising at an unsustainable rate, heightened scrutiny of any Medicaid service can be expected. Carefully choosing an option that does not place other Medicaid services at risk is an important policy consideration. A combination of options is also a strong possibility.

Finally, it is crucial to build a strong evaluation component. Accountability for public funds is essential, and there must be evidence of cost-effectiveness of the services. Evaluation should also be used to make mid-course corrections and to strengthen the services that children and families receive. Intervention strategies inherently employ data collection and it is reasonable to assume that this data be used to evaluate the efficacy of programs.

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February 9, 2010

Actuarial Cost Estimate: Alaska House Bill 187

An Act Requiring Insurance Coverage for Autism Spectrum Disorders

OLIVER WYMAN

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1

Executive Summary

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman or we) has been engaged by Autism Speaks to develop a cost model in order to analyze and estimate the impact of insurance benefits for autism spectrum disorders (ASD) mandated by Alaska House Bill 187 (HB 187). The most significant treatment mandated by HB 187 is applied behavior analysis, or ABA which accounts for a large portion of the additional costs under HB 187. The key provisions of HB 187 are explained further in Section 4 of this report.

Our analysis involved developing a robust model that reflects the likely behavior of consumers, providers and insurers of ABA services and includes Alaska demographic and insurance market information. Key assumptions including the treated prevalence of ASD, the age of diagnosis, ABA program utilization by age, ABA annual costs by age, and additional other (i.e. not ABA) medical costs, as well as the modeling methodology are explained in detail in Sections 5 and 6 of this report and summarized through graphs in the Appendix.

Our analysis included scenario testing to develop cost estimates under a range of assumptions. Our "Middle" estimate is that, in the long-term, costs would increase by about 0.33% of premiums and premiums would increase about 0.39% should HB 187 be enacted. Our estimated range of long-term premium increases is 0.26% to 0.56% based on our "Low" and "High" estimates. We expect that premium increases would be lower in the years immediately following the passage of a law consistent with the provisions of HB 187, with first year cost increases in the range of 0.09% to 0.37% percent of premiums. Our expectation of lower first year costs is based on experiences in other states that have seen low initial costs when ASD benefits are mandated. These lower costs can be expected due to the lags typically seen in accessing new benefits and the limited supply of ABA providers.

The estimated cost increases for our "Middle" scenario along with some statistics for the individual, small, and large group markets are shown in the table below; we would expect that costs for any government plans would be similar to those estimated for large groups.

Long-Term Cost Estimates - "Middle" Cost Scenario

	Market			
	Individual	Small Group	Large Group	All
Covered Persons	26,000	47,000	59,000	132,000
Average Premium per Person	$2,700	$4,700	$4,300	$4,127
Annual Mandate Claim Cost per Covered Person	$13.70	$13.70	$13.70	$13.70
Claim Cost as a Percentage of Premium	0.51%	0.29%	0.32%	0.33%
Estimated Premium Increase with Admin @ 15%	$16.10	$16.10	$16.10	$16.10
Premium Increase as a Percentage of Premium	0.60%	0.34%	0.37%	0.39%

For our scenario testing we varied the assumptions that drive cost estimates. The assumptions under the "Low", "Middle", and "High" scenarios and premium increase estimates are summarized in the table below.

Scenario	% Diagnosed Under Age 6 Starting ABA	Avg. Annual ABA Program Cost	Avg. Annual non-ABA Cost	Annual Premium Increase per Covered Person	Premium Increase (% of Premium)
Low	40.0%	$25,000	$2,100	$10.70	0.26%
Middle	50.0%	$30,000	$3,150	$16.10	0.39%
High	66.7%	$33,823	$4,200	$23.10	0.56%

Section 7 also includes cost estimates with without an annual benefit maximum.

While this analysis focused primarily on estimating the insured costs of mandated medical benefits, in Section 8 we summarize information related to the lifetime costs of ASD which include the costs associated with medical services, education, custodial care, and the lost productivity and wages of individuals affected by ASD, as well as their family caregivers. We also outline the potential savings to government financed education and medical programs associated with effective ASD treatments based on several studies.

2

Background

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman or we) has been engaged by Autism Speaks to develop a cost model in order to analyze and estimate the impact of mandated insurance benefits for autism spectrum disorders (ASD) on insurance premiums. As part of this work, Oliver Wyman has developed a range of independent estimates of the impact on insurance premiums of the benefits mandated by Alaska HB 187, which provides coverage for the diagnosis and treatment of autism spectrum disorders.

Oliver Wyman is a part of the Marsh & McLennan (MMC) family of companies. With over 60 members of the American Academy of Actuaries, Oliver Wyman is one of the largest actuarial practices in North America. Oliver Wyman's health practice, which has thirteen credentialed actuaries, advises insurers, regulators, governments, interest groups, and others.

This report, along with its supporting analysis, was developed by Marc Lambright, a Principal and consulting health actuary in Oliver Wyman's Philadelphia office. Marc is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and is professionally qualified to analyze the cost impact of HB 187 and provide the estimates shown in this report. As part of Oliver Wyman's quality assurance process, the underlying analysis and this report were independently peer reviewed by another credentialed Oliver Wyman actuary.

3

Scope and Limitations

The intent of this analysis is to provide a reasonable range of estimates for the insured costs of the mandated ASD benefits provided for in HB 187 and the associated premium impact on the individual, small group, and large group markets affected by HB 187. This analysis also identifies and partially quantifies identified offsetting cost savings associated with successful ASD treatment.

We note that cost estimates for autism mandates have varied widely state to state based on differences in the state-specific mandates and the methods and assumptions used in estimating costs, though typically independent estimates show premium increases due to mandated autism benefits of less than 1%. A March 2009 report of The Council for Affordable Health Insurance (CAHI) states: "CAHI's actuarial working team estimates that an autism mandate increases the cost of health insurance by about 1 percent."[1] The reason for this variability is that the largest component of the increase in costs under HB 187 mandated ASD benefits is for behavioral therapy, including applied behavior analysis (ABA), which is almost universally excluded from health coverage, and therefore essentially no insured data exists for use in developing credible utilization and unit cost estimates for ABA.

The reader is further cautioned that the ultimate cost of covering ABA benefits is uncertain; however, this analysis attempts to reflect the likely behavior of consumers, providers and insurers of ABA services in developing the assumptions underlying the cost estimates. Likewise, the additional costs for mandated medical services other than ABA are uncertain. Insurance policies often cover some services for children diagnosed with an ASD, although the mandate could cause the insured costs for certain services to increase because ASD exclusions or limitations are common, and certain services that may have been denied or terminated following utilization review might be covered due to the mandate.

[1] The Council for Affordable Health Insurance. "The Growing Trend Towards Autism Coverage." March 2009.

4

Description of Key HB 187 Provisions and their Impact on Covered Benefits

Insurance Markets Covered by the Mandate

HB 187 states: *"Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in this state shall provide coverage for the costs of the diagnosis and treatment of autism spectrum disorders."*

In reviewing the relevant section of the Alaska Statutes (AS 21.54.500) that defines *health care insurer*, it appears that HB 187 applies to all health insurance plans that Alaska has regulatory jurisdiction over. We are assuming that this means all insured plans other than those excluded specifically in the bill would be covered.

Covered Benefits

HB 187 provides for the diagnosis and treatment of autism spectrum disorders by stating that *"(a) a health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in this state shall provide coverage for the costs of the diagnosis and treatment of autism spectrum disorders... Coverage for the cost of treatment required by this subsection must cover the treatment of the disorders prescribed by a licensed physician or psychologist and provided by an autism service provider as identified in a treatment plan developed following a comprehensive evaluation. A treatment plan developed under this subsection must identify the medically necessary pharmacy care, psychiatric care, psychological care, rehabilitative care, and therapeutic care required. In this subsection,*

... (2) "rehabilitative care" means professional counseling, guidance services, and treatment programs, including applied behavior analysis necessary to develop, restore, and maintain the functioning of an individual to the maximum extent practicable; in this paragraph, "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement, and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function..."

The inclusion of applied behavioral analysis (ABA), in the definition of habilitative or rehabilitative care is especially important. The coverage of behavioral therapies, including ABA, has the most significant impact on cost of any mandated service. For the purpose of this report, reference to ABA encompasses ABA and all similar behavioral therapies. We note ABA is the most widely accepted behavioral therapy and that we would expect other approved behavioral programs to have similar costs.

ABA programs are marked by intensive therapy that may include 30-40 hours of therapy a week under the most intensive programs, although many programs would not utilize that level of resources. Key assumptions underlying our ABA cost estimates are outlined in Section 6.

Coverage Limits and Maximum Benefits

HB 187 states: *"Coverage under this section ... must provide a maximum benefit of $36,000 a year, adjusted annually, beginning January 1, 2011, by the percentage change in the Consumer Price Index for all urban consumers compiled by the United States Department of Labor, Bureau of Labor Statistics..."*

In our modelling, we assumed that HB 187 would cap ABA annual benefits at $36,000 in 2010. We also provide an alternative range of illustrative estimates without an annual benefit maximum.

Maximum Age for Benefits

HB 187 states: *"Coverage under this section ... (1) is required to be provided only to individuals under 21 years of age"* so we developed our estimates assuming that covered benefits under HB 187 are to be provided to individuals under the age of 21, only.

Medical Necessity and Treatment Review

HB 187 states: *"(1) 'medically necessary' means any care, treatment, intervention, service, or item prescribed by a licensed physician or psychologist in accordance with accepted standards of practice ..."*

We assume that ASD benefits under HB 187 will be subject to utilization review procedures currently in place by insurers. This is important as insurers will develop protocols to review treatments and manage care to which will limit unnecessary treatments outside of accepted standards of practice if utilization reviews are done appropriately.

5

Modeling Methodology

The following outlines the general modeling methodology used to develop our cost estimates. Estimates were developed both on a per covered person per year basis, and as a percentage of average annual premiums, as shown in Section 7. Details of key assumptions are discussed in Section 6 and illustrated graphically in the exhibits shown in Appendix 1.

Modeling Perspective

Our model was developed to produce costs under a range of assumptions, but generally assumes that a sufficient supply of providers would be available to meet the demand for autism services, especially with regard to ABA services. It also assumes that there would be sufficient awareness of autism and motivation (primarily by parents) to seek treatment so that the diagnosis and treatment of ASDs would be more in line with CDC diagnosed prevalence estimates.

We would expect that it would take a minimum of several years for both the supply of providers to meet the demand for mandated ASD services and for parents of autistic children to aggressively seek treatment of their children's disorders. Developing an adequate supply of providers may prove to be very difficult based on the geography and limited population of Alaska, however, we did not make any adjustment in our modeling for these factors which could mean there is some conservatism in our ABA utilization assumptions.

In spite of these real limitations that will likely limit short-term costs associated with mandated autism benefits, we feel that it is appropriate from a public policy perspective to look at the costs over a longer term and assume that both awareness of ASDs will increase and that supply and demand for ASD services would eventually be in balance. We have developed our estimates with this in mind.

Acknowledging that short-term costs are also important to policymakers, in the sections outlining our cost estimates, we have included illustrative exhibits showing the possible progression of costs for mandated benefits by assuming that initial costs would be roughly one-half of the long-term estimates. We also assumed that it would take five years for costs to reach their ultimate levels, although these assumptions varied by cost scenario.

It is also instructive to look at some of the limited evidence available related to actual costs of ABA mandated benefits in other states. Aetna noted in December 2008 that it had tracked the cost of the autism mandate in Texas for its first year of existence and found that it increased costs for policyholders who filed autism-related claims by $379 a month. A total of 235 policyholders had filed autism claims in the state as of the time the data was released. At that time, the company had not decided whether to pass those costs on to the policyholders because the cost of the mandate might change after the first year.[2] While this is only first year experience for a single insurer, it illustrates that initial mandate costs are likely low. Aetna's Texas block of business is quite large (approximately $1.5 - 2.0 billion in premium[3]), so the statistics provided indicate a mandate cost of less than 0.1% of premium.

General Modeling Process

The modeling process employed to develop our cost estimates was as follows:

1. A treated prevalence estimate for Alaska was developed based on the Center for Disease Control and Prevention's (CDC) Mortality and Morbidity Weekly Report (MMWR) on autism prevalence dated December 18, 2009.
2. Prevalence rates by diagnostic subtype (autistic disorder, PDD-NOS, Asperger's Syndrome) were estimated separately, since diagnosis patterns and service utilization could reasonably be expected to vary by diagnostic subtype.
3. The percentage of children diagnosed by age for each diagnostic subtype was estimated so that the average ages of diagnosis implicit in the modeling are consistent with publicly available age at diagnosis statistics.[4]
4. The percentage of diagnosed children who could be expected to have an ABA program was estimated for each age based on assumptions regarding how many children would start a program and typical program continuance.
5. A distribution of the number of annual hours for ABA by age was developed based on ABA provider input and an assumption that utilization review by insurers would impact utilization to some degree.
6. Based on the assumed treatment prevalence, likelihood of having an ABA program, assumed distribution of ABA program hours, and estimated ABA program cost per hour of therapy, ABA cost estimates by age were developed.
7. Non-ABA costs were estimated based upon studies of medical costs for children diagnosed with ASD and judgment regarding the increase in costs that could be expected due to the mandated benefits.
8. Based on Census demographic data and the cost estimates for mandated ASD services by age as outlined in 1-7 above, an annual cost per covered individual was developed.

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[2] Associated Press. *Lawmaker: Oklahoma autism bill has momentum.* December 4, 2008. http://newsok.com/article/3327594. Accessed January 2009.

[3] NAIC Annual Statements for 2007.

[4] IAN database. http://dashboard.ianexchange.org/StateStatsAdvanced.aspx?AT=VA&ADT=T. Accessed January 2009.

9. The cost of services was increased to reflect administrative and other insurer costs or profit charges.
10. The estimated size of the covered market was developed based on Census, Medical Expenditure Panel Survey (MEPS) enrollment and premium information for Alaska, and Kaiser Family Foundation coverage data. These assumptions are further documented in Section 5.
11. The cost of the mandated services per covered person and as a percentage of premiums were calculated based on the model cost estimates and market data under a range of assumptions to develop "Low," "Middle," and "High" cost scenario estimates.

6

Summary of Key Assumptions

Key assumptions underlying the cost estimates for the proposed mandated benefits are summarized in this section. In order to better illustrate the sensitivity of costs to various assumptions, we developed assumptions for "Low," "Middle," and "High" cost scenarios. Appendix 1 further illustrates these assumptions for the "Middle" scenario.

Treated Prevalence and Age at Diagnosis

The December 18, 2009 CDC MMWR[5] report included the following information related to the prevalence of ASD:

1. *Children aged 8 years with a notation of an ASD or descriptions consistent with an ASD were identified through screening and abstraction of existing health and education records containing professional assessments of the child's developmental progress at health-care or education facilities. Children aged 8 years whose parent(s) or legal guardian(s) resided in the respective areas in 2006 met the case definition for an ASD if their records documented behaviors consistent with the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR) criteria for autistic disorder, pervasive developmental disorder–not otherwise specified (PDD NOS), or Asperger disorder. Presence of an identified ASD was determined through a review of data abstracted from developmental evaluation records by trained clinician reviewers.*[6]

2. *In 2006, the overall identified ASD prevalence per 1,000 children aged 8 years varied across ADDM sites ...The average across all 11 sites was 9.0 (CI = 8.6–9.3) per 1,000 children.*[7] A prevalence rate of 9 per 1,000 is approximately 1 in 110.

[5] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. December 18, 2009. http://www.cdc.gov/mmwr/. Accessed January 2010.

[6] Ibid, p. 1

[7] Ibid, p. 7

3. *In general, estimated ASD prevalence was lower in ADDM sites that relied solely on health sources to identify cases (mean: 7.5 per 1,000 population; CI = 7.0–7.9) compared with sites that also had access to education sources.*[8]

4. *Among all children meeting the ADDM ASD surveillance case definition, approximately 77% had a documented ASD classification in their records.*[9]

5. *All children initially identified for screening were first stratified by two factors highly associated with final case status: information source (education only, health only, or both types of sources) and the presence or absence of either an ASD ICD-9 code (299.0 or 299.8) or an autism special education eligibility. The potential number of cases missed because of missing records, and the impact on prevalence, was estimated on the assumption that within each of the strata, the proportion of children with missing records who ultimately would be confirmed as having ASD cases would have been similar to that of children for whom no records were missing.*[10]

In estimating treated prevalence, which drives medical services utilization and costs, we used the population prevalence as a starting point, and then made adjustments based on details in the MMWR study which would indicate that treated prevalence could be expected to be lower than population prevalence. Treated prevalence rates would be expected to be lower than population prevalence rates for several reasons:

1. As noted in 4. above, approximately 77% of children had documented ASD classification in their records. Without a documented ASD diagnosis, it is not likely that someone would receive treatments for ASD covered by insurance. Note 77% of the 9.0/1000 population prevalence means a documented diagnosis prevalence rate of approximately 1 in 144.

2. There is a reasonable expectation that covered medical ASD services would be supported by documentation in health records. Based on a review of health records, only, the population prevalence of ASD is approximately 7.5/1000, or 1 in 133.

3. The CDC methodology assumed that where records and information were missing, the proportion of children with missing records who ultimately would be confirmed as having ASD cases would have been similar to that of children for whom no records were missing. There is a reasonable likelihood that records would be less likely to be missing for children with documented ASD diagnoses who would seek treatment.

4. With ASD, as with any other disease or disorder, there will be some subset of the diagnosed population that will not seek treatment for any number of reasons.

Based on our analysis of the CDC report, including the key items from the report noted above, a reasonable assumption for the treated prevalence of ASD is 1 in 150. While there is

[8] Ibid, p. 7

[9] Ibid, p. 9

[10] Ibid, p.7

obvious rationale for modeling cost sensitivities to changes in prevalence, we did not do so since the range of likely costs based on the sensitivity testing outlined in the remainder of this report provides a fairly wide range and illustration of potential costs, and determining the impact on costs of different treated prevalence rates is a simple task.

Prevalence by diagnostic subtype was estimated based on an academic study published in the American Journal of Psychiatry.[11] As noted in the previous section, the percentage of children diagnosed by age for each diagnostic subtype was estimated so that the average age of diagnosis implicit in the modeling is consistent with publicly available age at diagnosis statistics.

The treated prevalence and age at diagnosis assumptions for Alaska are shown below:

Alaska Treated Prevalence

Diagnostic Subtype	Ultimate Prevalence	Average Age of Diagnosis
Autistic Disorder	1 in 450	3
PDD-NOS	1 in 300	3
Asperger's	1 in 900	6
All ASD	**1 in 150**	

The average age of diagnosis stated in the 2009 CDC MMWR report is 53 months[12] which is higher than the average age used in our cost modeling of about 42 months, we believe that this difference is reasonable and explainable in that we are using parent reported data that is likely provided by the same parents who would most likely utilize insured benefits. Note a lower age of diagnosis results in higher cost estimates, all other things being equal.

ABA Program Utilization and Cost

ABA Program Utilization by Age

ABA programs require a significant commitment from affected children, as well as their families. It is likely that a significant number of ASD children will not have an ABA program regardless of the availability of a provider, and many others diagnosed with ASD, especially those in more rural areas, may have difficulty accessing a provider. For this reason, we have assumed that 40% to 66.7% (40% for "Low" scenario, 50% for "Middle" and 66.7% for "High") of diagnosed children under age 6 will begin an ABA program. Based on discussions with ABA providers and researchers, actual utilization of ABA programs has been lower in many cases due to the lack of providers, the lack of coverage, and to some extent the limited understanding of ABA programs and their efficacy.

In Minnesota, a state that is widely regarded as having some of the most extensive ABA coverage and services in the nation, provider data indicates ABA utilization of approximately 20% of diagnosed three to six year olds[13], which is considerably lower than assumed in each

[11] Fombonne, E. and S. Chakrabarti. American Journal of Psychiatry. June 2005.

[12] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. December 18, 2009. p. 9.

[13] Discussion with Dr. Eric Larsson Executive Director, Clinical Services, The Lovaas Institute for Early Intervention Midwest Headquarters regarding ABA utilization research in Minnesota. February 2009.

of the scenarios in our modeling. While our range of assumptions for ABA utilization may appear conservative, and likely is conservative in the near-term, we feel that the range is reasonable since insurers will likely have some conservatism in their cost estimates and premium rates. Private insurance utilization will also likely be higher than under the public/private programs in Minnesota, and utilization could increase over time due to increased awareness of ASD, and potentially, an increased supply of ABA providers.

In addition to the likelihood of starting a program, program continuance assumptions have a very significant impact on overall ABA utilization and cost estimates. ABA programs are generally geared towards addressing deficits in younger children and are not intended to be continued indefinitely. For this reason, we have assumed that no programs would terminate prior to school age, that a large percentage of ABA programs would terminate at ages six and seven when an autistic child could be expected to enter elementary school, and annually thereafter a large percentage of remaining programs would terminate until only a very small percentage of children have ABA programs by the time they reach their teenage years. Programs would be expected to terminate if a child has experienced sufficient progress whereby a program is no longer necessary or if the insurer or family sees no progress, as well as for other reasons.

The assumed percentage of children diagnosed with ASD that have an ABA program by age for our "Middle" scenario is shown in the table below:

	% of Diagnosed Children w/ ABA
Under 6	50.0%
6	37.5%
7	25.0%
8	16.7%
9	11.1%
10	7.4%
11	4.9%
12	3.3%
13 to 21	2.5%

ABA Program Annual Number of Hours

In developing the assumed annual ABA program hours, we discussed typical ABA programming with ABA providers, and reviewed some benefit materials from one of the few large self-insured employers who offer ABA benefits.[14] We developed a distribution of expected hours that resulted in the annual averages shown in the table below:

	Average ABA Program Hours
Ages Under 8	1,500
Ages 8 to 12	671
Ages 13 to 21	401

The general assumption is that pre-school aged children will have programs for 20 to 40 hours a week, averaging about 30 hours a week. This time will be reduced by over half by

[14] Autism Therapy Reference- Microsoft Corporation (administered by Premera Blue Cross).

age eight, when children would be expected to be in school and the school system would be required to provide services during the school day. It would then again be reduced significantly at age 13, as the child ages and ABA programs would be expected to be less time consuming and address a smaller number of behavioral deficits.

Cost per Hour of ABA Service

In developing the costs per hour, we reviewed ABA program staffing information and ABA provider wage and overhead cost assumptions. We developed an average cost for the entire United States and then adjusted this for Alaska, based on Bureau of Labor Statistics[15] health care wage data. The resulting average cost per hour of ABA therapy in Alaska is about $53 for a program based on the assumption that staffing will be in line with what best practices might recommend. This is the cost underlying our "High" assumption, though we note that costs would vary based on the mix of professionals and technicians providing the services, and likely would be lower if less experienced ABA practitioners need to be employed to meet the increasing demands for services.

Range of Annual ABA Program Costs for Scenario Estimates

Given the actual cost of an ABA program could vary significantly for many reasons, we have assumed annual average program costs by scenario as follows:

"Low" cost scenario - assumes average ABA program cost is $25,000 per year.
"Middle" cost scenario - assumes average ABA program cost is $30,000 per year.
"High" cost scenario - based on the assumptions outlined in this section for the continuance of ABA programming, the number of annual hours for ABA programming, an annual cap of $36,000 and an hourly rate of $53.47, the calculated average annual cost for an ABA program for all ages is $33,823.

Other (than ABA) Medical Costs

Based on several studies[16], we estimated that children with ASDs had costs covered by insurers of approximately three times the average for non-inpatient medical services under current benefit programs. It is also clear that the mandate would mean that some services that an insurer could currently deny or exclude would now be covered. In our range of estimates, we assumed that the mandate would result in additional insured medical costs of 50% to 100% of the current level of estimated covered non-inpatient costs for services to children diagnosed with an ASD which we assumed are currently three times higher than the population costs in the absence of the benefit mandates under HB 187 for children under 21 diagnosed with an ASD.

[15] BLS wage data. http://www.bls.gov/guide/geography/wages.htm accessed January 2009.

[16] Mandell, Cao, Ittenbach, & Pinto-Martin, 2006. Croen, Najjar, Ray, Lotspeich, & Bernal, 2006. Liptak, Stuart, & Auinger, 2006.

The estimated annual cost for additional non-ABA services (note many non-ABA medical services are already provided to individuals with ASD) that would be covered as a result of the mandate are shown for each scenario in the table below:

Scenario	Annual non-ABA Cost
Low	$2,100
Middle	$3,150
High	$4,200

(Amounts in 2010 dollars)

Administrative Costs

Typically, medical claim costs could be expected to be 80 to 90% of premiums, meaning 10 to 20% of premiums are available for administration, profit, or other costs, often collectively referred to as "retention." We have estimated the incremental retention charge to be 15% of premium.

Alaska Market Data

The MEPS survey provides average premiums, enrollees, offer rates, take-up rates, and self-insured percentages by employer size for healthcare coverage sponsored by privately insured employers. From this data we can estimate the size of the privately insured small group, insured large group, and self-insured markets. State-specific premium data for Alaska was available for 2006[17], so we trended this based on average recent employer premium increases provided from the Kaiser Family Foundation HRET[18] survey to estimate the 2010 average annual premium per member necessary to compute the cost of mandated benefits as a percentage of annual premiums.

To estimate average premiums for the individual market, we reviewed survey results developed by America's Health Insurance Plans[19] that showed average premiums and members per policy by state.

As part of our development of premiums and membership estimates, we completed reasonableness tests by reviewing Alaska insurer annual statement exhibits to ensure that the group premium estimate is not unreasonable.

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[17] MEPS state survey data. http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=-1&year=-1. Accessed January 2009.

[18] Kaiser Family Foundation and Health Research Educational Trust. Employer Health Benefits- 2008 Annual Survey.

[19] AHIP Individual Health Insurance 2006 - 2007: A Comprehensive Survey of Premiums, Availability, and Benefits. http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf. Accessed January 2009.

7

Cost Estimates

Long-Term Cost Estimates - "Middle" Cost Scenario

The table below summarizes our "Middle" scenario average annual cost estimates and premium increases on a per covered person basis, and as a percentage of the annual premiums. Our "Middle" estimate is that, in the long-term, the premium increase associated with the mandated benefits provided by HB 187 would be about 0.39% of insured premiums across all markets. However, we expect that costs would be lower in the years immediately following the passage of HB 187 based on experiences in other states that have mandated ASD benefits, lags typically seen in accessing new benefits, and the limited supply of ABA providers. We expect that government programs would have cost increases comparable to insured large groups.

The estimated cost increases for the large group market is shown in the table below. The annual claim cost per covered person estimate of $13.70 and premium increase of $16.10 are in 2010 dollars.

	Market			
	Individual	Small Group	Large Group	All
Covered Persons	26,000	47,000	59,000	132,000
Average Premium per Person	$2,700	$4,700	$4,300	$4,127
Annual Mandate Claim Cost per Covered Person	$13.70	$13.70	$13.70	$13.70
Claim Cost as a Percentage of Premium	0.51%	0.29%	0.32%	0.33%
Estimated Premium Increase with Admin @ 15%	$16.10	$16.10	$16.10	$16.10
Premium Increase as a Percentage of Premium	0.60%	0.34%	0.37%	0.39%

Scenario Estimates

As discussed in Section 3, very little insurance data exists that can be used to directly estimate the costs of ABA benefits mandated by HB 187. This causes uncertainty in developing actuarial assumptions and cost estimates. Due to this uncertainty, it is useful to develop cost estimates for scenarios using optimistic and pessimistic assumptions.

Cost estimates are very sensitive to various assumptions, especially those related to ABA utilization and costs. Therefore, we varied our assumptions to develop estimated costs for ASD services under "Low," "Middle," and "High" cost scenarios, as shown in the table below:

Scenario	% Diagnosed Under Age 6 Starting ABA	Avg. Annual ABA Program Cost	Avg. Annual non-ABA Cost	Annual Premium Increase per Covered Person	Premium Increase (% of Premium)
Low	40.0%	$25,000	$2,100	$10.70	0.26%
Middle	50.0%	$30,000	$3,150	$16.10	0.39%
High	66.7%	$33,823	$4,200	$23.10	0.56%

Short-Term Cost Estimates by Scenario

In addition to the uncertainty associated with long-term cost estimates, how quickly costs could reach their ultimate level due to the limited supply of ABA therapists is also uncertain. We have provided the table below to illustrate the potential short-term increases in premiums, and how they could grade into the long-term estimates over time.

Estimated Increase in Premiums due to HB 187						
Scenario	Year 1	Year 2	Year 3	Year 4	Year 5	Years 6 and Beyond
Low	0.09%	0.12%	0.16%	0.19%	0.22%	0.26%
Middle	0.20%	0.23%	0.27%	0.31%	0.35%	0.39%
High	0.37%	0.41%	0.45%	0.48%	0.52%	0.56%

Illustrative Cost Estimates without $36,000 Annual Benefit Maximum

Recently enacted federal mental health parity legislation and its associated federal rules may impact annual benefit caps for ASD services. For this reason, we also developed illustrative cost estimates assuming no annual benefit maximum, and that the remaining provisions in the Bill remain the same; cost estimates for the three scenarios are summarized in the table below:

Scenario	% Diagnosed Under Age 6 Starting ABA	Avg. Annual ABA Program Cost	Avg. Annual non-ABA Cost	Annual Premium Increase per Covered Person	Premium Increase (% of Premium)
Low	40.0%	$45,000	$2,100	$15.60	0.38%
Middle	50.0%	$55,000	$3,150	$23.80	0.58%
High	66.7%	$67,756	$4,200	$36.80	0.89%

Individual Market Comment

In developing the individual and small-group market cost estimates, we did not develop any assumptions regarding the impact of anti-selection which could lead to average cost and premium increases in excess of those shown in this report due to the guaranteed issue and adjusted community rating rules in Alaska. Determining the impact on the individual market premiums of adding a population of children with ASD, along with their family members to this market would require an assessment of the likely costs of those added to the individual pool relative to those currently in the pool. Completing an assessment of the potential for anti-selection to increase premium rates under HB 187 is complicated for several reasons, and beyond the scope of this review.

8

Cost – Benefit Analysis for ASD Treatments

There have been several studies related to the efficacy of ABA treatment programs, and the costs associated with ASD treatments, care, and supports. In this section, we summarize some of these studies.

Societal Costs of Autism- Ganz Report

One of the most often cited reports explaining the financial costs of ASD is *The Lifetime Distribution of the Incremental Societal Costs of Autism* by Michael Ganz, MS, PhD was published in 2007. This report summarized the modeled costs of a hypothetical cohort of children born in 2000 and diagnosed with autism in 2003. A study result is that the incremental societal cost of autism is $3.2 million per capita in 2003 dollars.[20] The report is very helpful in identifying specific costs of ASD, and in providing a framework for quantifying these costs, as well as providing actual cost estimates.

Direct Medical

- Physician and Dental
- Drugs
- Complementary and Alternative Therapies
- Behavioral Therapies
- Emergency and Hospital
- Home Healthcare
- Travel

[20] Ganz, Michael L. *The Lifetime Distribution of the Incremental Societal Costs of Autism.* Archives of Pediatrics & Adolescent Medicine. April 2007. Volume 161.

Direct Nonmedical

- Child Care
- Adult Care
- Respite Care
- Home Improvements
- Special Education
- Supported Work
- Other

Indirect

- Own Indirect- lost productivity and lower wages
- Not Own Indirect - lost productivity and lower wages of others (typically family)

Cost Savings to State and Local Governments

The Ganz study is probably the most comprehensive in terms of assessing the breadth of the financial costs associated with caring for individuals with ASD. Several other studies have attempted more limited quantifications of costs and savings to governments associated with providing early intensive behavioral interventions (EIBI) or ABA programs for young children. In summary, the studies quantify the costs of EIBI, assume success rates associated with EIBI based on efficacy studies, and then assume cost savings to educational and other government financed programs like Medicaid associated with these treatments.

Virginia's independent Joint Legislative Audit and Review Commission (JLARC) issued a report in August 2009: *Report of the Joint Legislative Audit and Review Commission To the Governor and The General Assembly of Virginia - Assessment of Services For Virginians With Autism Spectrum Disorders.* As part of this report, JLARC reviewed several studies related to the efficacy of EIBI, and potential cost savings to State and Local governments associated with effective EIBI treatments. The JLARC report outlines their assessment of the cost savings associated with EIBI as follows[21]:

> *"A study published in a national journal found that Pennsylvania could save an average of $187,000 to $203,000 on each child who received three years of EIBI relative to one who received special education services until age 22. The Pennsylvania study also suggested that cost savings would likely continue to accrue after children exit the school system. The study found that the state could save from $656,000 to $1.1 million per child if expenditures up to age 55 are included. Another study published in a national journal found that Texas could save an average of $208,500 in education costs for each student who received three years of EIBI relative to a student who received 18 years of special education from ages four to 22. Applied to the estimated 10,000 children with ASDs in Texas, it was estimated that the state could save almost $2.1 billion by implementing intensive treatment programs.*
>
> *By applying the methodology used in the Pennsylvania and Texas studies to Virginia-related data, JLARC staff estimate that the Commonwealth could save approximately $137,400 in special education costs per student with an ASD if EIBI was consistently provided. In fact, the analysis*

[21] *Report of the Joint Legislative Audit and Review Commission To the Governor and The General Assembly of Virginia - Assessment of Services For Virginians With Autism Spectrum Disorders*, p. 15. http://jlarc.virginia.gov/reports/Rpt388.pdf. Accessed December 2009.

indicates that Virginia could realize savings as long as at least 42 percent of students with ASDs who received EIBI make moderate improvements (require less intensive services and fewer supports), which is a substantially more conservative outcome than the outcomes reported in the research literature."

The actual success rates of EIBI treatments will drive the benefits derived from these treatments. Also, as noted in the JLARC report, moderate improvements in functioning could also lead to significant financial savings. The JLARC report also discusses various studies of the efficacy of EIBI and Table 3 on page 15 of the report summarizes the findings on the efficacy of EIBI of three research studies. This table is reproduced below:

Table 3: Multiple Studies Demonstrate Children Who Receive Intensive Treatment Fare Better Than Those Who Receive Less Intensive Services

	Outcomes	
Group	Average Change in IQ Points	Educational Placement
EIBI compared to less intensive public school special education (2006 study)		
Treatment	+25	• 29% in general class without supports • 52% in general class with supports
Comparison	+14	• 5% in general class
EIBI compared to less intensive parent-training model (2000 study)		
Treatment	+16	• 27% in general class without supports
Comparison	-1	• No children in general class without supports
EIBI compared to less intensive treatment (1987 study)		
Treatment	• 47% achieved IQ in normal range (94-120)	• 47% in general class without supports • 42% in less intensive special education class for language delayed • 11% in intensive special education class for children with autism or intellectual disability (ID)
Comparison	• 2% achieved IQ in normal range	• 2% in general class without supports • 45% in less intensive special education class for language delayed • 53% in intensive special education class for children with autism or ID

Note: A more detailed table on the results of these studies can be found in Appendix C.

We currently do not have Alaska specific data that would allow us to provide estimates of the potential educational and medical savings that could be achieved through EIBI. Under the assumption that the costs of ASD services and efficacy of EIBI are in line with those indicated in the studies noted, we would expect that the costs of ABA treatments covered under HB 187 could be recovered through reductions in educational and medical expenditures, alone. We would also expect that benefits associated with successful treatments would be realized in the areas noted in the beginning of this section through reducing other costs of care and improving the productivity of individuals with ASD and their caregivers, in addition to non-economic or quality of life benefits.

Appendices

Cost Assumptions – Illustrative Exhibits, and HB 187 Text

EXHIBIT I - SUMMARY OF HB 187 "MIDDLE" SCENARIO ASSUMPTIONS AND COSTS

State Alaska

Age Limits for Autism Benefits

Minimum	0
Maximum	20

Additional Annual Medical Costs for Non ABA Services

All Ages $ 3,150

Annual Limits by Covered Service

	Hours Limit	Max Hours	Dollar Limit	Max $s
ABA	No	-	Yes	$36,000

Key Assumptions:

United States Treated Prevalence

Diagnostic Subtype	Ultimate Prevalence	Average Age of Diagnosis
Autistic Disorder	1 in 450	3
PDD-NOS	1 in 300	3
Asperger's	1 in 900	6
All ASD	**1 in 150**	

Alaska Treated Prevalence

Diagnostic Subtype	Ultimate Prevalence	Average Age of Diagnosis
Autistic Disorder	1 in 450	3
PDD-NOS	1 in 300	3
Asperger's	1 in 900	6
All ASD	**1 in 150**	

% of Diagnosed Children w/ ABA

Under 6	50.0%
6	37.5%
7	25.0%
8	16.7%
9	11.1%
10	7.4%
11	4.9%
12	3.3%
13 to 21	2.5%

Average ABA Program Hours

Ages Under 8	1,500
Ages 8 to 12	671
Ages 13 to 21	401

Average cost of ABA Program: $30,000

Market	Coverage Estimates: Number of Persons Covered	Premium (Per Person)	Total Premium	Costs Excluding Administrative Expense: Costs	Costs (% of Premium)	Cost (Per Covered Person)	Premium Increase including Admin @ 15%: Incremental Premium	Premium Increase %	Annual Increase per Covered Person
Individual	26,000	$ 2,700	$ 70,200,000	$ 356,200	0.51%	$ 13.70	$ 419,000	0.60%	$ 16.10
Small Group	47,000	4,700	220,900,000	643,900	0.29%	13.70	756,000	0.34%	16.10
Large Group	59,000	$ 4,300	$ 253,700,000	$ 808,300	0.32%	$ 13.70	$ 951,000	0.37%	$ 16.10
Total	132,000	$ 4,128	$ 544,836,000	$ 1,808,400	0.33%	$ 13.70	$ 2,126,000	0.39%	$ 16.10

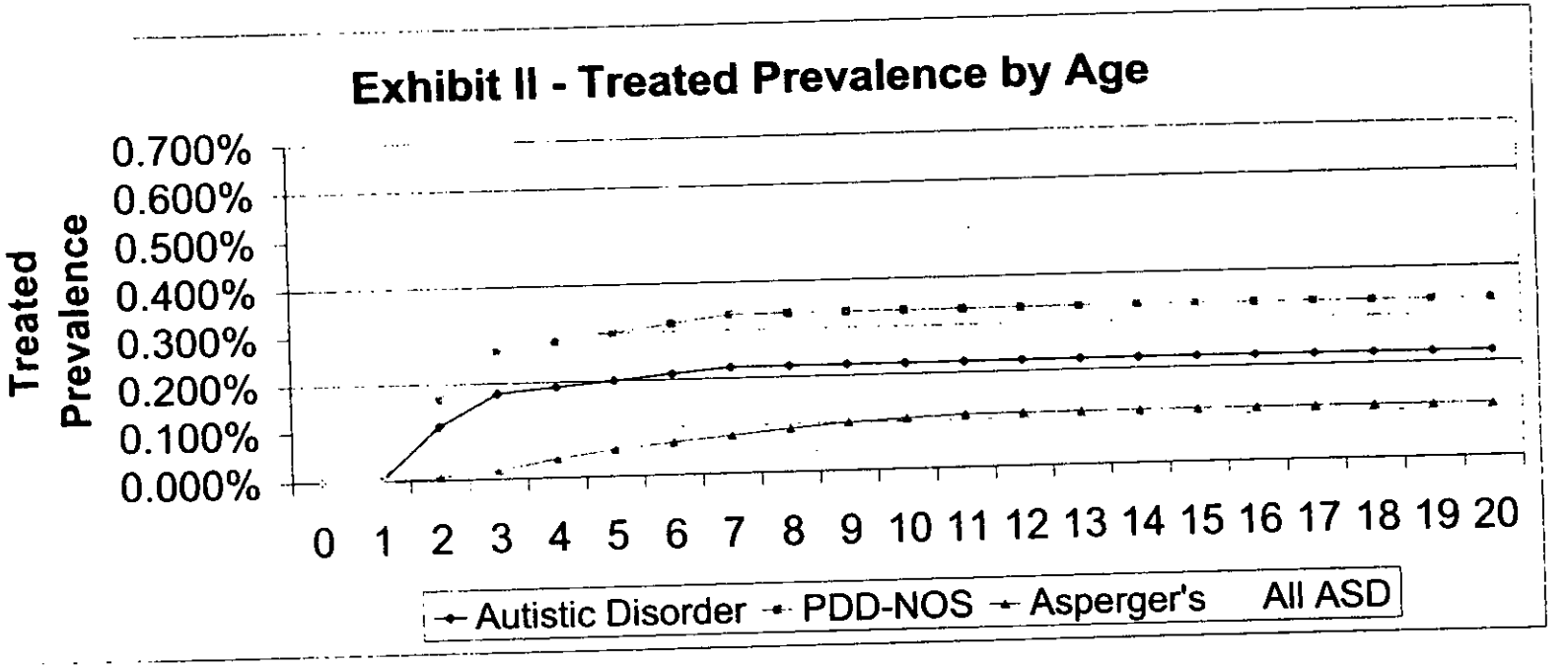
Exhibit II - Treated Prevalence by Age
Treated Prevalence
0.700%
0.600%
0.500%
0.400%
0.300%
0.200%
0.100%
0.000%
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Autistic Disorder
PDD-NOS
Asperger's
All ASD

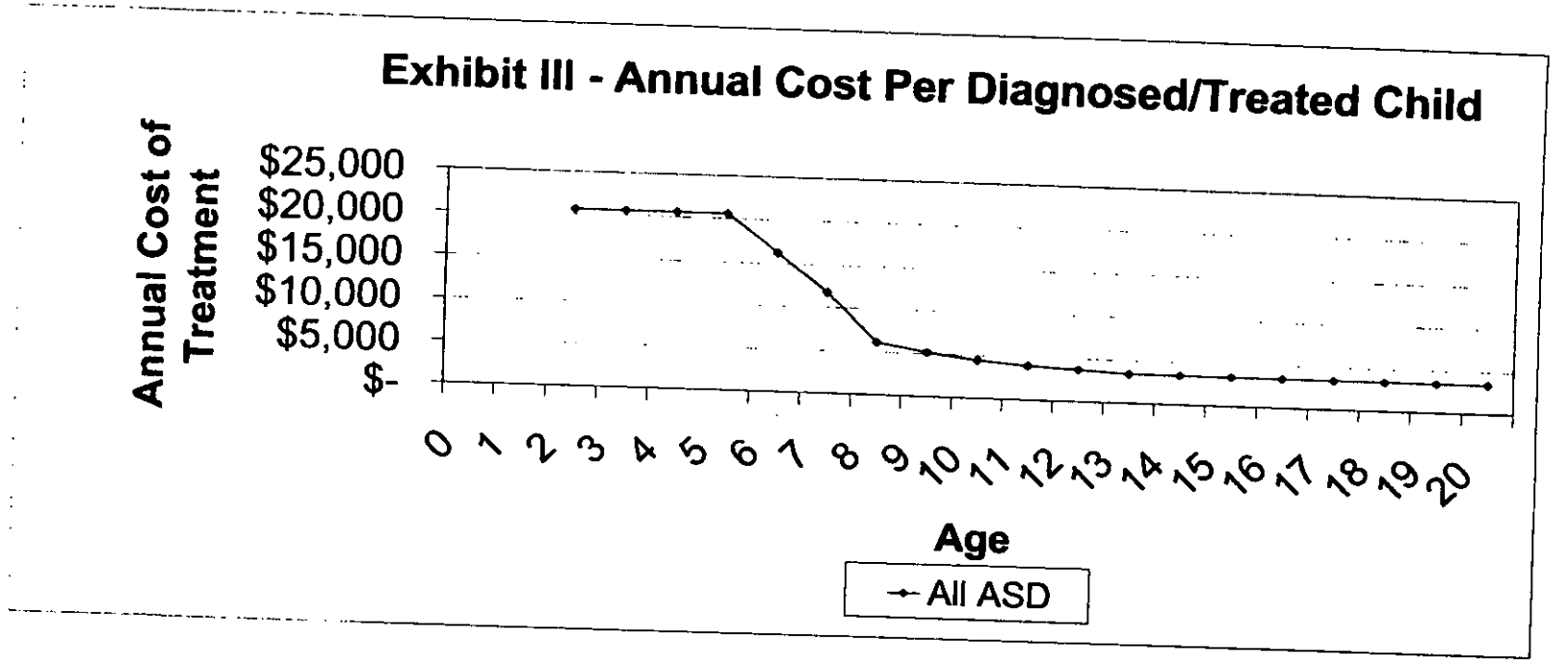
Exhibit III - Annual Cost Per Diagnosed/Treated Child
Annual Cost of Treatment
$25,000
$20,000
$15,000
$10,000
$5,000
$-
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Age
All ASD

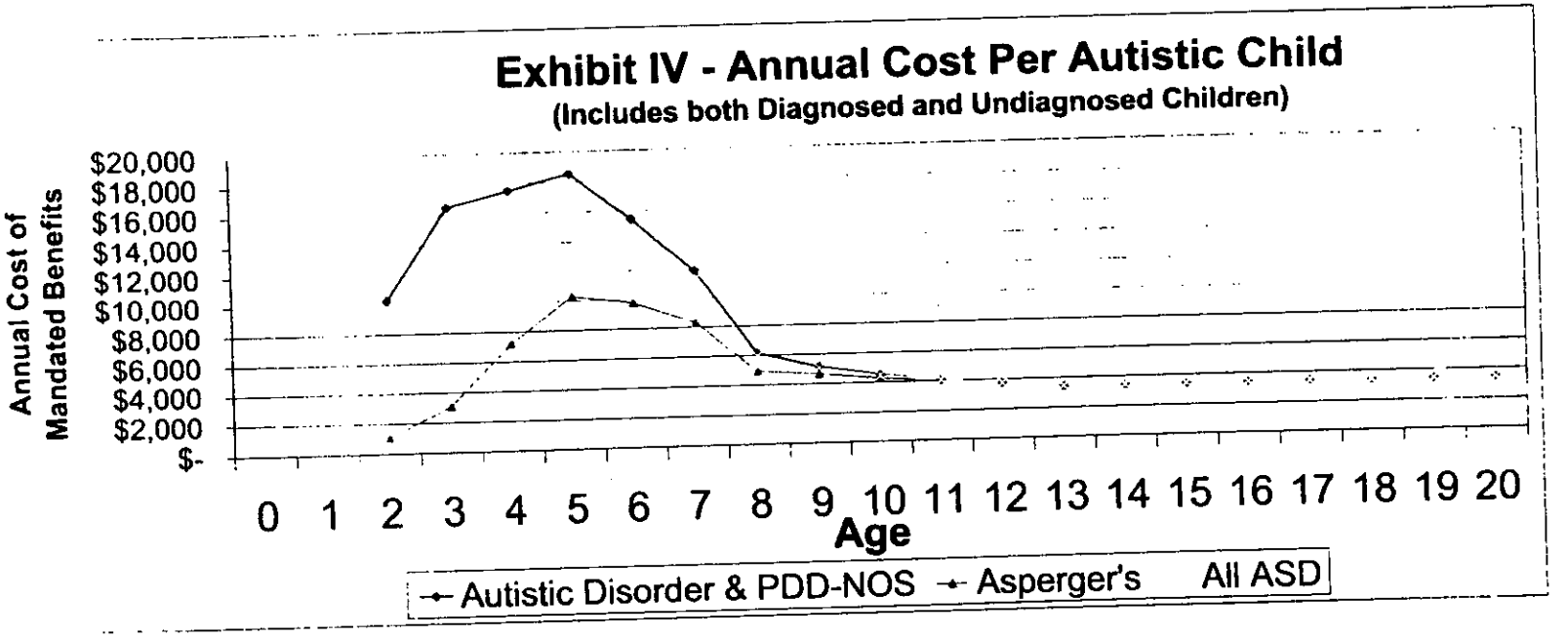
Exhibit IV - Annual Cost Per Autistic Child
(Includes both Diagnosed and Undiagnosed Children)
Annual Cost of Mandated Benefits
$20,000
$18,000
$16,000
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Age
Autistic Disorder & PDD-NOS
Asperger's
All ASD

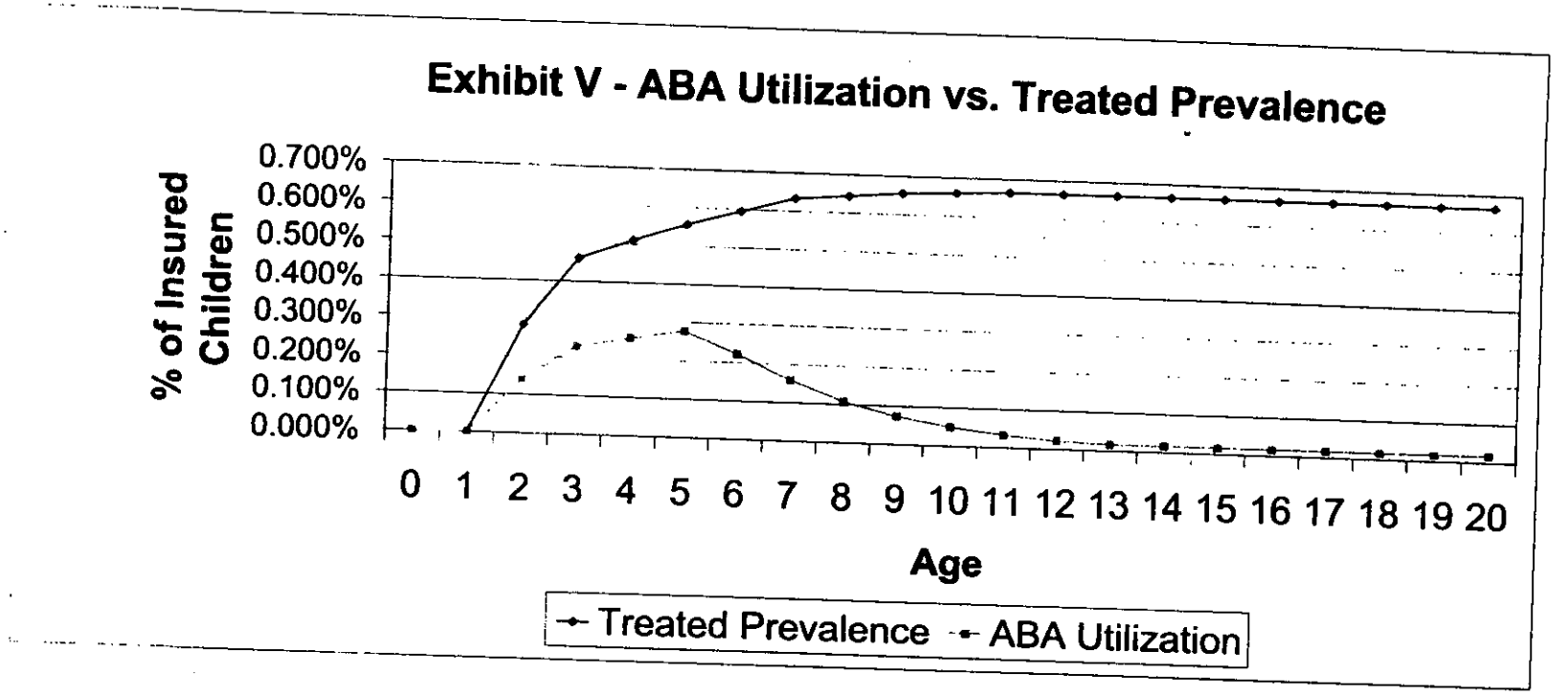
Exhibit V - ABA Utilization vs. Treated Prevalence
% of Insured Children
0.700%
0.600%
0.500%
0.400%
0.300%
0.200%
0.100%
0.000%
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Age
Treated Prevalence
ABA Utilization

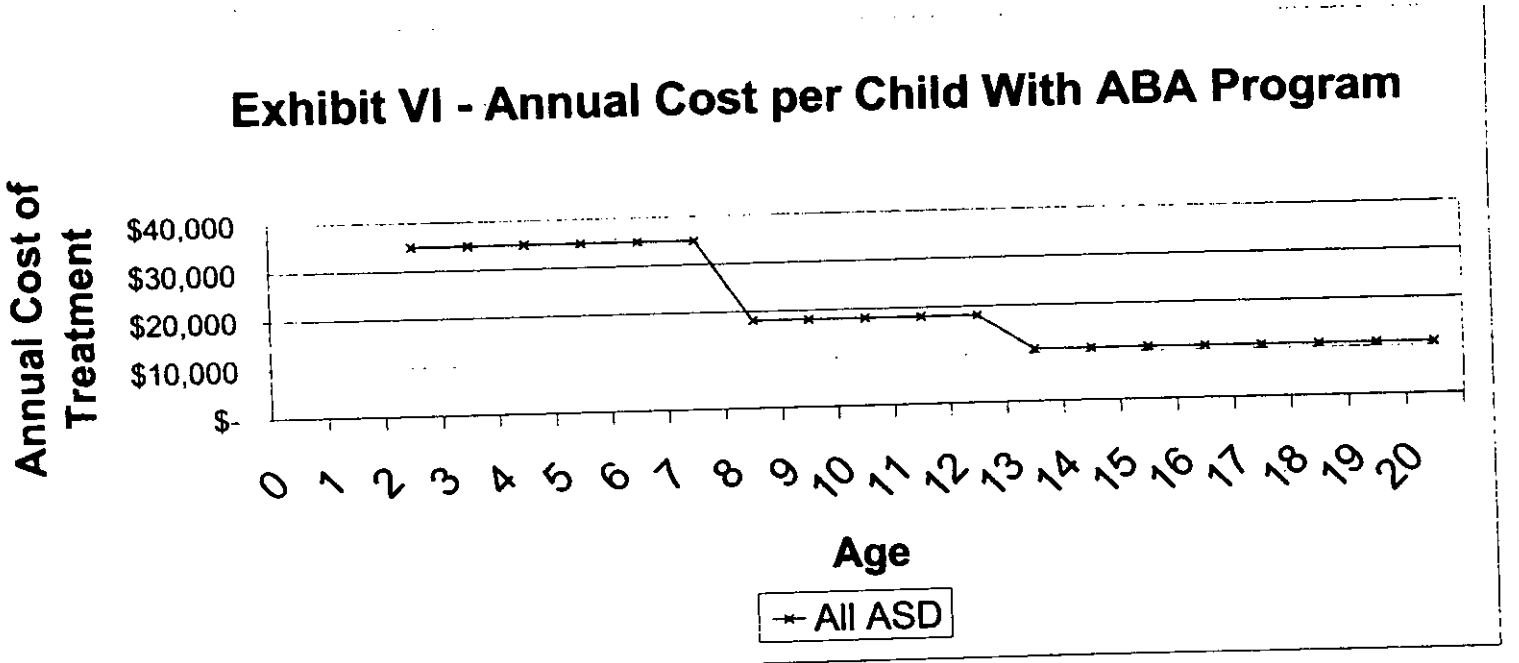
Exhibit VI - Annual Cost per Child With ABA Program
Annual Cost of Treatment
$40,000
$30,000
$20,000
$10,000
$-
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Age
All ASD

Autism Speaks

Arguments In Support of Private Insurance Coverage of Autism-Related Services

October 24, 2007

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Page 5	**About Autism**

Arguments in favor of a legislative mandate for coverage of autism:

Page 6	***Argument 1:*** **Mandated private health insurance coverage will provide services that are desperately needed by children with autism, who have greater health care needs than children without autism.**
Page 7	***Argument 2:*** **Treatments for autism are difficult to access, often inadequate, and frequently delayed. Denied coverage by private group health insurance companies, parents are often forced either to pay out-of-pocket or forego the treatments their children need.**
Page 10	***Argument 3:*** **Mandated private insurance coverage will bring effective autism services within the reach of children who need them. The efficacy of Applied Behavior Analysis (ABA), the centerpiece of this legislative mandate's benefits, has been established repeatedly.**
Page 12	***Argument 4:*** **Government and scientific organizations have endorsed Applied Behavior Analysis (ABA) and other structured behavioral therapies.**
Page 14	***Argument 5:*** **To combat the difficulty many families face in accessing Applied Behavior Analysis (ABA) and other structured behavioral treatments through public insurance, three states have passed autism insurance mandates that specifically require private insurance companies to provide coverage of these therapies, thus creating a public-private partnership for the provision of care.**
Page 16	***Argument 6:*** **The costs of this insurance reform are small and will have very little impact on the cost of health insurance premiums for the individual consumer.**

Page 17	***Argument 7:*** **By improving outcomes for children with autism, mandated private insurance coverage will decrease the lifetime costs of treating and providing services and will actually result in an overall cost savings in the long-run.**
Page 19	***Argument 8:*** **Without passage of legislation requiring private health insurance coverage for autism, the costs associated with autism will continue not only to affect families, but will have far reaching social effects as well.**
Page 21	**Conclusion**
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Executive Summary

Autism is a complex neurobiological disorder and is the fastest-growing serious developmental disability in the U.S. The Centers for Disease Control estimates that 1 in 150 children have autism. These children require extensive services from medical professionals. Early intervention is critical to gain maximum benefit from existing therapies. Most private health insurance plans do not provide coverage for Applied Behavioral Analysis (ABA) and other autism-related services. AK?

This document contains eight arguments in favor of requiring private health insurance policies to cover the diagnosis and treatment of autism spectrum disorders for individuals under the age of 21. These arguments are based on epidemiological, social, and economic studies of the children and families affected by autism and prove the significant long-term financial and public health benefits of this requirement.

We first point out that children with autism have substantial medical needs and have a difficult time accessing necessary treatments through Medicaid and private health insurance. Most insurance policies contain specific exclusions for autism. This is a hardship for many families, who are often forced to cope with delayed, inadequate, and fragmented care through the Medicaid system. Often, families must pay for costly treatments out-of pocket or forego them.

We then review some of the many studies and reports that document the effectiveness of intensive behavioral therapies in the treatment of autism. An autism insurance mandate should specifically target coverage of Applied Behavior Analysis (ABA) and other structured behavioral therapies, which are the most effective forms of treatment and have the best outcomes, both in human costs and in long-term economic benefits.

We then comment on the experiences of several states with insurance reform. Their experiences show that the policy holder costs resulting from the passage of legislation requiring comprehensive autism services have been relatively small.

Finally, we point out that the mandate offers hope that children with autism will need less intensive care in the future. They will, in short, have a better chance at a normal life.

What is Autism Speaks?

Autism Speaks is an organization dedicated to increasing awareness of autism spectrum disorders, to funding research into the causes, prevention, treatments, and cure for autism, and to advocating for the needs of affected families. The organization was founded in February 2005 by Suzanne and Bob Wright, the grandparents of a child with autism. Bob Wright is Vice Chairman, General Electric, and served as chief executive officer of NBC for more than twenty years. Autism Speaks has merged with both the National Alliance for Autism Research (NAAR) and Cure Autism Now (CAN), bringing together the nation's three leading autism advocacy organizations.

What is Autism?

Autism is a complex neurobiological disorder that typically lasts throughout a person's lifetime. It is part of a group of disorders known as autism spectrum disorders (ASD). Today, 1 in 150 individuals is diagnosed with ASD, making it more common than pediatric cancer, diabetes, and AIDS combined. It occurs in all racial, ethnic, and social groups and is four times more likely to strike boys than girls. Autism impairs a person's ability to communicate and relate to others. It is also associated with rigid routines and repetitive behaviors, such as obsessively arranging objects or following very specific routines. Symptoms can range from very mild to quite severe.

***Argument 1*: Mandated private health insurance coverage will provide services that are desperately needed by children with autism, who have greater health care needs than children without autism.**

Children with autism have a tremendous need for services from trained medical professionals. These children are at risk for a range of other medical conditions, including behavioral or conduct problems, attention-deficit disorder or attention-deficit/hyperactivity disorder, stuttering, stammering, and other speech problems, depression and anxiety problems, bone, joint, or muscle problems, ear infections, hearing and vision problems, allergies (especially food allergies), and frequent and severe headaches. These problems greatly affect their overall health and their need for and use of health care services.

A recent study by James G. Guerney and others[1] highlights the broad medical needs of children with autism. Using data from the National Survey of Children's Health, Guerney showed that relative to children without autism, children with autism require more services for physical, occupational, and speech therapy. Children with autism are also much more likely to have poor health, to require medically necessary care for behavioral problems, and to be using medications. As evidenced in the chart below taken from the study, parents of children with autism were more likely to report the presence of a variety of concurrent medical conditions and the need for more visits to a range of medical service providers than parents of children without autism.

Table 2. Parental Description of Health Status and Therapy and Services Use, From the National Survey of Children's Health

Variable	Children With Autism (n = 224 000)*	Children Without Autism (n = 61 100 000)*	OR (95% CI)†
Would you say your child's health is			
Excellent	33.7	60.2	1.0
Very good	22.8	23.5	1.8 (1.2-2.7)
Good	32.7	12.9	5.9 (3.9-9.1)
Fair	7.4	2.9	7.7 (4.2-13.8)
Poor	2.5	0.4	24.1 (9.2-47.0)
Does the child use more medical care, mental health or educational services than is usual for most children of the same age?	69.6	11.9	12.8 (24.7-60.4)
Is the child limited or prevented in the ability to do the things most children the same age can do?	48.5	5.7	35.2 (24.0-52.6)
Does the child get special therapy, such as physical, occupational, or speech therapy?	76.0	6.3	44.4 (31.0-61.9)
Does the child have any emotional, developmental, or behavioral problem for which she needs treatment or counseling?	75.4	7.0	36.0 (25.7-53.1)
Does the child currently need or use medicine prescribed by a doctor, other than vitamins?	54.7	21.1	3.5 (2.6-4.7)
If yes, is this for a condition expected to last 12 mo or longer?	51.4	14.5	11.0 (1.6-76.0)

Abbreviations: CI, confidence interval; OR, odds ratio.

*Data are given as the percentage of each group and are based on sampling fractions and weighted extrapolation from parent report of 485 children with autism and 64 785 children without autism.

†Data are adjusted for sex, primary language, age, insurance, and household educational attainment.

This reform of private health insurance coverage will address the broad medical needs of children with autism. It will ensure that these children will receive the full range of therapies necessary to ameliorate their condition.

***Argument 2*: Treatments for autism are difficult to access, often inadequate, and frequently delayed. Denied coverage by private group health insurance companies, parents are often forced either to pay out-of-pocket or forego the treatments their children need.**

Children with autism face barriers in accessing early intensive behavioral treatments and other therapies. According to the Institute of Medicine, the term "access" is defined as "the timely use of personal health services to achieve the best possible health outcomes."[2] For a child with autism, lack of access to services can be the cause of inconsistent and uncoordinated care. Children with autism often experience barriers to access with even greater frequency than children with other special health care needs. In fact, one study found that "over one-third of the children with autism were reported to have experienced an access problem with respect to specialty care from a medical doctor in the preceding 12 months." [3] A study of the Tennessee Medicaid system, TennCare, found that for children with autism, "the rate of service use was only one tenth what should be expected based on prevalence rates." The chart below illustrates these results and the significantly lower rates of service access for children with autism.

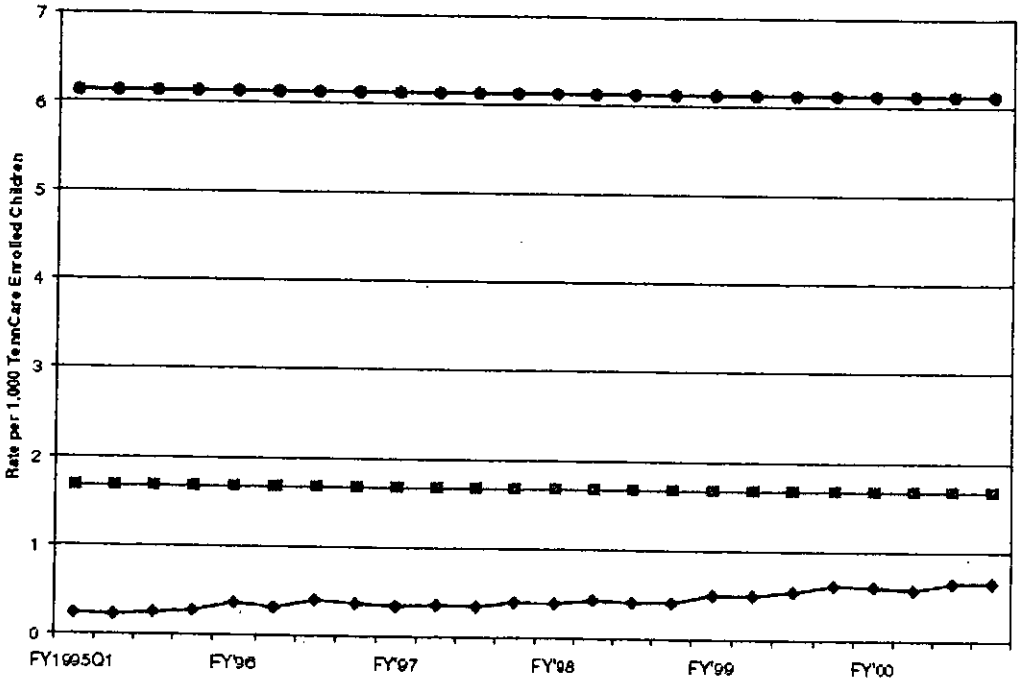

Fig. 1. Estimated incidence rates vs. service rates of autism spectrum disorders (ASDs) in TennCare for children ages 0-17 years, by quarter.

Within the Medicaid system, the amount of public money spent for services for developmental disabilities including autism is now eight times the rate of spending just a few decades ago.[4] Medicaid accounts for 75% of all funding for services for the developmentally disabled, making it the largest single public payer of behavioral health services.[5] Children with disabilities comprise a significant portion (15%) of all Medicaid recipients, and an even more significant portion (31%) of disabled children use the Medicaid system as their primary insurer.

Medicaid suffers from very low reimbursement rates that make it difficult for many locations to retain service providers. Moreover, services that can be accessed through the Medicaid system are often inadequate at meeting the specific needs of a child with autism. The system operates as a short-term service provider, tending to push children through treatment as quickly as possible. The success of the Applied Behavior Analysis, however, depends in part, on the amount of time the child with autism spends with the provider of the therapy.[6]

The failings of Medicaid point to the importance of the private health care system in providing services to children with autism. But nationwide there are very few private insurance companies or other employee benefit plans that cover Applied Behavior Analysis and other behavioral therapies. Most insurance companies designate autism as a diagnostic exclusion, "meaning that any services rendered explicitly for the treatment of autism are not covered by the plan, even if those services would be covered if used to treat a different condition."[7] A 2002 study by Pamela B. Peele and others of 128 behavioral health plans administered by one of two large managed behavioral health organizations found that all the plans had some type of limit on benefits for behavioral therapies – over half of the plans had limits on the number of annual outpatient sessions and 65 percent of the plans imposed limits on the number of inpatient days covered per year. [8]

Families that refuse to allow their children to suffer through the inadequate Medicaid system and are denied coverage by their private health insurance carriers often end up paying for therapies out of their own pockets. For these families, the financial burden is immense. Without the negotiating powers of an insurance company behind them, out-of-pocket prices are extremely high. Parents can often spend upwards of $50,000 per year on autism-related therapies, often being forced to wager their own futures and the futures of their non-autistic children to pay for necessary autism-related therapies. Children whose parents cannot afford to pay for behavioral and other therapies and who cannot access adequate therapies through the Medicaid system simply go without these interventions.

***Argument 3*: Mandated private insurance coverage will bring effective autism services within the reach of the children who need them. The efficacy of Applied Behavior Analysis (ABA), the centerpiece of this legislative mandate's benefits, has been established repeatedly.**

Private health insurance coverage of autism services will allow children with autism to access Applied Behavior Analysis (ABA), a proven treatment for their condition. Several studies have shown that as many as 47 percent of the children that undergo early intensive behavioral therapies achieve higher education placement and increased IQ levels. A significant portion of children who receive ABA are placed into mainstream educational settings. Children who begin their treatment with minimal IQ levels end treatment with substantially higher levels of intellectual functioning. These results have been shown to last well beyond the end of treatment. As such, the effectiveness of ABA therapy has allowed many children to forego costly intensive special education in the future.

Lovaas:

The most famous study of the effectiveness of behavioral modification treatments was conducted in 1987 by O. Ivar Lovaas.[9] Lovaas's study showed that when compared with other treatment programs that provide minimal therapy, Applied Behavior Analysis is extremely effective in helping many children struggling with autism, providing gained capacity for intellectual functioning and allowing a child to progress educationally.

Lovaas conducted his study of the effectiveness of behavioral modification treatments on very young children affected by autism. For his study, Lovaas split his 38 subjects into two groups: 19 subjects were put into an intensive-treatment experimental group that received more than 40 hours of one-to-one treatment per week, and 19 subjects were place in a minimal-treatment control group that received 10 hours or less of one-to-one treatment per week. Both groups were identical at intake in terms of intellectual functioning abilities, and both received their assigned treatment for 2 or more years.

Upon follow-up at age 7, the experimental group attained significantly higher results on education placement and IQ levels than the control group. According to the results of Lovaas's study, the 19-subject experimental group showed nine children (47%) who successfully passed through normal first grade in a public school and obtained an average or above average score on IQ tests.

McEachin:

Lovaas's landmark 1987 study was followed in 1993 by another study of these same 38 subjects. The objective of John J. McEachin's study was to discover the long-term effects of Lovaas's early intensive behavioral treatment and to find out if the results of the experimental group were preserved over time.[10]

For this study, Lovaas's original subjects were evaluated at a mean age of eleven-and-a-half years. The study was presented in two parts: the first examined whether the experimental group had maintained its treatment gains, the second part focused on the nine subjects who had achieved the greatest gain in the original study and examined the extent to which they "could be considered free of autistic symptomology."

McEachin's follow-up resulted in findings in three different categories: school placement, intellectual functioning, and presence of adaptive and maladaptive behaviors. In terms of class placement, the study found that "the proportion of experimental subjects in regular classes did not change from the age 7 evaluation (9 of 19, or 47%). In the control group, none of the 19 children were in a regular class, as had been true at the age 7 evaluation." (McEachin, *supra* note 10) In terms of intellectual functioning, the study found that "the experimental group at follow-up had a significantly higher mean IQ than did the control group... indicating that the experimental group had maintained its gains in intellectual functioning between age 7 and the time of the current evaluation." Finally, in terms of presence of adaptive and maladaptive behaviors, "the findings indicate that the experimental group showed more adaptive behaviors and fewer maladaptive behaviors than did the control group." (McEachin, *supra* note 10)

Based on these findings, the effectiveness of ABA and other structured behavioral programs, as provided by the proposed benefit, would be experienced in the short-term as well as the long-term.

Argument 4: **Government and scientific organizations have endorsed Applied Behavior Analysis (ABA) and other structured behavioral therapies.**

ABA is the treatment of choice for autism. Its efficacy has been recognized in a number of prominent reports, including the following:

- **The 2001 U.S. Surgeon General's Report on Mental Health**, which states, "Among the many methods available for treatment and education of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment. Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior." [11]

- **The New York State Department of Health** assessed interventions for children ages 0-3 with autism, and recommended that "behavioral interventions for reducing maladaptive behaviors be used for young children with autism when such behaviors interfere with the child's learning or socialization or present a hazard to the child or others." [12]

- **The Maine Administrators of Services for Children with Disabilities** notes in their report that "There is a wealth of validated and peer-reviewed studies supporting the efficacy of ABA methods to improve and sustain socially significant behaviors in every domain, in individuals with autism. Importantly, results reported include 'meaningful' outcomes such as increased social skills, communication skills academic performance, and overall cognitive functioning. These reflect clinically-significant quality of life improvements. While studies varied as to the magnitude of gains, all have demonstrated long term retention of gains made." [13]

- **The National Institute of Mental Health** reports, "The basic research done by Ivar Lovaas and his colleagues at the University of California, Los Angeles, calling for an intensive, one-on-one child-teacher interaction for 40 hours a week, laid a foundation for other educators and researchers in the search for further effective early interventions to help those with ASD attain their potential. The goal of behavioral management is to reinforce desirable behaviors and reduce undesirable ones." [14]

- **The National Institute of Child Health and Human Development** lists Applied Behavior Analysis among the recommended treatment methods for Autism Spectrum Disorders. [15]

- **The National Research Council's** 2001 report on Educating Children with Autism acknowledged, "There is now a large body of empirical support for more contemporary behavioral approaches using naturalistic teaching methods that demonstrate efficacy for teaching not only speech and language, but also communication." [16]

- **The Association for Science in Autism Treatment** recommends ABA-based therapies, stating, "ABA is an effective intervention for many individuals with autism spectrum disorders." [17]

Argument 5: **To combat the difficulty many families face in accessing Applied Behavior Analysis (ABA) and other structured behavioral treatments through public insurance, three states have passed autism insurance mandates that specifically require private insurance companies to provide coverage of these therapies, thus creating a public-private partnership for the provision of care.**

While there are several states that have passed autism specific private insurance mandates, very few states specifically mandate coverage for ABA and other structured behavioral therapy programs. Without coverage of these crucial, medically necessary, evidence based therapies, the effectiveness of most mandates is severely diminished. For this reason, we have concluded that only the following states have passed autism insurance legislation:

South Carolina:

Senate Bill 20, better known as Ryan's Law, was passed by both the South Carolina House of Representatives and Senate on May 31, 2007. [18] The bill was then vetoed by Governor Mark Sanford on June 6. On June 7, the bill was brought back to the House and Senate floors, and unanimous votes in both chambers overrode the Governor's veto. This law goes into effect in July 2008.

Coverage Includes: Treatments, including behavioral therapies, which are prescribed by the individual's treating medical doctor in accordance with a treatment plan.

Age Range: An individual must be diagnosed with autistic spectrum disorder at age eight or younger. The coverage must be provided to any eligible person less than sixteen years of age.

Dollar Cap: Coverage for behavioral therapy is subject to a $50,000 maximum benefit per year.

Texas:

On June 15, 2007, Texas enacted House Bill 1919, effective September 1, 2007. [19] While the Texas bill limits the ages for children who can benefit from coverage, it goes further than some other states in spelling out exactly what kinds of services are covered. The bill's text specifically cites which kinds of autism-related services are examples of treatments that must be covered.

Coverage Includes: Evaluation and assessment services, A BA, behavior training and behavior management, speech therapy, occupational therapy, physical therapy, medication or nutritional supplements used to address symptoms of autism spectrum disorder.

Age Range: An individual must be between ages three and five to receive this

coverage.

Dollar Cap: Same as afforded to physical illnesses

Indiana:

In 2001, the Indiana enacted House Bill 1122, requiring insurers that issue accident and sickness insurance policies on an individual basis to provide coverage for the treatment of autism spectrum disorders. [20]

Coverage Includes: Treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. The statute thus allows many different professionally accepted therapies, such as ABA, speech therapy, occupational therapy, physical therapy, and medications to address symptoms of autism.

Age Range: All ages are allowed coverage

Dollar Cap: Same as afforded to physical illnesses

Argument 6: **The costs of the proposed benefit are small and will have very little impact on the cost of health insurance premiums for the individual consumer.**

Earlier this year, The Council for Affordable Health Insurance, a research and advocacy association of insurance carriers, released its annual report on state health insurance mandates, *Health Insurance Mandates in the States 2007.* [21] The report defined a mandate as "a requirement that an insurance company or health plan cover (or offer coverage for) common – but sometimes not so common – health care providers, benefits and patient populations." (Bunce, *supra* note 21) Using this definition, the report identified legislative mandates for autism benefits in ten states: Colorado, Delaware, Georgia, Iowa, Indiana (which, as we have noted, provides comprehensive benefits), Kentucky, Maryland, New Jersey, New York, and Tennessee. The report assessed the incremental cost of state mandated benefits for autism in these ten states *as less than one percent.*

The Council's modest estimate of incremental premium costs is consistent with state government estimates across the country. Prior to enactment of Indiana's sweeping legislation, the Indiana Legislative Services Agency estimated additional premium costs as ranging from $.44 per contract per month to $1.67 per contract per month. [22] In vetoing Ryan's Law in South Carolina, Governor Mark Sanford estimated that the bill, with its $50,000 maximum yearly benefit for behavioral therapy, would add $48 annually to insurance policies.[23] And in Wisconsin, where pending Assembly Bill 417 would provide the same broad coverage Indiana's statute mandates, the Department of Administration estimates policy increments of between $3.45 and $4.10 per month – about the same as Governor Sanford's estimate for Ryan's Law. [24]

The cost estimates for Indiana, South Carolina, and Wisconsin – all states whose legislation allows a maximum benefit that can be considered high – suggest that an average autism insurance coverage mandate will cost approximately $50 annually per policy holder. For only a modest effect on premium cost, this insurance reform holds the promise of significantly improving the lives of thousands of children.

Argument 7: **By improving outcomes for children with autism, mandated private insurance coverage will decrease the lifetime costs of treating and providing services and will actually result in an overall cost savings in the long-run.**

A 1998 study by John W. Jacobson and others titled, *Cost-Benefit Estimates for Early Intensive Behavioral Intervention for Young Children with Autism – General Model and Single State Case,* examined the cost/benefit relationship of early intensive behavioral intervention treatment at varying levels of treatment success.[25] The study used estimates of costs for early intensive behavioral interventions (EIBI) from childhood (age three) through adulthood (age 55) based on prices in the Commonwealth of Pennsylvania and compared these costs with the expected amount of income the child would earn later in life to arrive at an estimated cost savings.

With a success rate of 47 percent for early intensive behavioral intervention therapy (as determined by Lovaas), Jacobson's study found that cost savings per child served are estimated to be from $2,439,710 to $2,816,535 to age 55.

Table 6. Financial benefits at different levels of effectiveness, age 3–55 years, per 100 children served and per child served – Pennsylvania model

	Inflated total	*1996 $ total*	*Inflated: student*	*1996 $, student*
At 20% normal range				
20 norm range vs. partial effect	96,085,200	36,654,400	4,804,260	1,832,720
70 partial vs. minimal effect	72,520,910	28,984,130	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	168,606,110	65,638,530	1,686,061	656,385
At 30% normal range				
30 norm range vs. partial effect	144,127,800	54,981,600	4,804,260	1,832,720
60 partial vs minimal effect	62,160,780	24,843,540	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	206,288,580	79,825,140	2,062,886	798,251
At 40% normal range				
40 norm range vs. partial effect	192,170,400	73,308,800	4,804,260	1,832,720
50 partial vs. minimal effect	51,800,650	20,702,950	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	243,971,050	94,011,750	2,439,710	940,118
At 50% normal range				
50 norm range vs. partial effect	240,213,000	91,636,000	4,804,260	1,832,720
40 partial vs. minimal effect	41,440,520	16,562,360	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	281,653,520	108,198,360	2,816,535	1,081,984

Note: This table presents a comparison of financial benefits at different levels or rates of achievement of normal skills or functioning achieved by EIBI, for people ages 3–55 years, ranging from 20% of children achieving normal range skills or functioning (an assumed minimal rate) to 50% of children. At each level of effectiveness, differing rates of normal range functioning, as well as partial benefit are estimated. Costs are shown in terms of the aggregate of 100 children served, and averages per person served, with inflation and in 1996 dollars.

The study also accounts for the initial investment in early intervention by concluding that, with an initial annual cost of $32,820, the total cost-benefit savings of EIBI services per

child with autism or PDD for ages 3-55 years averages from $1,686,061 to $2,816,535 with inflation.

According to a 2005 Government Accounting Office (GAO) report, "the average per pupil expenditure for educating a child with autism was more than $18,000 in the 1999-2000 school year. This amount was almost three times the average per pupil expenditure of educating a child who does not receive any special education services."[26] With this insurance reform in place, more children would be able to access the early intervention services they need. That investment will, in the long run pay benefits, both economic and social, to the greater population.

Argument 8: **Without passage of legislation requiring private health insurance coverage for autism, the costs associated with autism will continue not only to affect families, but will have far reaching social effects as well.**

The cost of autism is borne by everyone. Michael L. Ganz's study of the societal costs of autism, *The Lifetime Distribution of the Incremental Societal Costs of Autism*, examined how the large financial burdens of autism affect not only families with an autistic child but society in general. [27]

Ganz broke down the costs associated with autism into two distinct categories, direct costs and indirect costs. Direct costs include direct medical costs, such as physician, outpatient, clinic services, dental care, prescription medications, complementary and alternative therapies, behavioral therapies, hospital and emergency services, allied health, equipment and supplies, home health, and medically related travel, as well as direct nonmedical costs, such as child care, adult care, respite and family care, home and care modification, special education, and supported employment. Indirect costs include productivity losses for people with autism (calculated by combining standard average work-life expectancies for all men and women with average income and benefits and estimated age and sex specific labor force participation rates).

According to Ganz's study, direct medical costs reach their maximum during the first five years of life, averaging around $35,000. As the child ages, direct medical costs begin to decline substantially and continue to decline through the end of life to around $1,000. Ganz goes on to report, "The large direct medical costs early in life are driven primarily by behavioral therapies that cost around $32,000 during the first 5-year age group and decline from about $4,000 in the 8-to 12-year age group to around $1,250 for the 18- to 22-year age group." (Ganz, *supra* note 27)

In terms of direct medical costs "the typical American spends about $317,000 over his or her lifetime in direct medical costs, incurring 60% of those costs after the age of 65 years. In contrast, people with autism incur about $306,000 in incremental direct medical costs, which suggests that people with autism spend twice as much as the typical American over their lifetimes and spend 60% of those incremental direct medical costs after age 21 years." (Ganz, *supra* note 27)[27]

The study also found the indirect costs of autism to be significant as well. While in the first 22 years of life, indirect costs are mostly associated with lost productivity for the parents of a child with autism, the costs from age 23 on are associated with lost productivity of the actual individual with autism as depicted in the chart below taken from the study. The impact of this lost productivity can have enormous ramifications for the tax base of an entire society and the future of the older generation as their children with autism transition into adult care.

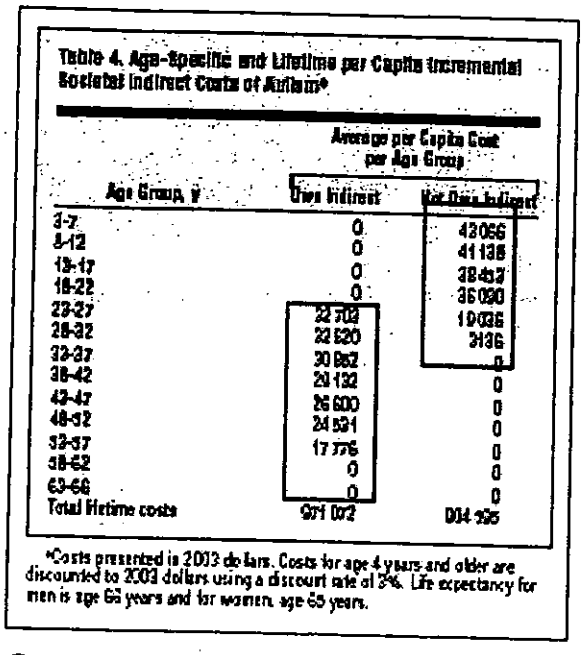

Table 4. Age-Specific and Lifetime per Capita Incremental Societal Indirect Costs of Autism*

Age Group, y	Average per Capita Cost per Age Group	
	Uses Indirect	Not Uses Indirect
3-7	0	43066
8-12	0	41138
13-17	0	38452
18-22	0	36090
23-27	22 703	19036
28-32	22 520	3136
33-37	30 962	0
38-42	29 132	0
43-47	26 600	0
48-52	24 531	0
53-57	17 776	0
58-62	0	0
63-66	0	0
Total lifetime costs	971 092	914 925

*Costs presented in 2003 dollars. Costs for age 4 years and older are discounted to 2003 dollars using a discount rate of 3%. Life expectancy for men is age 68 years and for women, age 65 years.

Ganz posited that direct medical costs "combined with very limited to non-existent income for their adult children with autism combined with potentially lower levels of savings because of decreased income and benefits while employed, may create a large financial burden affecting not only those families but potentially society in general."(Ganz, *supra* note 27)

Without the help of private insurance coverage, families affected by autism may never be able to pull their heads above water and provide their children with the medically necessary, evidence- based treatments that they need. It is to the advantage of these families, to the 1 in 150 children affected by autism, and to all of society that private health insurance coverage is provided for these services.

Conclusion

A legislative mandate for coverage of autism asks private insurance companies to make a limited, but significant, contribution to help pay for medically necessary, evidence- based treatments that have been established to be of the greatest impact in fighting this terrible disorder.

Unbelievably, it is not uncommon for insurance carriers to have line- item exclusions for treatment of individuals diagnosed with autism. Across the nation, children with autism are routinely denied insurance benefits for treatment of their disorder. We believe that private insurance companies must contribute their fair share and partner in the financial burdens with these families.

With every new child diagnosed with autism costing an estimated $3 million over his or her lifetime, the current practices are both unfair and not cost effective in the long run for states and their citizens. Autism Speaks is confident that many more state governments will recognize the significant long-term cost benefits found in these legislative measures, will do what is right for their constituents, and will pass legislation requiring private health insurance coverage of autism services.

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15 March 2009

The Honorable Pete Petersen
Alaska State Capitol
Juneau, AK 99801

Letter of Endorsement -- HB 187

ASA strongly endorses Alaska House Bill 187 since this legislation offers clear and practical solutions that will enable Alaska families to have equal access to appropriate treatments and services that would be covered by private health insurance if it were not for the diagnosis of an autism spectrum disorder (ASD).

BACKGROUND

Autism is a complex neurodevelopmental disability that typically appears during the first two years of life and affects a person's ability to communicate and interact with others. ASA estimates the lifetime cost of care for an individual with autism at $3.5 to $4 million; with access to early diagnosis and intervention, these costs can be reduced by two-thirds. However, appropriate, effective and evidenced-based interventions are costly – upwards of $50,000 a year – and frequently not covered by private health insurance plans. Many families simply cannot afford to give their children the treatments that could help affected individuals reach their fullest potential and enjoy a happy and productive life.

Although there is no known "cure", autism is treatable. According to the American Academy of Pediatrics (AAP), "early diagnosis resulting in early, appropriate, and consistent intervention" is "associated with improved long-term outcomes."

Autism Spectrum Disorder (ASD) includes three diagnoses as defined in the *Diagnostic and Statistical Manual* (DSM IV) of the American Psychiatric Association:

1. Autism: Difficulty in the developmental areas of communication, socialization and repetitive/restricted interests and behaviors.
2. Asperger's Syndrome: Similar characteristics to autism but do not have a significant delay in language.

3. Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS): This term is used when an individual displays developmental deficits but does not meet diagnostic criteria for the other two ASD diagnoses.

ASD is now the number one childhood developmental disability with 1 of every 150 children in the US being diagnosed (CDC 2007). 26,670 children born in the US this year will eventually be diagnosed with ASD (CDC, 2007), making the diagnoses more common than all types of pediatric cancer, AIDS, and diabetes combined. According to the American Academy of Pediatrics, 44% of primary care physicians reported that at least ten of their patients have ASD.

Males are four (4) times more likely to be diagnosed than females; in contrast, females are more likely to be severely impacted by autism when a diagnosis exists. Females are also more likely than males to have a co-diagnosis of mental retardation (58.2% and 41.8%, respectively [CDC, 2007]). Younger siblings of children diagnosed with an ASD are 20 times more likely to be diagnosed, resulting in families with up to five children known to be on the autism spectrum in the US. A recent study highlights the fact that relative to children without autism, children with autism are much more likely to have poor health, to require medically necessary care for behavioral problems, and to be using medications.

Societal Impact of ASD

ASD results in annual societal costs of $35 billion per year, or over $60,000 per person per year, for services, education and other publicly funded supports. (Ganz, 2006) Over the lifespan, the average societal cost of caring for one person with autism is $3.2 million. (Harvard School of Public Health, 2006) Comprehensive intervention programs for preschool aged children with autism, including behavioral and speech therapies, may cost up to $50,000 per year. (New York Times 2006) Comprehensive intervention programs for young children, including behavioral therapies, may cost up to $100,000 per year.

Autism first became a special education classification under the Individuals with Disabilities Education Act (IDEA) in 1991. Between 1991 and 1999, the number of persons receiving special education services for autism increased 500% (CDC, 2007). In 2005, approximately 224,000 children were served under the autism classification in US schools. To describe the estimates of per pupil expenditures for educating children with autism, we reviewed data collected and analyzed by the Special Education Expenditure Project (SEEP). (GAO-05-220, Special Education Report to Congress 2005)

The average per pupil expenditure for educating a child with autism was estimated by SEEP to be over $18,000 in the 1999-2000 school year, the most recent year for which data were available. This estimate was nearly three times the expenditure for a typical regular education student who did not receive special education services and was among the highest per pupil expenditures for school-age children receiving special

education services in public schools. In contrast, the cost of a typical child's education was $5,000. (Senate Education Committee, 2006) Many, who are employed, tend to be underemployed in dead end or entry level positions. For the population with autism, the number of individuals unemployed has been estimated to be as high as 90% (New Jersey Autism Society). Without effective intervention, that means that of the 560,000 children currently living with autism, 504,000 may be unemployed in adulthood. This would obviously be a human tragedy.

Effective Treatment for ASD

Early Intervention

The CDC reports that "early identification and participation in intervention can improve the long term outcome for children with an ASD" (2007). The Harvard School of Public Health corroborates, writing that "improving behavioral and educational therapies for autistic children may not only lessen these costs but also improve quality of life" (Ganz, 2005).

The National Research Council report offered several key features of successful approaches to the education of children with autism, including early intervention soon after the diagnosis of autism, which can generally occur by the age of 3. The report also offered guidelines regarding educational objectives for children with autism, including the development of social skills and expressive and receptive language and communication skills. (GAO-05-220, Special Education Report to Congress 2005)

Despite the research supporting early intervention, the 2007 CDC study suggests a significant nationwide lag between the first sign of developmental delay and the receipt of an autism diagnosis and subsequent interventions, which may compromise children's potential progress, and increase their likelihood to require publicly funded supports over the lifetime. If such barriers can be eliminated, however, a child's prognosis improves dramatically. In many cases, by a certain age, children with an ASD diagnosis no longer require treatment, thereby reducing or eliminating associated costs to society.

Effective Therapeutic Interventions for ASD

While treatment plans for individuals with ASD are individually tailored to each person's unique needs according to the severity of their deficits and any co-occurring diagnoses, persons with ASD typically require a combination of medical, psychological, psychiatric, physical therapy (PT), occupational therapy (OT), speech therapy (ST), behavioral therapies (ABA) and other developmentally-based interventions. Individuals with ASDs should be engaged in functional and appropriate activities as much as possible. In 2001, the National Research Council Report recommended a minimum of 25 hours per week and the American Academy of Pediatrics recommends 20 hours or more of active engagement in evidence-based interventions. Behavioral therapy typically comprises the largest proportion of therapeutic hours, with children receiving between 10-35 hours per week in most cases. Other therapies, such as speech, PT, and OT, are generally

required for 1-2 hours per week per child. Michael L. Ganz's study of the societal costs of autism supports the fact that ASD treatment costs decline over time. According to Ganz, direct medical costs reach their maximum during the first five (5) years of life.

As the child ages, direct medical costs begin to decline substantially and continue to decline through the end of life. Ganz goes on to report, "The large direct medical costs early in life are driven primarily by behavioral therapies that cost [an average of] $32,000 during the first 5-year age group and decline from about $4,000 in the 8-to 12-year age group to around $1,250 for the 18- to 22-year age group."

Behavioral Therapy

Behavioral therapies for ASD are derived from behavioral science, which is the examination of human and animal behavior using the principles of science, including observation, reproduction, testing, objectivity, etc. Behavioral therapy is also commonly known as, or otherwise includes, Lovaas therapy, early intensive behavioral intervention, applied behavior analysis (ABA), pivotal response treatment, or other similar terms.

ABA is the application of behavioral science in order to improve socially important behaviors and establish new skills. ABA-based procedures apply behavioral principles of skill development to increase or decrease a particular behavior, improve the quality of a behavior, stop an old behavior, or teach a new behavior.

Effective behavioral-based programs include intervention that is:

1. Implemented early (ideally, before school age)
2. Intensive with respect to the number of hours children are actively engaged
3. Provided in natural environments (i.e. home, school, community)
4. Actively involving of families.

Evidence Supporting Behavioral Therapy's Effectiveness with ASDs

Behavioral-based interventions are based upon decades of scientific investigation with individuals affected by a wide range of behavioral and developmental disorders, including autism. Specifically for children with autism, research demonstrates the efficacy of ABA in teaching complex communication, social, play, and self-help skills, and in reducing disruptive behaviors. The seminal article on this type of intervention was published by Ivar Lovaas at UCLA in 1987. This controlled, long-term study found that 47% of children with autism achieved normal intellectual educational functioning after treatment intensive behavioral treatment, compared to only 2% in the control group.

Since the Lovaas article was published, 20 years of research and over 500 studies continues to support the effectiveness of behavioral therapy for autism.

Lovaas's landmark 1987 study was followed in 1993 by another study of these same 38 subjects. The objective of John J. McEachin's study was to discover the long-term effects of Lovaas's early intensive behavioral treatment and to find out if the results of the experimental group were preserved over time. In terms of intellectual functioning, the study found that "the experimental group at follow-up had a significantly higher mean IQ than did the control group... indicating that the experimental group had maintained its gains in intellectual functioning between age 7 and the time of the current evaluation... [and] ... the experimental group showed more adaptive behaviors and fewer maladaptive behaviors than did the control group."

In another study, more than 50% of children with autism who participated in comprehensive treatment programs using ABA were successfully integrated into typical classrooms, with many requiring little ongoing treatment. (Harris and Handleman, 1994) Only four behavioral interventions are scientifically validated for the treatment of ASD, and all of these are derived from the principles of ABA, according to Simpson (2005).

Scientifically validated behavioral-based interventions for autism include:

1. Applied Behavior Analysis (ABA)
2. Discrete Trial Teaching (DTT)
3. Pivotal Response Treatment (PRT), and
4. Learning Experiences: An Alternative Program for Preschoolers & Parents (LEAP).

Reasons to support private health insurance coverage for ASD:

HB 187--Update of Coverage – less of a mandate

- It wasn't long ago that the medical community erroneously believed autism was untreatable. Today, research has proven otherwise. We are asking insurers to simply update their coverage to reflect the widely held belief in the scientific community that autism is treatable.

Reducing the financial burden on Alaskan Families

- Since insurance coverage is not available, families incur significant financial burdens to pay for necessary and appropriate services, sometimes as much as $50,000 a year, if not more. No family can support this burden.

- In addition to the crushing financial burden placed on families affected by autism, the time, energy, stress and emotional commitment can become absolutely overwhelming and, if left unchecked, can adversely impact employment, health and the marriage.

Cost/Benefit Analysis

- Actuarial and economic studies done in Alaska and other State's indicate adding coverage would increase policy premium costs less than 1%

- A 1998 study by John W. Jacobson and others titled, *Cost-Benefit Estimates for Early Intensive Behavioral Intervention for Young Children with Autism – General Model and Single State Case,* examined the cost/benefit relationship of early intensive behavioral intervention treatment at varying levels of treatment success. The study used estimates of costs for early intensive behavioral interventions (EIBI) from childhood (age 3) through adulthood (age 55) based on prices in the Commonwealth of Pennsylvania and compared these costs with the expected amount of income the child would earn later in life to arrive at an estimated cost savings. The Jacobson's study found that cost savings per child served are estimated to be from $2,439,710 to $2,816,535 to age 55.

- The benefit to Alaskan taxpayers, families and the school system is clear—spend a little now or, spend a lot later.

Consequences for the Status Quo

Without treatment, the taxpayers of Alaska will certainly bear the enormous financial burden of a life-time of care for children who live a normal life span and often need round the clock care. In contrast, many children who receive effective, intensive and evidenced-based treatments require less support in school and go on to lead productive lives as taxpayers.

President Obama and Federal Policy

Autism is a National health care crisis. President Obama is committed to supporting Americans with ASDs, their families, and their communities. There are a few key elements to their support, which are as follows:

1. President Obama supports increased funding for autism research, treatment, screenings, public awareness, and support services. There must be research of the treatments for, and the causes of, ASD.
2. The Obama administration supports improving life-long services for people with ASD for treatments, interventions and services for both children and adults with ASD.
3. The Obama administration supports comprehensive autism services legislation, funding of the Combating Autism Act and working in a bi-partisan fashion with Congress, parents and ASD experts to determine how to further improve federal and state programs for ASD.
4. The Obama administration supports universal screening of all infants and re-screening for all two-year-olds, the age at which some conditions, including ASD, begin to appear. These screenings will be safe and secure, and available for

every American that wants them. Screening is essential so that disabilities can be identified early enough for those children and families to get the support and services they need.

Other States

- Ten (10) states specifically require insurers to provide coverage for the treatment of autism. Eight (8) states enacted such legislation during the 2007-2008 legislative sessions: Arizona, Connecticut, Florida, Illinois, Louisiana, Pennsylvania, South Carolina and Texas. Thirty-four (34) others have reform measures pending.

Thank you for your strong leadership. If I can be of further assistance, please feel free to contact me.

Sincerely,

Jeff Sell, Esq.
Vice President of Advocacy & Public Policy

American Academy of Pediatrics (2001). Policy Statement: The Pediatrician's Role in the Diagnosis and Management of Autistic Spectrum Disorder in Children (RE060018) Pediatrics, 107, 1221-1226. Committee on Children With Disabilities (2001). Technical Report: The Pediatrician's Role in the Diagnosis and Management of Autistic Spectrum Disorder in Children. Pediatrics, 107, e85.

Plauch, Chris, and Aae Johnson, MD, MEd. Identification and Evaluation of Children with Autism Spectrum Disorders. Pediatrics. Vol. 120, No. 5. American Academy of Pediatrics, November 2007.

James G. Gurney, Melissa L. McPheeters, Matthew M. Davis, Parental Report of Health Conditions and Health Care Use Among Children With and Without Autism, 160 Archives of Pediatric and Adolescent Medicine, 825-30 (2006).

Lovaas Institute for Early Intervention. See http://www3.scoe.net/npsa/index/index.cfm?fuseaction=basicDetails&id=420&searchType=adv.

Michael L. Ganz, The Lifetime Distribution of the Incremental Societal Costs of Autism. 161 *Archives of Pediatric and Adolescent Medicine*, 343-49 (2007). Retrieved from www.archpediatrics.com .

J. J. McEachin, T. Smith, O. Ivar Lovaas, Long-term Outcome for Children with Autism Who Received Early Intensive Behavioral Treatment, 97 American Journal on Mental Retardation, 359-72 (1993).

Douglas L. Leslie, Andres Martin, Health Care Expenditures Associated with Autism Spectrum Disorders, 161 Archives of Pediatric and Adolescent Medicine, 350-55 (2007).

ALTCS eligibility is determined according to a subjective determination of whether an individual is "at-risk for institutionalization." For autism, this criterion is not appropriate. The "PAS" tool, which ALTCS

administers during the screening process, is weighted to provide more emphasis on items such as feeding tubes; in fact, the tool provides ZERO points for a diagnosis of autism.

Approximately 50% of personal bankruptcy cases are due at least in part to medical costs. See "Too Great a Burden: Arizona's Families at Risk." Publication No. 07-112AZ. Families USA, December 2007.

Myers, Scott M. Management of Children with Autism Spectrum Disorders. American Academy of Pediatrics, October 29, 2007.

U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General, 163-64 (1999).

National Research Council, Educating Children with Autism. (Catherine Lord & James P. McGee, Eds. 2001). Retrieved from http://www.nap.edu/openbook.php?isbn=0309072697.

John W. Jacobson, James A. Mulick, Gina Green, Cost-Benefit Estimates for Early Intensive Behavioral Intervention for Young Children with Autism – General Model and Single State Case. 13 Behavioral Interventions, 201-26 (1998).

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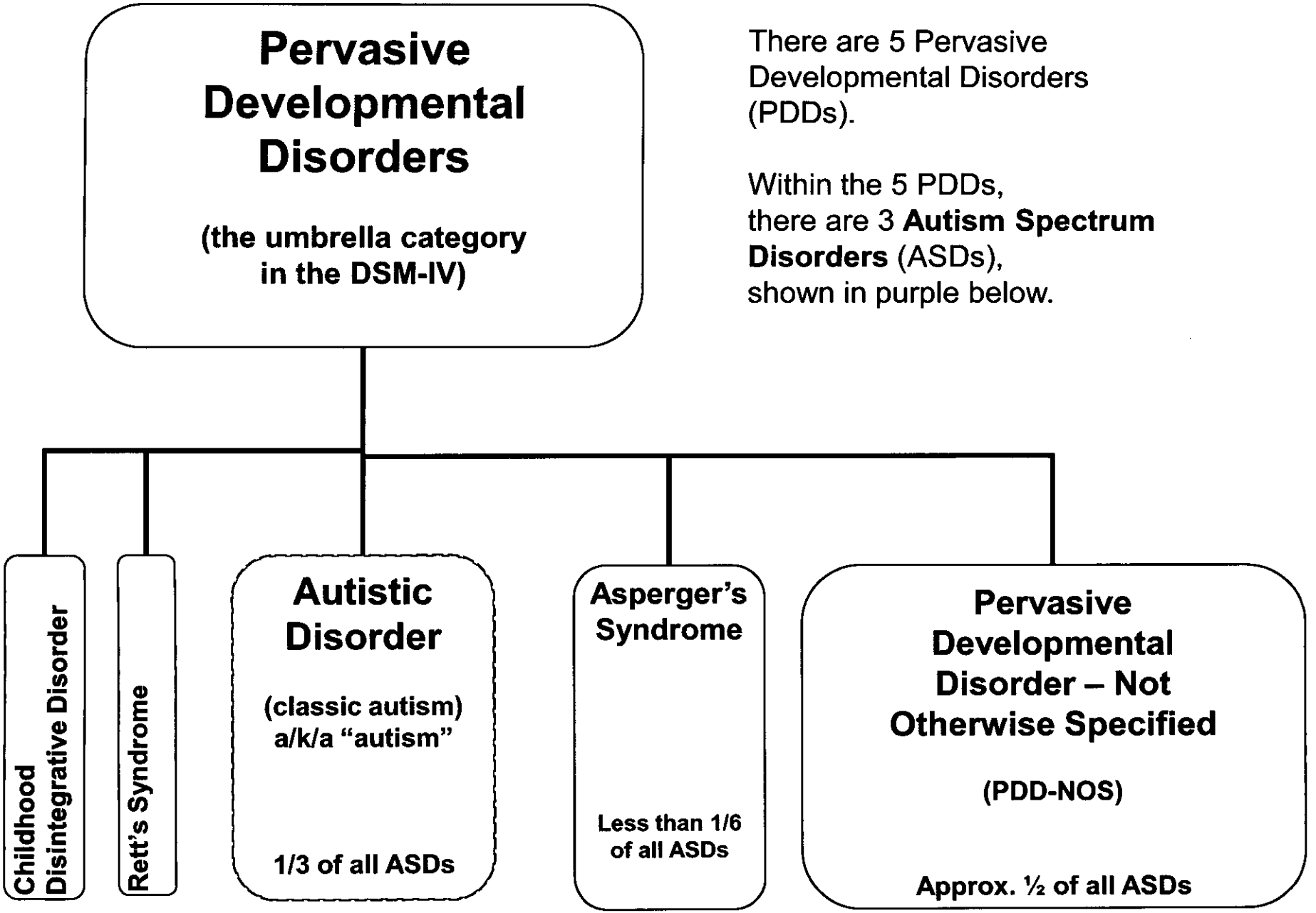
Autism Insurance in Missouri

Lorri Unumb, Esq.
Autism Speaks


Pervasive Developmental Disorders
(the umbrella category in the DSM-IV)
There are 5 Pervasive Developmental Disorders (PDDs).
Within the 5 PDDs, there are 3 Autism Spectrum Disorders (ASDs), shown in purple below.
Childhood Disintegrative Disorder
Rett's Syndrome
Autistic Disorder
(classic autism) a/k/a "autism"
1/3 of all ASDs
Asperger's Syndrome
Less than 1/6 of all ASDs
Pervasive Developmental Disorder – Not Otherwise Specified
(PDD-NOS)
Approx. ½ of all ASDs

Applied Behavior Analysis: A Sample Program

- Consultant
  - Highly educated and trained
  - Board certified
  - Evaluates, designs, trains
  - 3-6 hours per month

- Mid-level supervisor (lead therapist)
  - Highly educated and trained
  - May be board certified
  - Updates programming; trains; oversees
  - 6 hours per week

- Line therapists
  - May be college students, trained by above
  - Provide 40 hours per week of direct therapy, usually in 3-hour shifts

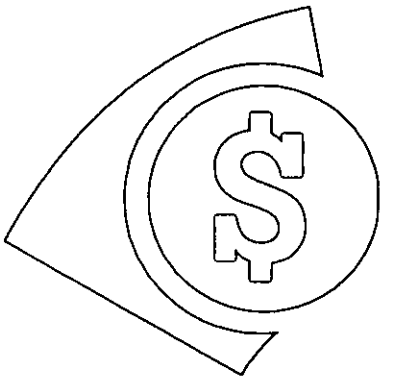
Applied Behavior Analysis: Cost of a Sample Program

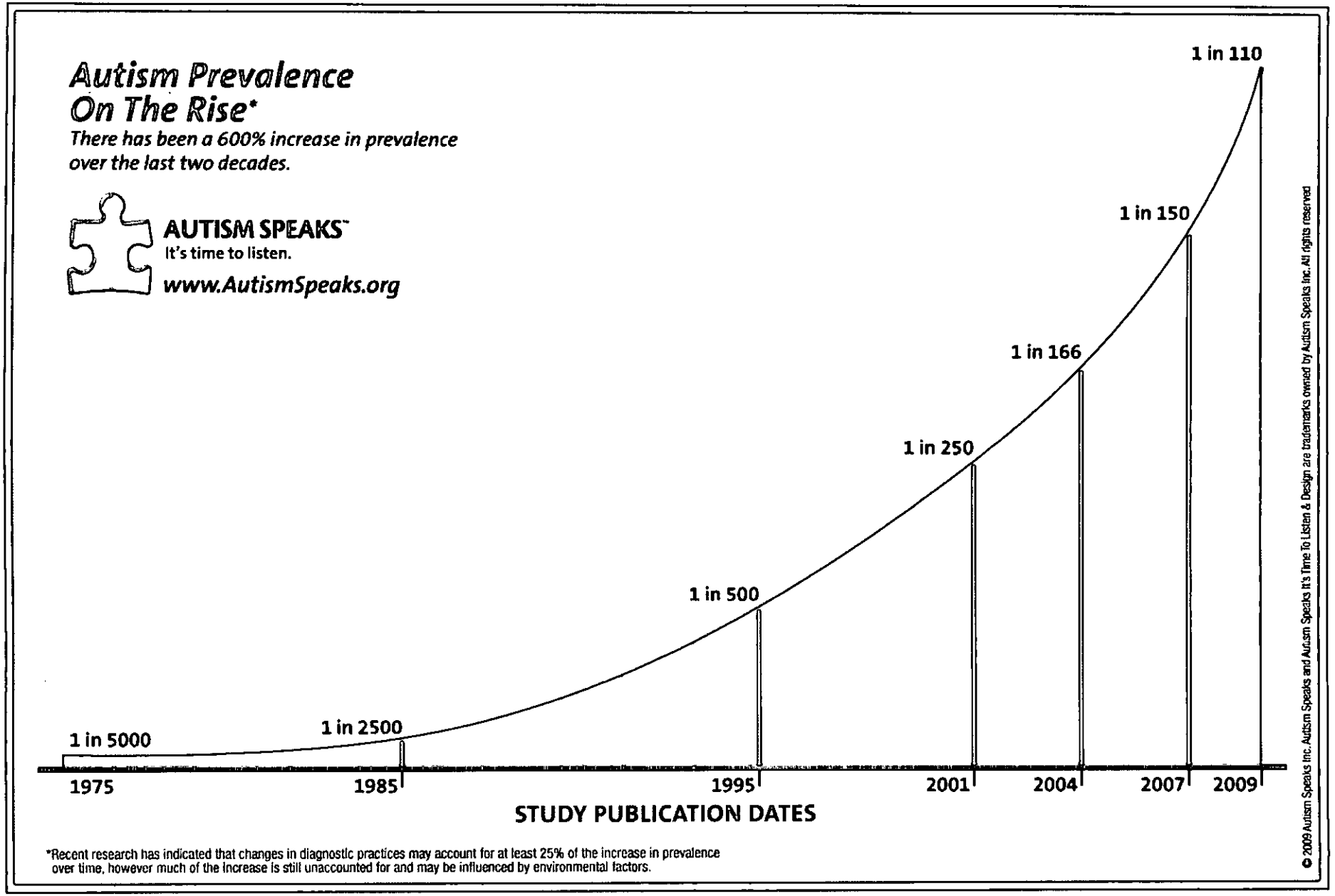
- Consultant
  - 3-6 hours per month
  - $100-$150/hour
  - 6 hours x $150 = $900/month
  - $900 x 12 months = **$10,800**

- Mid-level supervisor (lead therapist)
  - 6 hours per week
  - $30-$60/hour
  - 6 hours x $60 = $360/week
  - $360/week x 52 weeks = **$18,720**

- Line therapists
  - 40 hours per week
  - $10 - $30/hour
  - 40 hours x $20 = $800/week
  - $800/week x 52 weeks = **$41,600**

- $10,800 + $18,720 + $41,600 = **$71,120**




Autism Prevalence
On The Rise*
There has been a 600% increase in prevalence over the last two decades.
AUTISM SPEAKS™
It's time to listen.
www.AutismSpeaks.org
1 in 5000
1 in 2500
1 in 500
1 in 250
1 in 166
1 in 150
1 in 110
1975
1985
1995
2001
2004
2007
2009
STUDY PUBLICATION DATES
*Recent research has indicated that changes in diagnostic practices may account for at least 25% of the increase in prevalence over time, however much of the increase is still unaccounted for and may be influenced by environmental factors.
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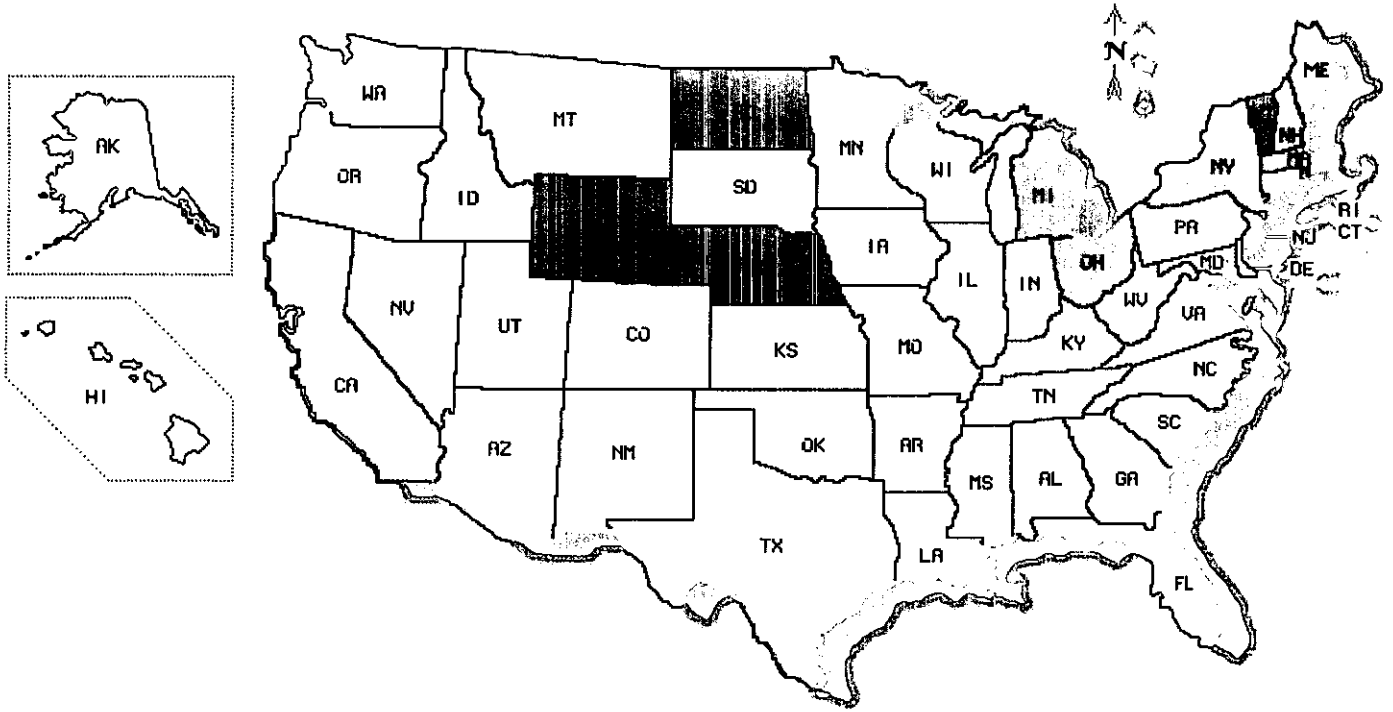
States with Autism Insurance Reform



8-19-09

2001 – Indiana
2001 – Minnesota*

2007 – South Carolina
2007 – Texas

2008 – Arizona
2008 – Florida
2008 – Louisiana
2008 – Pennsylvania
2008 – Illinois

2009 -- Montana
2009 – New Mexico
2009 – Colorado
2009 -- Nevada
2009 -- Connecticut
2009 – Wisconsin
2009 – New Jersey

Green = passed; Red = intro'd in 2009; Yellow – developing bill; Blue – not currently pursuing

Excerpt from 2008 Report of Council of Affordable Health Insurance: "Health Insurance Mandates in the States"

BENEFITS:	Est. Cost	#
Alcoholism	1-3%	45
Autism	<1%	11
Contraceptives	1-3%	31
In Vitro Fert.	3-5%	13
Prescriptions	5-10%	2

Available at www.CAHI.org.

The Council for Affordable Health Insurance is a research and advocacy association of insurance carriers active in the small group, individual, HSA, and senior markets. CAHI is an active advocate for market-oriented solutions to the problems in America's health

South Carolina
State Employee Health Plan

- Autism insurance statute passed in 2007
- Applicable to state health plan as of 1-1-09
- Population: 4.5 M
- State health plan has 350,000 members
- Projected annual fiscal impact to state:

  Estimates ranged $9 million - $18.9 million
- Actual cost in 2009:

  $856,371

  PMPM: 20 cents

"[N]o disability claims more parental time and energy than autism."

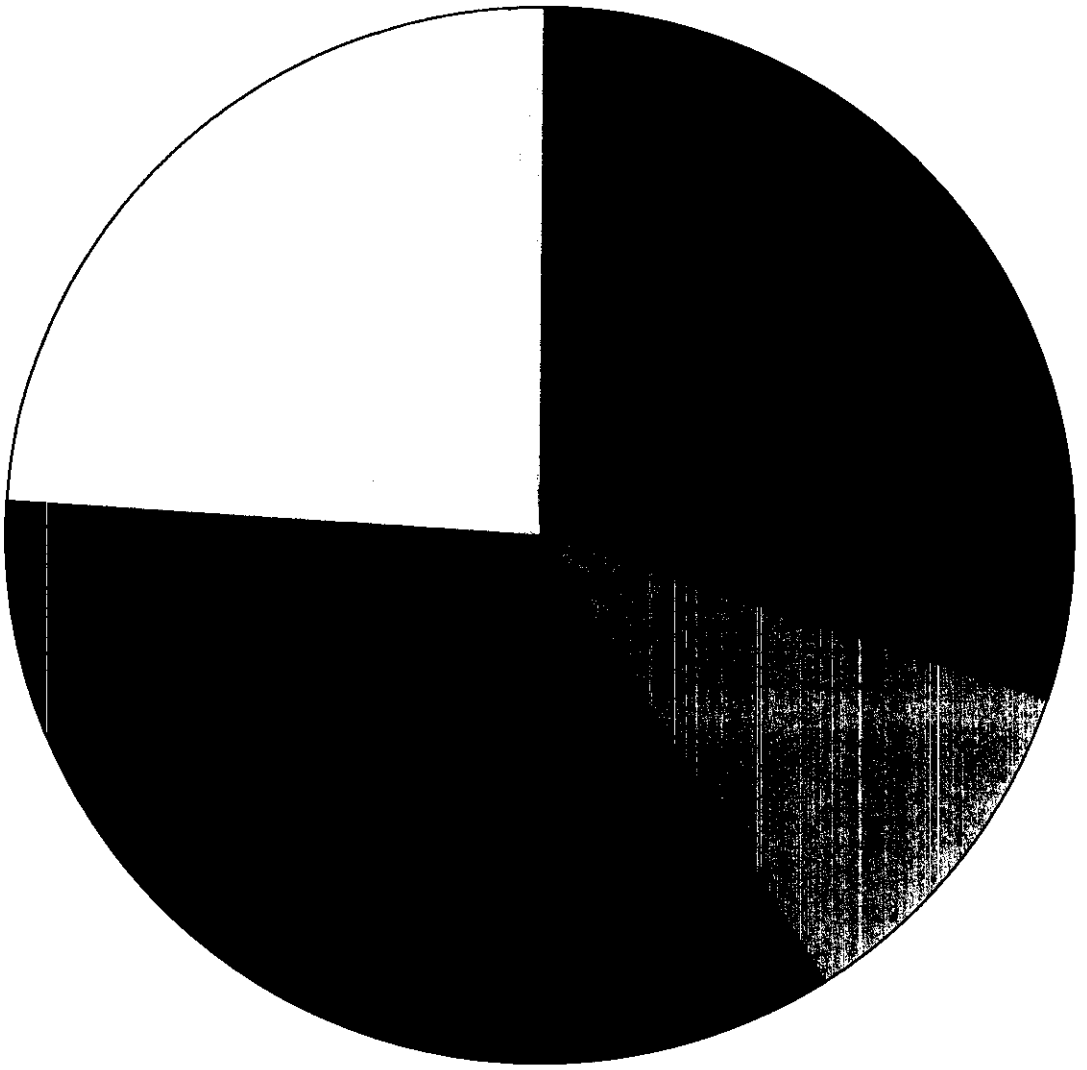
New York Times, 12/20/04

Comparison of State Autism Benefits

	S.C.	Minnesota BCBS	Ariz.	Montana	Indiana	Penn.
Annual Cap	$50K (cap only on ABA)	Unlimited	$50K thru 8; $25K 9-16	$50K thru 9; $20K 9-18	Unlimited	$36K
Benefits until age	16	No age cap	17	18	No age cap	21

Treatment must be prescribed by licensed physician or psychologist.

Sources of Health Care Coverage



- Medicaid - 20%
- Medicare - 10%
- Uninsured - 11%
- State Health Plan - 10%
- ERISA - ASO - 25%
- Federal Tricare - 2%
- Federal Civilian - 2%
- Other Insured - Large Group - 15%
- Other Insured - Small Group - 4%
- Other Insured - Individual - 1%

Self-Funded ERISA Plans

- Microsoft
- Home Depot
- Intel
- Arnold & Porter
- Halliburton
- Eli Lilly
- Deloitte
- Ohio State University
- Lexington Medical Center
- University of Minnesota
- Progressive Group
- Michelin
- Greenville Hospital System
- Symantec

Provider Credentials
www.BACB.com

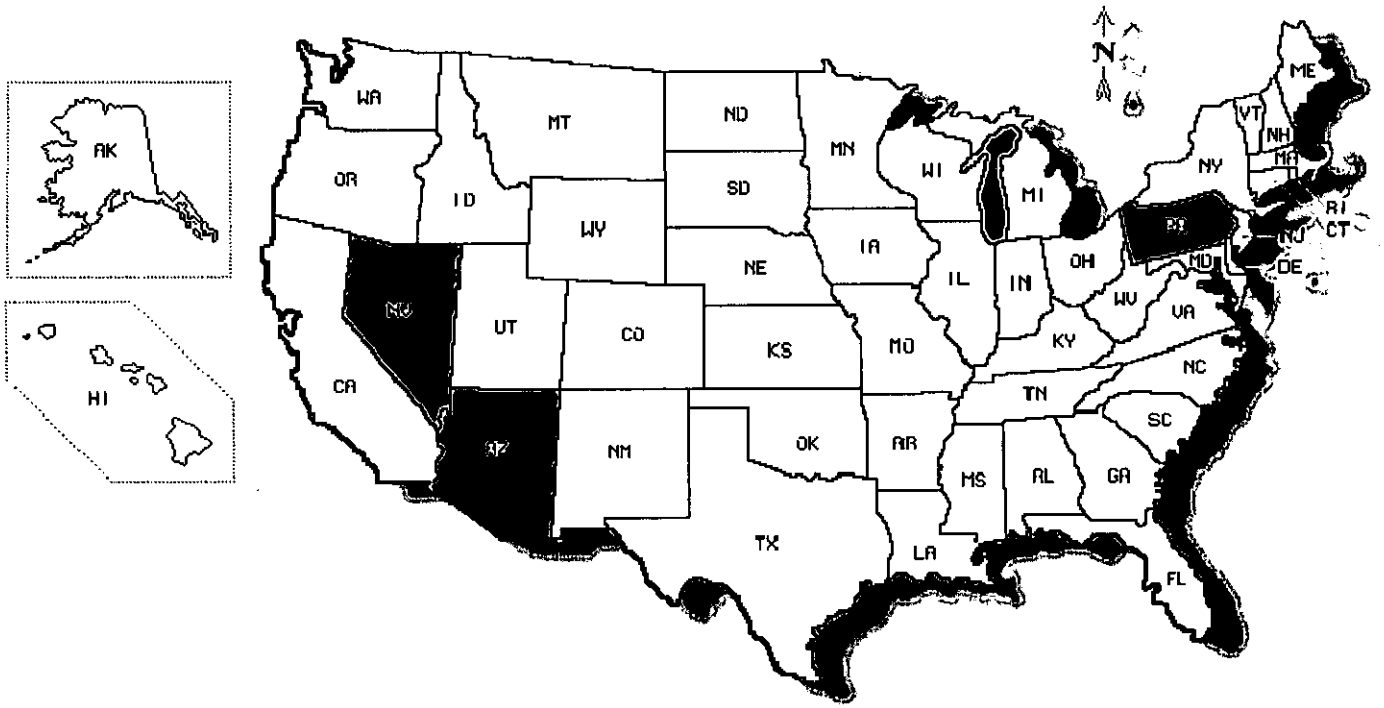
The Behavior Analyst Certification Board, Inc.® (BACB®) is a nonprofit corporation established as a result of credentialing needs identified by behavior analysts, state governments, and consumers of behavior analysis services.

The BACB's mission is to develop, promote, and implement a voluntary international certification program for behavior analyst practitioners. The BACB credentials Board Certified Behavior Analyst® BCBA®) and Board Certified Assistant Behavior Analyst® (BCaBA®).

NCCA ACCREDITED PROGRAM

Insurance States that License Behavior Analysts

Licensure states



1-19-10

Neurology
January 2007 Issue

Table 3 Summary of evidence: Incidence and prevalence of 12 neurologic disorders

Disorder	Class of evidence	Range of ages included (y)	Median estimates: Annual incidence Rate/ 100,000	Annual incidence No.*	Prevalence Rate/ 1,000	Prevalence No.*	Rate ratio, M/F†	Age(s), y, of peak incidence
Autism spectrum disorders	I, II	2–15	—	—	6.8	500,000‡	4.2	—
Cerebral palsy	I, II	3–13	—	—	2.4	207,000‡	1.3	—
Tourette syndrome	II	7–17	—	—	3.5§	301,000	4.8	—
Migraine	I, II	12–65	—	—	121	35,461,000	0.4	—
Epilepsy	I, II	All	48	142,000	7.1	2,098,000	1	<1, ≥80
Multiple sclerosis	I	All	4.2	12,000	0.9	266,000	0.5	30
Traumatic brain injury	I	All	101	298,000	—	—	2.1	20, ≥80
Spinal cord injury	I,II	All	4.5	13,000	—	—	4.2	20
ALS	I, II	All	1.6	5,000	0.04	12,000	1.3	≥60
Stroke	I, II	All	183	541,000	10	2,956,000	1.1	≥80
		≥65	1,093	401,000	—	—	—	
Alzheimer disease	I,II	≥65	1,275	468,000	67	2,459,000	0.5	≥80
Parkinson disease	I,II	≥65	160	59,000	9.5	349,000	1.8	≥70

* Estimated number of cases in United States in 2005, rounded to nearest 1,000.
† Ratio of rates among males to rates among females.
‡ Estimated number of cases among children younger than 21 years of age only.
§ Data inadequate for firm estimate.

SB 258

ALASKA STATE LEGISLATURE

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907-376-4866
907-373-4724 - Fax
Senator_Charlie_Huggins@legis.state.ak.us

State Capitol, Room 119
Juneau AK 99801-1182
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800-862-3878
www.akrepublicans.org/huggins/

Charlie Huggins
Senator

SPONSOR STATEMENT SB 258

SB 258 protects access to dental care by prohibiting insurance companies from setting fee limits on non-covered procedures and also prevents them from setting age limitations for covered services.

A national trend has developed where dental managed care insurance plans limit a patient's access to dental care by setting caps on dentist's fees for services that are not even covered by the insurance plan. Dental managed care plans offer a service providing consumers with dental care at reduced rates. The insurance company sets a fee limit for a service and the consumer knows upfront how much will be covered and how much he or she will have to pay out of pocket. The problem arises when an insurance carrier tries to set fee limits on services that are not covered. Insurance companies have begun setting fee limits for certain non-covered services, forcing dentists to reevaluate their decision to participate in the insurance plan thus decreasing the number of dentists participating in the managed care plan. This leaves consumers with fewer dental care options, which usually results in greater costs both financially and in quality of care.

A second, more recent trend in dental managed care plans is minimum age restrictions. Before benefits are allowed, some insurance companies require that a child be at least four years old. This presents a huge problem in young children obtaining necessary dental care. Dental cavities in very young children continue to be a problem in Alaska and arbitrarily setting minimum age requirements will handicap efforts to restore dental health to this vulnerable population. Tooth decay is highly preventable through early and sustained home care and regular professional preventive services. In May 2003, the American Academy of Pediatrics issued a policy statement urging dental exams for very young children. The policy recommends that infants receive an oral health assessment from a health care professional by six months and be referred to a dental health professional by one year. This important statement recognizes that oral health problems can begin long before a child reaches the age of three.

SB 258 goes a long way towards protecting consumers' access to care and preventing the aforementioned problems, thus ensuring that Alaskans continue to receive the dental care they need. I strongly urge your support of SB 258.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 258
() Publish Date:

Identifier (file name): SB258-CED-INS-2-11-10
Dept. Affected: DCCED
Title: Dental Care Insurance
RDU: Insurance
Component: Insurance
Sponsor: Senator Huggins
Requester: Senate Health and Social Services Committee
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost: None

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill would prohibit health care insurers that provide dental care coverage from setting a minimum age for receiving dental care coverage, allow those insurers to set a maximum age for receiving dental care coverage as a dependent, and prohibit those insurers from setting fees that a dentist may charge for dental services not covered under the insurer's policy.

The department does not expect additional operating expenses as a result of this legislation.

Prepared by: Linda Hall, Director — Phone 907-269-7900
Division: Insurance — Date/Time 2/11/10 9:30 AM
Approved by: Emil Notti, Commissioner — Date 2/11/2010
Department of Commerce, Community and Economic Development

(Revised 11/6/2009 OMB)

5384

SUPPORTING DOCUMENTS RECEIVED FROM:

1. Alaska Dental Society - Gary Moeller, DDS President

1

Alaska Dental Society
9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
info@akdental.org

20 January 2010

To whom it may concern:

On behalf of the members of the Alaska Dental Society I urge the swift passage of HB309/SB 258

HB309 will prohibit dental managed care insurance plans from setting fee limits on noncovered procedures and setting minimum age limitations for covered services. A national trend has developed where dental managed care insurance plans are setting caps on dentists' fees for services not covered by the insurance plan. Dental managed care plans offer a service providing consumers with dental care at reduced rates in exchange for limitations on the numbers of dentists who participate and services that are covered. The insurance companies' actions are causing dentists to reevaluate their decision to participate in plans due to philosophical opposition to insurance companies dictating fee levels for services not covered and the economic impact on their practices. The result is increasing numbers of dentists stopping their participation in managed care plans leaving the consumers with fewer choices for participating providers. Patients could then lose the benefit provided and either have to pay more to stay with their dental home, or seek care from another practitioner causing disruption to treatment. access

A second, more recent, trend is dental managed care plans setting minimum age restrictions before benefits are allowed. Dental cavities in very young children continue to be a problem in Alaska and arbitrarily limiting the age dependants receive covered benefits will handicap efforts to restore dental health to this vulnerable population. children

The insurance companies are requiring state plans to amend provider contracts in a way that allows the managed care plans to control what dentist's charge, even for services they DO NOT cover. The contract amendment says that dentists serving covered patients will not be able to charge the patient a fee in excess of the managed care plans prescribed fee for the non-covered service. It should be noted the two services that fee caps have been set for are orthodontics and veneers, services that are generally discretionary and rarely covered under any insurance plan.

The managed care plans decision to set fee limitations for noncovered services raises questions about the sincerity of their most recent approach to lowering costs. Managed care plans artificially capping a dentist's fee without providing a concurrent benefit for the patient amounts to a subsidy from participating dentists for the insurance companies marketing. At the outset, the reduced fees help the insurer attract customers and, therefore improves the insurer's bottom line. Dentists front the costs of this marketing approach and have a tough decision to make when faced with a contract amendment that caps the non-covered fees

Sincerely,

Gary A Moeller

Gary A. Moeller, DDS
President, Alaska Dental Society

Alaska Dental Society, Inc.
9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
akdental@alaska.net

HB309/SB258

- Encourages increased access to dental care
- Prevents insurance companies from intruding on patient-dentist relationship
- Ensures at risk children will continue to receive dental benefits
- Prohibits insurance companies from setting fees on services they do not provide dental benefits for
- Insures dental plans work for the patients best interest not the insurance companies best interest

example

Rhode Island

Chapter 041
2009 -- H 5454 SUBSTITUTE A AS AMENDED
Enacted 06/18/09

AN ACT
RELATING TO INSURANCE - DENTAL SERVICE CORPORATIONS

Introduced By: Representative John J. McCauley
Date Introduced: February 12, 2009

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 23-17.13 of the General Laws entitled "Health Care Accessibility and Quality Assurance Act" is hereby amended by adding thereto the following section:

23-17.13-6. Contracts with providers for dental services. – (a) No contract between a dental plan of a health care entity and a dentist for the provision of services to patients may require that a dentist provide services to its subscribers at a fee set by the health care entity unless said services are covered services under the applicable subscriber agreement. "Covered services," as used herein, means services reimbursable under the applicable subscriber agreement, subject to such contractual limitations on subscriber benefits as may apply, including, for example, deductibles, waiting period or frequency limitations.

(b) For the purposes of this section "dental plan" shall include any policy of insurance which is issued by a health care entity which provides for coverage of dental services not in connection with a medical plan.

SECTION 2. This act shall take effect upon passage.

LC01675/SUB A/2

WASHINGTON STATE DENTAL ASSOCIATION
Bringing a Better State of Health to Washington

Non-Covered Services

Non-Covered Services Talking Points

WSDA has proposed legislation for the 2010 session which would prohibit dental insurers from limiting fees for services not included in dental benefit plans.

Why is legislation necessary?

In July 2009 Washington Dental Services , the state's largest dental insurer, announced new provider contract provisions, allowing it to limit fees charged by its contracted dentists for services that are not covered by the insurer's dental plans. WDS said it was doing so to stay competitive with other insurers implementing similar provisions, however WDS also indicated it disagreed with this policy and was forced to implement it due to its alliance nationally with the Delta Dental system.

- Unless prohibited by insurance law, these provisions constitute an unjust interference in the financial affairs of dental practices.
- Some dental insurers have also added contract provisions to force dental practices to reduce charges when patients reach annual benefit maximum limits.
- Non-covered services vary by insurer and include such items as use of nitrous oxide to control dental fear and anxiety, implants, and posterior composite restorations. While a complete list from WDS is not yet available, WSDA understands these will likely be elective procedures that are consented to by the patient after discussion with the dentist.
- Limiting fees for non-covered services will force dental practices to cost shift. This will result in higher fees charged to uninsured patients and reduced participation in low-reimbursement plans, such as a Medicaid.
- Rhode Island enacted a prohibition on non-covered fee limits in June 2009.
- The National Conference of Insurance Legislators is now considering model legislation to prohibit non-covered service fee limits. Federal legislation is also being pursued to prohibit this practice by ERISA plans not regulated under state laws.

This directory does not yet contain any files.

*Supplied by Academy of General Dentistry: http://www.agd.org/issuesadvocacy/hotissues/casonfees/

1/19/2010

Putting Caps on Fees for Non-Reimbursed Services
Several major dental benefits carriers are adding language to provider participation agreements to allow them to set fees for dental services that they do not pay for, i.e., non-covered services. That is, if a dentist agrees to the contract language, he or she will be required to charge the patient what the carrier has told him or her to charge even when the carrier will not pay for the service.

To enact a fee cap on non-covered services, a dental benefits carrier must amend the current contract it has with its existing providers. Here's an example of such an amendment:

Dentist may bill a Member for non-covered services (which are defined as any service for which no payment is made under the applicable plan or arrangement for any reason, including but not limited to, services in excess of contractual maximums, services not covered under plan design, and services denied due to contractual limitations). Dentist's charge to Member for non-covered services may not exceed the Maximum Allowable Charge for the applicable CDT code as specified in the most current Maximum Allowable Charge schedule. Fees for all non-covered services will be collected from the Member, and not billed to the Carrier.

Note that this is just one of many variations of such a provision that you may find in your participation contract. The provider then has the choice of signing the new contract, thus accepting the new fee caps, or terminating his or her contract. If the provider elects not to sign, then he or she will be excluded from the provider networks presented to patients by that carrier's dental plans.

What are the non-covered services?
Non covered services are those services that a patient's dental plan has chosen not to pay for. Note that a carrier may offer numerous dental plans. Often however, dental plans without coverage for expensive, cosmetic, or other dental services are cheaper for employers to purchase for their employees. This is especially attractive to employers in the current economic climate. Each dental plan may have a different list of non-covered services, and therefore one cannot specify any particular services as universal "non-covered services."

Scope of the issue
Because dental benefits carriers can fall under the protection of the Employee Retirement Income Security Act of 1974 (ERISA), this is both a national and state issue. ERISA is a federal law that sets minimum standards for retirement and health benefit plans in private industry. Insurers that cover large employee groups who self-insure will more likely fall under ERISA. Some state laws do not exempt dentists from ERISA dental insurance plans that want to implement this policy change.

Rationale of carriers enacting such policy
To stay competitive with one another, dental benefits carriers use the argument of market pressure or gaining a marketing advantage as one of the reasons they are implementing this policy. Market need, the carriers assert, is being driven by patients who can save money on services not covered by their dental benefits plan and see value in limiting their out-of-pocket expenses. However, limiting dentists' charge to patients for non-covered services allows these carriers to market their dental plans as costing patients less without bearing any of the financial risk of the discount; that is, these carriers gain the marketing advantage by shifting the risk to the providers. Therefore, the market trend will drive all carriers to implement similar restrictions in order to avoid a competitive disadvantage. Accordingly, any legislation enacted against the practice of fee-capping for non-covered services must be sufficiently broad to prevent all carriers from engaging in this practice.

**Supplied by Academy of General Dentistry: http://www.agd.org/issuesadvocacy/hotissues/casonfees/*

Impact to Patients and the Practice of Dentistry

As primary care providers of oral health care, general dentists strive first and foremost for access to quality care for all as the ultimate goal of the profession. However, to serve its patients, a dental office must be viable and sustainable. Today, more patients than ever rely upon dental insurance to be able to afford oral health care. Studies have shown that, without dental insurance, far fewer persons will choose to see a dentist. Understandably, in the present economy, each of us must make cutbacks to our expenses in order to survive. Public awareness and understanding of the impact of oral health on systemic health issues such as diabetes and cardiovascular afflictions is still at its fledgling stages. Therefore, out-of-pocket expenses for oral health are often among the first to be avoided by the public.

Concurrently, businesses including those of dental benefits carriers and employers are also seeking cutbacks. Carriers striving to maintain or increase their revenues and marketshare in this economy offer employers cheaper plans for their employees by covering fewer services and paying less than true market value even for those services they cover. However, by covering fewer services, carriers compel patients to pay for more services out-of-pocket, which they may be unable or unwilling to do. Second, by paying less for the services they do cover, carriers compel dentists to function at a net loss when providing these covered services.

Therefore, today's dentist must often rely upon billing at market rates for non-covered services to compensate for the loss he or she absorbs in accepting paltry fees from carriers for covered services. However, unlike the carriers' actions of limiting services they cover, the dentists' actions do not impose an undue burden upon patients. Here's why. In the absence of fee-caps for non-covered services, dentists work with each patient on a case-by-case basis to charge what each patient may be able to afford with an understanding that some patients may be able or willing to afford more than others.

Fee capping takes away this opportunity! If fees for non-covered services are capped across the board without regard to what each patient can afford, the practice of the participating dentist may become unsustainable. The result may be two-fold. He or she may no longer be able to offer that specific service to that carrier's patients, thus limiting the patients' treatment options. In some markets, providers may feel compelled to stop participating with certain carriers in order to survive. In either case, the patients would face decreased access care.

Noncovered services: House supports legislative action to counter trend

Posted Nov. 12, 2009

By Arlene Furlong

Honolulu—Seeking legislative action to prevent dental plans from capping the amount dentists can charge for services a plan doesn't cover, the 2009 House of Delegates adopted Resolution 59H-2009.

Dental plans began implementing contract provisions holding dentists to maximum allowed fees for services for which no benefit is available with increasing frequency last year.

Many dentists fear such provisions limit access.

"Why should insurance companies be able to charge for things that aren't even in their benefit packages?" asked Dr. Robert Plage, chair of the ADA Dental Benefit Information Service. "If dentists aren't reimbursed for services, the insurance companies won't suffer but the public may. Exercising this contract provision doesn't cost insurers a dime."

ADA News has heard from insurers on the issue. Insurers say including a maximum allowable fee as part of the benefit or plan design allows patients access to services that otherwise would not be covered. They also say the competition is doing it—a reason for employing the provision.

In its first provision, Res. 59H-2009—Maximum Fees for Noncovered Services—establishes ADA policy supporting legislative action to stop the capping of fees for nonscheduled dental services. It resolves that:

• as a matter of policy, the American Dental Association opposes any third-party contract provisions that establish fee limits for nonscheduled dental services.

"The importance of having ADA policy calling for legislative action on this is to let the insurance companies and our members know exactly where we stand on this," said Dr. Plage.

The second resolving clause says the ADA will continue to actively pursue federal legislation to prohibit ERISA covered plans from applying such provisions (ERISA supercedes state plans) and the third directs the ADA to encourage individual states to pursue legislation to prohibit insurance plans from applying noncovered services provisions. (In June, Rhode Island passed a bill preventing dental plans there from capping the amount dentists can charge for services the plan doesn't cover.)

The Employee Retirement Income Security Act of 1974 is a federal law that sets minimum standards for retirement and health benefit plans in private industry.

The second and third clauses of Res. 59H-2009—Maximum Fees for Noncovered Services—resolves as follows:

• that the American Dental Association continue to actively pursue passage of federal legislation to prohibit ERISA covered plans from applying such provisions;

• that the American Dental Association encourage constituent dental societies to work for the passage of state legislation to prohibit insurance plans from applying such provisions.

The Council on Dental Benefit Programs prioritizes the noncovered services issue as one of dentists' top concerns and is working with the Council on Government Affairs to introduce federal legislation that would get directly at the issue for ERISA plans (federally regulated plans). State legislatures cannot effect changes to ERISA.

"This resolution accomplishes a lot," commented Dr. Plage. "It formally establishes our policy, while giving our members and our respective state dental societies direction on what to do."

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SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/5/10

FURTHER: Labor and Commerce

Date of 5-Day Notice: 2/11/2010
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/16/2010

Health and Social Services Committee considered SENATE BILL NO. 258

SB 258 DENTAL CARE INSURANCE

"An Act prohibiting health care insurers that provide dental care coverage from setting a minimum age for receiving dental care coverage, allowing those insurers to set a maximum age for receiving dental care coverage as a dependent, and prohibiting those insurers from setting fees that a dentist may charge for dental services not covered under the insurer's policy."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
Dept. of Com Insurance	2/11/2010	✓		✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Ellis	X			
	Thomas	✓			
	Paskvan			X	
CHAIR: Betty Davis		X			

5394

SB 277

FLOOR PRESENTATION
Wednesday, April 14
House Bill 277
"CERTIFY EMERGENCY USE OF EP-I-NEPH-RINE"

- House Bill 277 allows the Department of Health and Social Services to adopt standards for the approval of training programs for the use of ep-i-neph-rine auto-injectors and am-pules for individuals to administer in emergency situations.

- The Division of Public Health/EMS Unit currently approves similar training programs for emergency medical technicians and instructors and will be able to implement the bill with existing resources. The bill carries a zero fiscal note.

- The passage of HB277 would increase access to this life-saving medication and I would appreciate a yes vote.

SENATE COMMITTEE REPORT

DATE: 4/6/10

FURTHER:

DATE TURNED
IN TO OFFICE: _____

Health and Social Services Committee considered CS FOR HOUSE BILL NO. 277(HSS)

HB 277 CERTIFY EMERGENCY USE OF EPINEPHRINE

"An Act requiring the Department of Health and Social Services to adopt standards for the approval of and to approve certain training programs relating to the possession of epinephrine and the administration of epinephrine in emergency situations; and authorizing certain individuals to obtain a prescription for epinephrine, purchase epinephrine, and administer epinephrine in emergency situations."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

Previous
~~NEW~~ **FISCAL NOTE(S):**

Department	Date	Fiscal	Indet.	Zero	FN#
HSS/EMS				✓	1
HSS/FMS				✓	2

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	PASKVAN	✓			
	DYSON	X			
CHAIR: Betty Davis	DAVIS	↑			

5397

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHB 277(HSS)
(H) Publish Date: 3/31/10

Identifier (file name): HB277CS(HSS)-DHSS-EMSG-03-29-10
Dept. Affected: Health & Social Services

Title: Certify Emergency Use of Epinephrine
RDU: Public Health
Component: Emergency Medical Services Grants

Sponsor: P. Wilson, Lynn

Requester: House HSS
Component Number: 2309

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill requires the Department of Health and Social Services to adopt standards for the approval of training programs for the use of epinephrine auto-injectors and ampules for individuals to administer epinephrine in emergency situations. The Division of Public Health/EMS Unit currently approves similar training programs for emergency medical technicians and instructors and will be able to implement the bill with existing resources.

Prepared by: Ward B. Hurlburt, M.D., MPH, Chief Medical Officer / Director
Phone 269-8126
Division: Public Health
Date/Time 3/26/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/29/2010
DHSS Finance & Management Services

5398

(Revised 11/6/2009 OMB)

COMMITTEE COPY

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: CSHB 277(HSS)
(H) Publish Date: 3/31/10

Identifier (file name): HB277CS(HSS)-DHSS-IPEMS-03-29-10
Dept. Affected: Health & Social Services

Title: Certify Emergency Use of Epinephrine
RDU: Public Health
Component: Injury Prevention & Emergency Medical Services

Sponsor: P. Wilson, Lynn

Requester: House HSS
Component Number: 2876

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill requires the Department of Health and Social Services to adopt standards for the approval of training programs for the use of epinephrine auto-injectors and ampules for individuals to administer epinephrine in emergency situations. The Division of Public Health/EMS Unit currently approves similar training programs for emergency medical technicians and instructors and will be able to implement the bill with existing resources.

Prepared by: Ward B. Hurlburt, M.D., MPH, Chief Medical Officer / Director
Phone 269-8126
Division: Public Health
Date/Time 3/26/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/29/2010
DHSS Finance & Management Services

5399

(Revised 11/5/2009 OMB)

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ALASKA STATE LEGISLATURE

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REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

SPONSOR STATEMENT
House Bill 277

"An Act requiring the Department of Health and Social Services to approve training programs to certify individuals to possess epinephrine and to administer epinephrine in emergency situations; and authorizing certified individuals to obtain a prescription for, purchase, and possess epinephrine, and to administer epinephrine in emergency situations."

House Bill 277 allows individuals who have passed a departmentally-approved program to purchase and administer epinephrine.

Epinephrine (adrenalin) is used in emergency situations to combat severe allergic reactions, anaphylactic shock and heart attacks.

It is difficult to foresee the possibility of an allergic reaction when an individual has no known allergies. A victim of an allergic reaction can go into anaphylactic shock and medical attention may not be readily available. During these situations, the administration of epinephrine could be necessary to save a victim's life. Under current statute, the administrator can be held personally liable.

The passage of this bill would increase access to this life-saving medication, maintain and increase available safety measures, and reduce personal liability for acts of good faith.

26-LS0951\P

5400

CS FOR HOUSE BILL NO. 277(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES PEGGY WILSON AND LYNN

A BILL

FOR AN ACT ENTITLED

"An Act requiring the Department of Health and Social Services to adopt standards for the approval of and to approve certain training programs relating to the possession of epinephrine and the administration of epinephrine in emergency situations; and authorizing certain individuals to obtain a prescription for epinephrine, purchase epinephrine, and administer epinephrine in emergency situations."

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

*** Section 1.** AS 17 is amended by adding a new chapter to read:

Chapter 22. Use of Epinephrine in Emergency Situations.

Sec. 17.22.010. Prescription, purchase, and administration of epinephrine by a trained individual. An individual who is 18 years of age or older may obtain a prescription for, purchase, and may, in an emergency situation, administer epinephrine using

(1) an auto-injector, if the individual has successfully completed a

training program approved by the department under AS 17.22.020(b); or

(2) an ampule, if the individual has successfully completed a training program approved by the department under AS 17.22.020(c).

Sec. 17.22.020. Approval of training programs. (a) The department shall adopt standards for the approval of training programs for the use of

(1) epinephrine auto-injectors; and

(2) epinephrine ampules.

(b) The department shall approve an auto-injector training program that meets standards adopted under (a)(1) of this section. The standards must require an epinephrine auto-injector program to provide training in

(1) techniques on how to recognize symptoms of severe asthmatic or allergic reactions, including anaphylaxis;

(2) standards and procedures for the storage of epinephrine auto-injectors and administration of epinephrine using auto-injectors; and

(3) emergency follow-up procedures.

(c) The department shall approve an epinephrine ampule training program that meets standards adopted under (a)(2) of this section. The standards must require an epinephrine ampule program to provide training in

(1) techniques on how to recognize symptoms of severe asthmatic or allergic reactions, including anaphylaxis;

(2) standards and procedures for the storage of epinephrine ampules and administration of epinephrine using ampules; and

(3) emergency follow-up procedures.

Sec. 17.22.030. Applicability. This chapter does not apply to a person who is authorized under another law to administer epinephrine or to a person who is prescribed epinephrine for personal use.

Sec. 17.22.040. Liability of certified individual. A claim for relief may not be brought against an individual who has successfully completed a training program approved by the department under AS 17.22.020 for an act or omission relating to the administration of epinephrine to another individual in an emergency situation if the individual who completed the training program acted in good faith under the authority

granted by this chapter.

Sec. 17.22.090. Definitions. In this chapter,

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

(2) "emergency situation" means a circumstance where an individual experiences, or appears to experience, a severe asthmatic or allergic reaction, including anaphylaxis, that requires the administration of epinephrine to avoid severe injury or death and where a certified or licensed health care provider authorized to administer epinephrine is not reasonably available.

ALASKA STATE LEGISLATURE

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State Capitol, Room 406
Juneau, AK 99801-1182
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REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

Sectional

Committee Substitute for House Bill 277

"An Act requiring the Department of Health and Social Services to approve training programs to certify individuals to possess epinephrine and to administer epinephrine in emergency situations; and authorizing certified individuals to obtain a prescription for, purchase, and possess epinephrine, and to administer epinephrine in emergency situations."

Section 1:

- An individual who successfully completes training requirements may obtain a prescription for epinephrine, purchase it, and may in an emergency situation administer epinephrine either through epinephrine auto-injectors or ampules.
- Department of Health and Social Services shall approve a set of standards for the training of both epinephrine auto-injectors and ampules.
- Applicability does not apply to an authorized administrator or to someone already prescribed epinephrine.
- Outlines liability of the certified individual.
- Defines "certified individual," "department," and "emergency situations."

26-LS0951\P

ALASKA STATE LEGISLATURE

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REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

Summary of Changes

House Bill 277 to
Committee Substitute for House Bill 277

The original bill made the Department of Health and Social Services (DHSS) responsible for creating a detailed program for the certification of individuals to administer epinephrine in emergency situations. Instead of creating an entirely new program, CSHB 277 allows the DHSS to approve existing programs. Individuals who have successfully completed one of these programs may obtain a prescription, purchase, and administer epinephrine in a narrowly defined emergency situation. The fiscal note was reduced to zero with this change.

26-LS0951\P

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 29, 2010

SUBJECT: Epinephrine: Immunity for responding to an emergency (CSHB 277( ); Work Order No. 26-LS0951\S)

TO: Representative Peggy Wilson
Attn: Michael Dunning

FROM: Tamara Brandt Cook
Director TBC

You ask how the provision in CSHB 277( ) addressing immunity from suit differs from the general Good Samaritan statute.

Sec. 17.22.040 of the bill draft prevents a claim from being brought for an act or omission against a person who (1) has completed an approved training program for the use of epinephrine auto-injectors or epinephrine ampules; (2) administers epinephrine to another; (3) does so in an emergency situation; and (4) acts in good faith under the authority granted in AS 17.22. For purposes of (3) an "emergency situation" is defined in sec. 17.22.090 to mean:

> a circumstance where an individual experiences a severe asthmatic or allergic reaction, including anaphylaxis, that requires the administration of epinephrine to avoid severe injury or death and where a certified or licensed health care provider authorized to administer epinephrine is not available.

This is a narrow grant of immunity that will not apply in some situations that involve the use of epinephrine to aid another person. For example, if the epinephrine is administered but the situation does not meet the definition of "emergency situation" because the victim's reaction is due to heart attack, stroke, diabetes, or some other cause, or the epinephrine turns out not to be required to avoid injury or death, the immunity provided in sec. 17.22.040 will not apply.

Some of those situations might still be covered by the general Good Samaritan statute that broadly applies to emergency aid found at AS 09.65.090. It provides:

> (a) A person at a hospital or any other location who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid

> to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.
>
> . . . . .
>
> (d) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

Since cases involving liability or immunity for negligence are often fact specific, there may be some situations when a trained individual administers epinephrine but does not enjoy immunity under AS 17.22.040. In those situations, the individual might be granted immunity under AS 09.65.090. It does not appear that either statute precludes potential application of the other.

Note that Alaska statutes contain other provisions granting immunity or limited immunity in particular situations. AS 08.64.366 (liability for services rendered by a mobile intensive care paramedic) uses language somewhat similar to that in sec. 17.22.040. In addition to other specific grants of immunity in AS 09.65, examples are AS 18.08.086 (liability for services rendered by certain medical professionals); AS 14.30.325(b) (surrogate parents); AS 44.21.450 (volunteer guardians).

TBC:med
10-063.med

EXECUTIVE SUMMARY

Introduction

In 1999 the Washington State Legislature passed the "Kristine Kastner Act" (SHB 1992) requiring the Department of Health, with the respective House and Senate Health Care Committees, to prepare a report on the statewide incidence of anaphylaxis (severe allergic reactions) and the training and care necessary to allow Emergency Medical Technicians (EMTs) to carry and administer epinephrine. This legislation was driven by the concern that EMTs are not currently trained to diagnose the need for epinephrine by emergency patients they encounter. Epinephrine, when appropriately administered to the patient experiencing anaphylaxis or severe allergic reaction, may be required to save the patient's life.

This report includes data on the incidence of anaphylaxis statewide, and information on a pilot training program to determine the training and care standards necessary for EMTs to carry and administer epinephrine. Also included is an estimate of costs to provide that training. Recommendations are provided on the identification of any mitigating circumstances such as age, patient care protocols and specific signs and symptoms required to determine whether to administer epinephrine.

Recommendations

Education and Training -

- Training EMTs to safely administer epinephrine to anaphylaxis patients less than 30 years old must:
  - include no less than two hours didactic time;
  - include department-approved educational objectives; and
  - include a written and practical assessment of each EMT by the instructor.
- Instructors of new epinephrine material must be recommended by the county EMS Medical Program Director (Physician responsible for oversight of EMS personnel in each county) and approved by DOH.
- To maintain effective quality assurance of EMT performance, medical program directors must evaluate and report to DOH every use of epinephrine by EMTs and any anaphylaxis death in their monthly report.
- To retain knowledge and skill competency, each EMT's required Continuing Medical Education must include the use of epinephrine for anaphylaxis during each certification period (3 years).

Supplies -

All licensed basic life support vehicles must carry at least one adult and one pediatric auto-injector of 1:1000 epinephrine for anaphylaxis.

Mitigating Factors -

Age Factors:

- Based upon the limits of the pilot program, for patients who do not have a prescription or parental request, we recommend epinephrine be administered to persons under the age of 30.

Signs & Symptoms:

- To ensure safe administration of epinephrine to persons, EMTs may only administer epinephrine when signs and/or symptoms of anaphylaxis include respiratory distress or hypoperfusion.

Medical Control

- Usual medical program director specific methods of on-line/offline medical control will be followed.

From: Mike Motti [mailto:mikemotti@mac.com]
Sent: Friday, January 22, 2010 9:06 AM
To: Rep. Peggy Wilson
Subject: HB 277

Rep Wilson: I fully support this bill. I have been involved in EMS in Alaska since 1973 and have been teaching wilderness medicine for 20 years. However, as currently written, the Department is going to attach a huge fiscal note to the bill. I respectfully suggest that the wording be changed to direct the Section of EMS and Emergency Preparedness to approve the TRAINING COURSES, and that anyone showing a current certification card for one of these courses be allowed to purchase epinephrine without a prescription.

Right now the State EMS Training Committee approves CPR courses. They meet 3 times a year, and could approve epi training courses during their meetings without any significant expense to the State.

Respectfully,

Mike Motti
Sitka, Alaska

From: Bobbi Leichty [mailto:director@serems.org]
Sent: Friday, February 26, 2010 2:15 PM
To: Rep. Peggy Wilson
Subject: HB 277

The curriculum for training of people to deliver epi via epi pen has been developed by the American Heart Association, Wilderness Medical Society and the Red Cross. These plans are geared to the general public, are included with CPR instruction and would suit the requirements for training for the proposed bill.

I think that the Department should be able to review and endorse any or all of these nationally approved training modules to do the job.

If there are any other questions I can help with, let me know.

Bobbi Leichty, Director
SEREMS
907-747-8005

From: messa@mtaonline.net

I am writing to ask that you have HB277 CERTIFY EMERGENCY USE OF EPINEPHRINE heard and voted on this session. I recently received my Wilderness First Responder (WFR) Certification. The reason I took the course is that I work in wilderness settings, for many years, as an outdoor educator with youth. I have been very fortunate to not have a trip go bad from an emergency stand point. I have come close a few times. A big worry I have is the need to treat Anaphylaxis or Severe Asthma in the field. Many of my clients have Epinephrine (Epi)prescribed to them and they carry it. There are other clients that may not know they have the predisposition to Anaphylaxis. The way the law is now I cannot administer Epi to this person because it is not prescribed to them. If I had a physicians order on hand I could, but in todays litigious society most physicians won't stick their neck out. I also subject my clients to stress, new environments and new natural vegetation (nature). These things can exacerbate Asthma to severe levels. Epi would give my Asthmatic clients a fighting chance if a severe attack occurs. I dread the day when, under the current law, I have to make a chance at life with the use of Epi or death because I am not allowed, by law, to administer the drug to my client. Please support HB277 and the many people who enjoy the wilds of Alaska. Thank You. Roger Gossett (907)746-3181.

~ Roger Gossett
Zip Code: 99645
Voter ID: I have one

SB 295

[redacted] **SENATE COMMITTEE REPORT** [redacted]

First Committee of Referral

DATE: 2/24/10

FURTHER: Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/22/10

Health and Social Services Committee considered SENATE BILL NO. 295

SB 295 FLAME RETARDANTS AND TOXIC CHEMICALS

"An Act relating to flame retardants and to the manufacture, sale, and distribution of products contain flame retardants; relating to bioaccumulative toxic chemicals; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
Health	3/13/10	✓			

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AM
Jim Thomas	Thomas	✓			
Lyle Hackman	Hackman	X			
Fred Dyson	Dyson			X	
CHAIR: Bettye Davis	DAVIS	X			

ALASKA STATE LEGISLATURE

Session
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Senator_Bill_Wielechowski@legis.state.ak.us

Co-chair
Joint Armed Services Committee
Resources Committee

Member
Energy Committee
Judiciary Committee
World Trade Committee

SENATOR BILL WIELECHOWSKI

SB 295
SPONSOR STATEMENT

SB 295 will limit the use of polybrominated flame retardants (PBDEs) in products such as mattresses, upholstered furniture, and other textiles.

PBDEs are toxic flame retardants added to certain manufactured products. While fire retardancy is important, some flame retardants used in electronics and other products, such as PBDEs, are leaving a lasting toxic legacy in human beings and the environment.

Laboratory studies show that PBDEs are harmful to people, especially children. PBDEs have been found in the sediment of remote Alaskan lakes, fish, marine mammals, air, polar bear, birds, and sea otters. High PBDE levels found in Yupik mothers living in the Yukon Kuskokwim River Delta are a cause for concern because there is evidence that PBDEs can be passed to their children *in utero* and in breast milk.

Over fifty million pounds of PBDEs continue to be built into TVs, mattresses, and other products annually in North America, even though it is a developmental toxin and possible carcinogen. Safer alternatives exist for PBDEs and 4 states have enacted legislation banning all types of PBDEs while 11 other states have proposed similar legislation.

Please join me in supporting this much needed legislation.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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FAX (907) 465-2029
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State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 16, 2010

SUBJECT: Sectional Summary (SB 295; Work Order No. 26-LS0890\E)

TO: Senator Bill Wielechowski
Attn: Megan Rogers

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. Adds a new article relating to toxic chemicals in products.

Sec. 18.31.600. Prohibits a person from manufacturing, selling, or distributing certain products containing 0.1 percent by mass of pentaBDE, octaBDE, and decaBDE, or products otherwise prohibited by the Department of Environmental Conservation (DEC) under sec. 18.31.610 as described.

Sec. 18.31.610. Allows DEC to prohibit by regulation the manufacture, sale, and distribution of products containing a flame retardant that is not a brominated flame retardant if DEC makes certain listed determinations, if DEC consults with the Department of Health and Social Services (DHSS), and if the state fire marshal makes a certain determination.

Sec. 18.31.620. Exempts certain products from the prohibitions in sec. 18.31.600.

Sec. 18.31.630. Requires manufacturers of prohibited products to inform retailers in the state of the prohibitions in sec. 18.31.600 and the penalty in AS 18.31.660.

Sec. 18.31.640. Directs DEC to develop a program to help retailers identify prohibited products.

Sec. 18.31.650. Allows DEC to request that the manufacturer of a product that is suspected of being sold in violation of sec. 18.31.600 (1) provide a sworn certificate that the product does not violate AS 18.31.600, or (2) notify retailers that the sale is prohibited and provide DEC with retailer names and addresses.

Sec. 18.31.660. Subjects a violator of secs. 18.31.600 - 18.31.650 to a civil penalty.

Sec. 18.31.670. Directs DEC to review certain hazards and risks of brominated fire retardants, review possible alternatives, and review EPA findings and rulings related to brominated flame retardants and alternatives.

Sec. 18.31.680. Directs DEC, in consultation with DHSS, to establish and update every three years a list of persistent bioaccumulative toxic chemicals occurring in or used in products used by human beings. Requires consideration of specified information when establishing the list.

Sec. 18.31.690. Allows DEC to participate in establishing and using a regional multistate clearinghouse to help DEC carry out its duties under this article and to help coordinate education and outreach activities related to brominated flame retardants.

Sec. 18.31.710. Allows DEC to adopt regulations to implement this new article.

Sec. 18.31.790. Defines terms for this new article.

Section 2. A transition section to allow DEC to adopt its regulations before the Act goes into effect.

Section 3. A transition section indicating when DEC is to establish its first required list of persistent bioaccumulative toxic chemicals.

Section 4. Directs the revisor of statutes to make certain technical changes caused by the addition of the new article.

Section 5. Makes sec. 2 effective immediately.

Section 6. Makes the rest of this Act effective January 1, 2011.

If I may be of further assistance, please advise.

JMM:ljw
10-188.ljw

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB295**
() Publish Date:

Identifier (file name): SB295-DHSS-EPI-3-13-10
Dept. Affected: Health & Social Services

Title: Flame Retardants and Toxic Chemicals
RDU: Public Health
Component: Epidemiology

Sponsor: Wielechowski

Requester: Senate HSS
Component Number: 296

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	37.3		37.3				
Travel							
Contractual	8.8		8.8				
Supplies	0.5		0.5				
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**46.6**	**0.0**	**46.6**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	46.6		46.6				
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**46.6**	**0.0**	**46.6**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The bill requires the Department of Environmental Conservation (DEC) to work with Health & Social Services to establish a list of persistent bioaccumulative toxic chemicals that occur or are used in products used by human beings, and to develop a comprehensive strategy to reduce and phase out the products and other sources of the toxic chemicals on the list. DHSS would be consulted by DEC in three situations when: (1) proposing to prohibit a flame retardant under Section 18.31.610; (2) performing a one-time review of brominated flame retardants under Section 18.31.670; and (3) establishing a list every three years of persistent bioaccumulative toxic chemicals that occur or are used in products used by human beings. This environmental health consultation will require a total appropriation of $46.6 GF. This will not require a new position as as the work will done by an existing PCN that is only partially funded. Personal Services for 0.25 FTE Health Program Manager III will be $37.3. Additional costs of $9.3 are for are for indirect contractual costs and office supplies. No travel or equipment costs are anticipated. It is anticipated that this project will not take more than 2 years to complete.

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Officer/Director
Phone 907-269-8126
Division: Public Health
Date/Time 3/9/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/13/2010
DHSS Finance & Management Services

What are Polybrominated Diphenyl Ethers (PBDEs)?
Polybrominated Diphenyl Ethers (PBDEs) are chemicals used as flame retardants in many consumer products. The EPA is concerned that certain PBDE's are persistent, bioaccumulative, and toxic to both humans and the environment.

Why should Alaskans be concerned about these chemicals?
PBDEs impact our hormones, our ability to learn, can cause developmental problems and affect the male reproductive system (decreased sperm count and testicular cancer).

Are these chemicals found in Alaska?

- The highest known concentrations of PBDEs in human populations in the Arctic were found in Yupik women from the Yukon Kuskokwim Delta of Alaska.[i]
- In the most recent study of wild Alaskan salmon, mean PBDE levels were higher than those reported in previous studies of Alaskan salmon.[ii]
- PBDEs were found in blood samples of all 8 Alaskans who participated in biomonitoring projects.
- Exposure to PBDEs can happen *in utero* and through breast milk.

The solution.
Across the country states are passing laws to prohibit the manufacturing, selling and distribution of products that contain PBDE's.

Senate Bill 295 will end in-state sales of TVs, computers, mattresses, and residential upholstered furniture containing the toxic flame retardant by 2011.

Senate Bill 295 also:

- Allows the Department of Environmental Conservation (DEC) work with businesses to implement the law;
- Allows for exemptions for the transportation, mining and power industries;
- Allows DEC to work with other state agencies to share information; and
- Directs DEC to compile a list of chemicals of concern.

---

[i] Arctic Monitoring and Assessment Programme (AMAP). 2009. AMAP Assessment 2009: Human Health in the Arctic, p. 93. Available: www.amap.no [Accessed 31 December 2009].
[ii] Shaw SD, Berger ML, Brenner D, Carpenter DO, Tao L, Hong CS, et al. 2008. Polybrominated diphenyl ethers (PBDEs) in farmed and wild salmon marketed in the Northeastern United States. Chemosphere, 71: 1422-1431.

Safer Alternatives to Deca

Achieving Fire Safety Without Toxic Chemicals

... We did not see any evidence thatflame retardants being used as alternatives to decaBDE do not meet all required fire safety standards.[i] - Illinois Environmental Protection Agency

SB 295 would limit the use of Deca in the following products:
• TVs • Computers • Residential Upholstered Furniture • Mattresses

Current Uses of Deca:

Approximately 80% of Deca used in the United States is in electronics, with the vast majority used in the plastic casings of televisions. The use of Deca in computer monitors is extremely rare. According to Washington State, 95% of computer products are Deca-free.[ii]

Textiles comprise the second largest use of Deca in the country. However, the chemical is not currently typically used in residential upholstered furniture and "furniture industry sources suggest that, in 99% of cases, chemical flame retardants will not be needed to meet pending national standards for residential upholstered furniture."[iii]

With regard to mattresses, Deca was previously used by manufacturers. However, the industry has made a shift. "The International Sleep Products Association (ISPA), a trade association representing mattress manufacturers, reports that all its members use fire-resistant barriers that minimize the need for flame retardant chemicals." In addition, manufacturers have uniformly avoided the use of Deca to meet a national flammability standard that took effect in July 2007.[iv]

Current Uses of Deca.

Plastic housing of TVs	Vast majority
Plastic housing of computers	Very rare
Residential upholstered furniture	Not Used
Mattresses or mattress pads	Industry shift away from Deca

Fire Safety Standards for TV

Underwriters Laboratory (UL) sets fire safety standards for TVs sold in the United States.

The UL standard for TV enclosures requires the UL 94 V-0 rating for any plastic within two inches of an ignition source.

This is a vertical burn test where five vertically mounted samples of plastics are exposed to two consecutive ten-second ignitions from an open flame. The UL 94 V-0 rating, one of the most stringent, means that:

- The extinguishment time for each sample does not exceed 10 seconds
- The total combustion time for all five samples does not exceed 50 seconds
- The afterglow time per sample does not exceed 30 seconds
- There were no flaming drips
- No burning occurred up to the holding clamps

Deca-free TVs that meet the UL 94 V-0 standard are already on the market.

95% of Computers are already Deca-free

Source: Washington State DEP. *Washington State Polybrominaled Diphenyl Ether (PHDE) Chemical Action Plan: Final Plan.* January 2006.

Meeting Fire Safety Standards

Fire safety standards for televisions, computers, furniture, and mattresses can be achieved without Deca by using non-chemical and chemical substitutes.

Non-chemical alternatives to Deca can include the redesign of a product or the use of materials that are inherently more flame resistant. For example, in electronic equipment, metal components could be used to protect the power supply. And with textiles, easily ignitable fabrics could be replaced with materials that are difficult to ignite or burn more slowly (such as wool).[v]

Fire safety standards can also be met by using chemical alternatives to Deca. For example, a phosphorous-based compound called resorcinol bis (diphenyl phosphate) (RDP) is a common substitute for Deca in electronics. According to the Maine Department of Environmental Protection and the Maine Center for Disease Control and Prevention, "RDP presents a significantly lower threat to the environment and human health than decaBDE."[vi]

Affordable Alternatives:

Alternatives to Deca are not only available, but are cost effective. According to reports written by the states of Illinois, Maine, and Minnesota, there are affordable alternatives to Deca for consumer electronics, residential upholstered furniture, and mattresses.

In fact, many of these alternatives are already being used in the marketplace. For instance, Washington State estimates that roughly 57% of televisions and 95% of computer products do not contain Deca.[vii] And as noted above, mattress manufacturers have already shifted away from the use of Deca.

Many electronic manufacturers have already removed Deca from their products including:

- Sony
- Apple
- LG Electronics
- Sharp
- Dell
- Samsung
- Lenovo
- Hewlett Packard
- Panasonic
- Phillip
- Toshiba Personal Computing

Source: Clean Production Action. Progress Towards PVC and BFR Elimination by Leading Electronic Manufacturers Selling Products in the US. February 2008.

Leading mattress manufacturers that do not use Deca include:

- Sealy
- Kingsdown
- Simmon
- Englander
- Serta
- Tempur-Pedic
- Select Comfort
- International Bedding Corp.
- Restonic
- Corsicana
- King Koil
- Lady Americana

Source: Michigan Network for Children's Environmental Health. Leading Companies Not Using Deca-BDE. Available at: http://www.mnceh.org/Fact%20Sheets%20-%20MNCEH/Deca_leading_companies_not_using_BDE_10262009d.pdf

For all applications in which decaBDE currently is used, alternatives without decaBDE are available ... No applications were identified in which decaBDE is the only flame retardant used or in which decaBDE offers unique or exceptional properties. No application was identified in which the use of alternatives requires a compromise in fire safety.[viii]

– Maine Department of Environmental Protection & Maine Center for Disease Control and Prevention

(Tbe information in this factsheet was compiled by Vermont PIRG)

i Illinois Environmental Protection Agency, *Report on Alternatives to the Flame Retardant DecaBDE: Evaluation a/Toxicity, Availability, Affordability, and Fire Safety Issues* (Appendix I, p.16), March 2007.

ii Washington State DEP. *Washington State Polybrominated Diphenyl Ether (PBDE) Chemical Action Plan: Final Plan* (p.65). January 2006.

iii Maine Department of Environmental Protection and Maine Center for Disease Control and Prevention, *Brominated Flame Retardants: Third Annual Report to the Maine Legislature* (p.25-26, 35), January 2007.

iv Maine Department of Environmental Protection and Maine Center for Disease Control and Prevention, *Brominated Flame Retardants: Third Annual Report to the Maine Legislature* (p.26, 35), January 2007.

v The Lowell Center for Sustainable Production, University of Massachusetts Lowell, *Decabromodiphenylether: An Investigation of Non-Halogen Substitutes in Electronic Enclosure and Textile Applications* (p.35), April 2005.

vi Maine Department of Environmental Protection and Maine Center for Disease Control and Prevention, *Brominated Flame Retardants: Third Annual Report to the Maine Legislature* (executive summary), January 2007.

vii Washington State DEP. *Washington State Polybrominated Diphenyl Ether (PBDE) Chemical Action Plan: Final Plan* (p.65). January 2006.

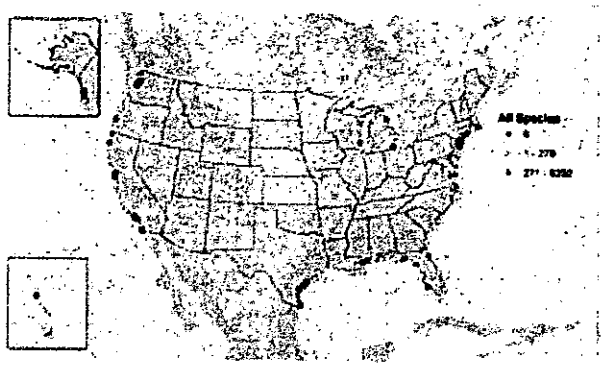
viii Maine Department of Environmental Protection and Maine Center for Disease Control and Prevention, *Brominated Flame* Retardants: Third Annual Report to the Maine Legislature (p.36), January 2007.

NOAA NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION
UNITED STATES DEPARTMENT OF COMMERCE

NOAA Report Calls Flame Retardants Concern to U.S. Coastal Ecosystems

Health Care Concerns Also Noted

April 1, 2009



National Distribution of 200X PBDE tissue concentration in parts per billion lipid weight (where 200X = between 2004 and 2007). Categories low (green dot), Medium (yellow dot), High (red dot) were determined by cluster analysis.

High resolution (Credit: NOAA)

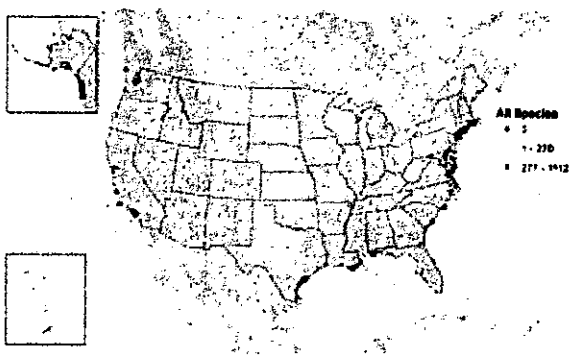
NOAA scientists, in a first-of-its-kind report issued today, state that Polybrominated Diphenyl Ethers (PBDEs), chemicals commonly used in commercial goods as flame retardants since the 1970s, are found in all United States coastal waters and the Great Lakes, with elevated levels near urban and industrial centers.

The new findings are in contrast to analysis of samples as far back as 1996 that identified PBDEs in only a limited number of sites around the nation.

Based on data from **NOAA's Mussel Watch Program**, which has been monitoring coastal water contaminants for 24 years, the nationwide survey found that New York's Hudson Raritan Estuary had the highest overall concentrations of PBDEs, both in sediments and shellfish. Individual sites with the highest PBDE measurements were found in shellfish taken from Anaheim Bay, Calif., and four sites in the Hudson Raritan Estuary.

Watersheds that include the Southern California Bight, Puget Sound, the central and eastern Gulf of Mexico off the Tampa-St. Petersburg, Fla. coast, and Lake Michigan waters near Chicago and Gary, Ind. also were found to have high PBDE concentrations.

"This is a wake-up call for Americans concerned about the health of our coastal waters and their personal health," said John H. Dunnigan, NOAA assistant administrator of the National Ocean Service. "Scientific evidence strongly documents that these contaminants impact the food web and action is needed to reduce the threats posed to aquatic resources and human health."



National Distribution of 1996 PBDE tissue concentration in parts per billion lipid weight. Categories low (green dot), Medium (yellow dot), High (red dot) were determined by cluster analysis.

High resolution (Credit: NOAA)

PBDEs are man-made toxic chemicals used as flame retardants in a wide array of consumer products, including building materials, electronics, furnishings, motor vehicles, plastics, polyurethane foams and textiles since the 1970s. A growing body of research points to evidence that exposure to PBDEs may produce detrimental health effects in animals, including humans. Toxicological studies indicate that liver, thyroid and neurobehavioral development may be impaired by exposure to PBDEs. They are known to pass from mother to infant in breast milk.

Similar in chemical structure to polychlorinated biphenyls, or PCBs, they have raised concerns among scientists and regulators that their impacts on human health will prove comparable. PBDE production has been banned in a number of European and Asian countries. In the U.S., production of most PBDE mixtures has been voluntarily discontinued.

The NOAA Mussel Watch survey found that the highest concentrations of PBDEs in the U.S. coastal zone were measured at industrial and urban locations. Still, the chemicals have been detected in remote places far from major sources, providing evidence of atmospheric transport. Significant sources of PBDEs introduction into the environment include runoff and municipal waste incineration and sewage outflows. Other pathways include leaching from aging consumer products, land application of sewage sludge as bio-solids, industrial discharges and accidental spills.

NOAA and the Southern California Coastal Water Research Project have recently held meetings with representatives from the Environmental Protection Agency, U.S. Geological Survey, the National Institute of Standards and Technology, and the California State Water Resources Control Board to discuss water quality monitoring of emerging contaminants. NOAA's research and monitoring information found in this report will be used by relevant resource managers to better understand, assess and address the threats from PBDEs.

NOAA understands and predicts changes in the Earth's environment, from the depths of the ocean to the surface of the sun, and conserves and manages our coastal and marine resources.

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Respected Burn Physician Encourages EPA Deca-BDE Phase-Out Initiative

2/17/2010 (printed in Citizens For Fire Safety newsletter, cffsi.org, 310-310-2616)

I am writing to express my support for a national solution to the EPA's recent deca-BDE phaseout. Any individual state bill that would immediately ban fire safety protections without the development of alternatives is dangerous. As a director of burn centers for 37 years, I have seen the ravages of burns and the devastating effects of these injuries that inflict both the burn survivor and their families. Burns are some of the most physically and emotionally damaging, as well as some of the most monetarily costly injuries. The extensive medical procedures necessary to restore any vestige of normalcy to these patients is costly both to the families and the hospital. These fire safety products, flame retardants, allow critical seconds for these most vulnerable citizens to escape a burning structure and reduce the chances of more severe burns. The relationship between time of exposure and extent of injury is well known. The greater the surface area burns, the higher the mortality. We are committed to saving lives and preventing burns any way possible. Thus, we are deeply concerned about this reckless and unscientific attempt to weaken standards and put millions of people at risk to serious burn injuries and death.

While I know that this product has saved countless lives over many years, I will encourage and promote a new generation of safe and effective fire retardants. I believe that fire safety manufacturers will commit to their decision to safely phase out existing products, and I commend them for their proactive development of new technologies. A national solution considers the interest of all Americans rather than just those of individual states, and this is the only way to safely progress in national fire protection.

The EPA agreement sets forth a rational, effective transition to newer alternatives, while allowing critical services such as police, fire and airlines to continue to use existing fire safety products that are critically important to saving lives. Manufacturers have already announced the production of environmentally-friendly fire retardants which minimize the use of raw materials,

energy, byproducts and waste. This progressive thinking is largely aresult of the efforts of Citizens for Fire Safety and their coalition ofsupporters across the nation.

As we make this transition, we must remain watchful of legislation that would preemptively ban existing products, leaving communities without adequate fire safety protection. I oppose any preemptive state bans, as I believe the timeline that has been worked out with the EPA is the most appropriate. Let's trust the scientists of the federal environmental agencies and not act precipitously to put our families and children at risk of serious injury or death. An effective national solution to this critical issue is the only solution that is truly safe.

I want to thank you for your time and effort concerning this extremely important matter, and I hope that you will join me as we continue to hold our nation to the highest fire protection standard.

Roger E. Salisbury, MD

Emeritus Director of Burn Center

Westchester Medical Center

Valhalla, New York

Past Vice President, American Bum Associaton

Senator Bettye Davis

March 15th 2010

Capitol Room 30

Juneau, AK 99811

Subject: SB 295, Flame Retardants and Toxic Chemicals

Dear Senator Davis:

I have been reading different articles and publications about an effort to ban certain fire retardants.

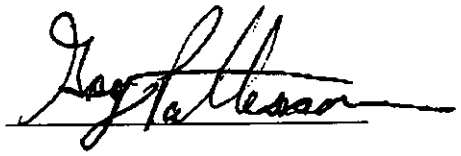
Your committee has a bill it called SB 295 dealing with the banning of these retardants. Because I am interested in human health, the environment and safety this issue has peeked my interest.

After reading the outline of the bill I have some questions.

1) Why is the ban to be placed on some products i.e. bedding etc. but at the same time other products are exempt? If it is so dangerous shouldn't it be on all products across the board that could pose a danger?
2) The bill states that the department in charge will review the hazards after it becomes law. (They will review the hazards after it becomes law??? I have to scratch my head on this one.) Isn't this putting the cart before the horse? Because the scientific community is still out on the dangers of these retardants shouldn't we wait until the Center for Disease Control has finished its definitive research before making this law? It seems that although well intentioned, the ones who wish to rush this into law are running around screaming that the house is on fire when it might be that it is just someone with a book of matches in their pocket. And without the definitive research how many business's will be disrupted and have to incur the substantial costs of complying only to find out that the benefits of these life saving retardants far outweigh the dangers of using them? How many people will be burned if these proven retardants are taken off the market?
3) Let us be very clear, the studies of these bio-accumulative toxins do indicate that dangers under "certain exposure and controls" potentially are very bad. If you will go to www.cdc.gov/toxprofiles/tp68-c4.pdf you can read the CDC's study. One of the first things that the study states is that "conditions have to be ideal" to enter the environment. The study also states that "exposure has to be acute and repeated."

I would urge that you wait until all the data is available. It just isn't clear yet that the way these chemicals are being used meet the standards that actually pose dangers to us. And I am certain that people who are burned and have to go to the burn units certainly would prefer not to suffer that agony.

I am sincerely hoping that your deliberations are insightful and that you continue to protect us.



Greg Patterson

Greg Patterson

1513 Kinnikinnick

Anchorage, AK 99508

Alaska Fire Chiefs Association
Resolution
2007- 07

A RESOLUTION SUPPORTING A BAN UPON THE SALE OF OR IMPORTATION OF PRODUCTS CONTAINING POLYBROMINATED BIPHENYLETHERS FIRE RETARDANTS WITHIN THE STATE OF ALASKA.

WHEREAS Alaska Fire Chiefs Association is an organization dedicated to public safety, and

WHEREAS polybrominated biphenylethers are used as a fire retardant in plastic products but can leach from those products and enter the environment and

WHEREAS high concentrations of polybrominated biphenylethers have been found in breast milk and fat cells of humans living in North America and

WHEREAS polybrominated biphenylethers have been linked with neurological development deficits and immunological impairments in children and

WHEREAS other fire retardants that are effective and less toxic are readily available for use in plastic products,

NOW. THEREFORE, BE IT RESOLVED that:

The Alaska Fire Chiefs Association supports legislative efforts to ban polybrominated biphenylethers containing products from being imported to or sold within the State of Alaska.

Adopted this 6th day of December 2007 during the December teleconference.

Attested by: Douglas R. Schrage, Alaska Fire Chief's Association President

March 16, 2010

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
State Capitol Room 30
Juneau AK, 99801

RE: SB 295
Set for hearing, March 17, 2010
Senate Health and Social Services Committee

Dear Senator Davis:

On behalf of the member companies of the American Chemistry Council (ACC), thank you for the opportunity to comment on SB 295, legislation that would, among other things, direct the Department of Health and Social Services to establish, and update every three years a list of "persistent bioaccumulative toxic chemicals (PBTs)" that occur or are used in products used by human beings.

ACC shares the objective of protecting human health and the environment from any significant risks associated with chemicals with PBT properties. PBT substances represent a very small percentage of chemicals in the United States. Many are either strictly regulated, are not currently in production, or are the by-products of human and natural activity. PBTs encompass a range of substances, including some metals and a variety of organic compounds.

As currently drafted, Section 18.31.680 does not contain a clear set of definitions for the characteristics of P or B or T. Though the bill does ask the Department to consider other sources of PBT information (e.g. Washington State PBT program, USEPA high production volume challenge program), ACC believes that the legislation should clearly state that only information and conclusions from "authoritative" sources be used to develop any PBT list. Generally, an authoritative governmental entity or body should be defined as a government agency or formalized scientific organization that satisfies all of the following requirements:

1. It characterizes chemicals pursuant to an open, deliberative and transparent scientific process in which stakeholders are able to participate formally, and communicate directly with the authoritative body through written and oral comments.

2. It does not engage in advocacy.

3. It bases its characterization of chemicals on a weight-of-evidence approach. To the extent available, it considers multiple reliable studies, conducted by different laboratories, at different times, and involving not only different strains but different species and gives full consideration to mode of action, confounding factors, maternal toxicity, historical controls and any other scientific information that may be relevant to understanding the potential effects of chemicals on health and the environment.

4. It publishes its characterizations of chemicals through governmental regulations, periodic reports, monographs or similar publications.

Should Alaska consider making PBT determinations on its own, it is important to understand that the scientific thinking behind identifying and characterizing PBT substances continues to evolve. In 1997 and again in 2008 the Society for Environmental Toxicology and Chemistry (SETAC), sponsored workshops on PBT/POPs substances (aka "Pellston Workshop").

The workshops helped advance the science of PBT characterization by reaching consensus on how to better identify PBTs and POPs at an early stage, using new scientific information and tools, rather than simply defaulting to criteria that have been in place since the late 1970s. This workshop included leading scientists from academia, government, regulatory bodies and industry. Follow-up from the 2008 workshop is underway, and Alaska should consider this scientific discussion on PBTs and POPs to assure that the most up to date, reliable scientific methods are applied.

In addition, the bill as drafted does not answer the question of why the PBT list is being created, nor does the bill provide any insight into the long-range plans for how the Department intends to utilize the list. SB 295 should include specific language that clearly describes the intent and future plans for creating and utilizing a state-specific PBT list.

Finally, ACC encourages your committee to consider adding language to ensure transparency in the PBT list process by providing an opportunity for the public and other interested stakeholders to comment on the development and future use of the list.

Thank you for the opportunity to share these comments. If you or your staff has any questions or comments, please do not hesitate to contact me at 916-448-2581 or via email at tim_shestek@americanchemistry.com

Sincerely,

Tim Shestek
Senior Director, State Affairs

Environmental Stewardship and Fire Safety

By Citizens For Fire Safety

In recent years, the debate about the safety and efficacy of flame retardants has raged on both in state legislatures and in public opinion, pitting concerned mothers and environmentalists against fire safety advocates. Legislation that would seek to ban flame retardants without meaningful scientific support materialized in many states. To support these bans, proponents chose to propagate pseudoscience as truth, drawing their conclusions from speculation rather than science. Unfortunately, the message of a conscientious, responsible chemical industry went largely unheard. In the wake of mass poisonings and news stories on asbestos, PCBs and Tris, it almost makes sense to paint the chemical industry with a large brush. However, it is crucial to separate fact from fiction and to let science have the final say on safety.

The most widely used and ferociously debated flame retardant is Deca-BDE or decabromodiphenyl ether. This particular flame retardant is used in a variety of applications, from electronics to furnishings. It helps slow the progress of a fire and can mean the difference between an ignition source sustaining charring and total devastation of a structure. Many environmentalists and social activists have heard mixed messages about the safety of this product. Those advocating the removal of flame retardants have cited its toxicity and bioaccumulation. They lump Deca into a category of proven toxic chemicals without basis. The "science" used to substantiate their claims is speculative at best. The reality is that the studies that exist on this topic are isolated to mice and rats and consist of dosages far exceeding those present in products or seen in environmental studies. The more confusion and misinformation promulgated about this issue the less safe we will all be in the end.

Here are the facts: Deca-BDE is by far the most studied and most understood flame retardant available commercially. In fact, it was the sole focus of a 10-year-long Risk Assessment conducted by the European Union, and has also been analyzed and by such other groups as the US EPA, the National Academy of Sciences and the Consumer Product Safety Commission,

all of which have concluded that the product is safe for continued use. Most recently, a study sponsored by an industry affiliate concluded that Deca-bde poses no risk to human health. There have been claims that Deca-bde degrades into other toxic chemicals. This is untrue. This matter was extensively reviewed under the European Risk Assessment of Deca-BDE and, after reviewing the most recent data available through August 2005, the European Union reinforced its earlier findings on degradation.

In fact, laboratory studies indicating degradation of Deca-BDE do not reflect real environmental conditions. These studies use artificial conditions, including specially cultivated bacteria and accelerants, to produce an artificial degradation potential. Studies carried out under realistic environmental conditions find no indications for degradation of Deca to substances of concern. The findings of the European Risk Assessment of Deca-BDE, including the findings on degradation, were reviewed, updated and reaffirmed in December 2007.

Deca-BDE, is not a persistent, bioaccumulative and toxic (PBT) substance. Deca is not classified as a PBT by the U.S. Environmental Protection Agency. Deca is persistent, which means it will be present in the consumer good throughout the life of that product, providing protection against fires.

While there may still be questions regarding yet-to-be determined risks, there are things we do know about this chemical. We know that it saves lives. We know that its efficacy is unquestioned and that the crucial moments that it adds allow firefighters to extinguish a blaze and would-be victims to escape with their lives and possessions.

It's always important to ask questions about environmental stewardship, and it's often easy to assume that being "anti-chemical" is aligning yourself with the right position on an issue. And while it is true that without careful stewardship, chemicals can be bad for our environment, it is also important to recognize that chemophobia is not an answer. There are many chemicals that exist in the world

around us—some good, some not so good. But the distinction between those that are helpful and those that are harmful cannot be more empathically stated. We must remain vigilant about public health and the environment, but we must never be reckless concerning something as vital as fire safety.

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Alaska Community Action on Toxics

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Senator Bettye Davis and Members of the Committee
Senate Health and Social Services Committee
State Capitol
Juneau, AK 99801-1182

March 16, 2010

Dear Chair Davis and Members of the Senate Health and Social Services Committee:

Alaska Community Action on Toxics urges your support of SB 295, *"An Act relating to flame retardants and to the manufacture, sale, and distribution of products containing flame retardants; relating to bioaccumulative toxic chemicals; and providing for an effective date."* Alaska Community Action on Toxics ("ACAT") is a statewide environmental health organization that conducts research and provides educational programs, technical assistance, and training. Thank you for providing the opportunity of a hearing on this bill in the Senate Health and Social Services Committee on Wednesday March 17, 2010.

Polybrominated diphenyl ethers, or PBDEs, are a class of flame retardant chemicals added in the manufacturing process of plastics, fabric or foam padding to reduce the flammability of computers, upholstered furniture, appliances and other products. Three mixtures used widely—penta-BDE, octa-BDE, and deca-BDE—made up 14%, 6%, and 80% of the 1999 worldwide production, respectively. They can be released from these manufactured items.

PBDEs are part of a larger chemical class called polyhalogenated aromatic hydrocarbons (PHAHs) which include other highly toxic chemicals such as polychlorinated biphenyls (PCBs) and dioxins. PHAHs are intrinsically hazardous because of their chemical make-up: (1) they persist in the environment and do not break down easily; (2) they are lipophilic, meaning they build up in fatty tissues of living organisms; and (3) they have toxic properties, including the potential to act as endocrine disruptors. Their persistence and fat solubility allow them to both biomagnify and bioaccumulate. Thus, PBDEs build up in the bodies of animals and humans as they move through the food chain. Concentrations of PBDEs have increased over the years in marine mammals due to atmospheric transport of chemicals into the north (transported long distances from areas of production and use via air and ocean currents) and bioaccumulation. Although the main component in deca-BDE, BDE-209, has a relatively short half-life in people, animal studies show that the liver breaks down BDE-209 into the more persistent and bioaccumulative forms of PBDEs. Research indicates that we may be exposed to PBDEs through our diet, household air, household dust, and certain jobs.

Due to their widespread use, persistence and bioaccumulative properties, PBDEs have been found in humans at high levels. A recent study by scientists from the U.S. Centers for Disease Control and Prevention (CDC) found PBDEs in nearly all 2,040 participants in a sample representative of the 2003-2004 U.S. population. Another study showed that 5 percent of American women have levels of PBDEs that are close to the levels linked to reproductive problems in animals. PBDEs have been found in mothers' breast milk and in the blood of mothers and their babies. People of the Arctic,

including Alaska, may experience an even higher risk of exposure due to their traditional subsistence diet rich in fat from marine mammals. The highest known concentrations of PBDEs in human populations in the Arctic were found in Yupik women from the Yukon Kuskokwim Delta of Alaska. In a study of this population, 210 samples of blood serum were tested for PBDEs. The levels of PBDEs found were similar to those seen in studies of people from the continental United States. Similar studies on European populations have shown that Europeans have 3-10 times *lower* levels of PBDEs.

The following information is intended to inform you about the current state of knowledge on the health effects of PBDEs, including both human and animals studies. Research has found associations between PBDEs and many adverse health effects, including:

Neurodevelopmental Effects: Human studies indicate that prenatal exposure to PBDEs adversely affect childhood development including compromised fine motor skills and attention, and decreases in mental and physical development. A recent peer-reviewed scientific consensus statement by the Collaborative on Health and the Environment's Learning and Developmental Disabilities Initiative states, "*Recent studies have left little doubt that PBDEs are developmental neurotoxicants in animals and lead to changes in motor activity and reduced performance on learning and memory tests.*" Numerous studies on rodents suggest that neonatal exposure to PBDEs permanently affects learning and memory functions, impairs motor activity, and is linked to aberrations in spontaneous motor behavior and hyperactivity.

Thyroid Problems: Some PBDE congeners are structurally similar to thyroid hormone and have been shown to disrupt (by decreasing, increasing, or mimicking) the biological action of thyroid hormone. In a study of newborn babies, high PBDE levels in cord blood were associated with decreased levels of thyroid hormones. PBDE exposure has also been linked to hypothyroidism in adults. Corresponding animal studies have also shown that PBDE exposure is linked to decreased circulating concentrations of thyroid hormone and decreased thyroid weight in adult rodent offspring. Exposure to deca-BDE has been linked to thyroid hyperplasia in rodent studies. In a 2-year study by the National Toxicology Program, deca-BDE was found to increase the incidence of follicular cell hyperplasia (proliferation of follicular cells, which are responsible for making thyroid hormones) in the thyroid gland in male and female mice.

Reproductive Effects: PBDEs can be both mildly estrogenic and anti-androgenic compounds. PBDEs have been correlated to cause cryptorchidism, or undescended testes in new born boys, and permanent impairment of sperm development in laboratory animal studies. In human, exposure to PBDEs has been associated with a decrease in testicle size and the sperm concentration in humans. Exposure to PBDEs in household dust at levels commonly encountered in the US has been linked with lower levels of androgens (male hormones) in adult men. PBDEs have also been associated with delay of puberty in both male and female rodents and changes in sexual development and gender-specific sexual behavior. Exposure to PBDEs has been linked to low birth weight, birth defects, reduced weight gain during pregnancy, changes in ovary cells and reduced sperm count. The breakdown products of PBDEs may inhibit human aromatase, an enzyme important in the formation of androgens and estrogens (male and female hormones), and in skeletal development.

Cancer: One study suggests that *in utero* exposure to PBDE concentrations is associated with an increased risk of testicular cancer in men. The Agency for Toxic Substances and Disease Registry (ATSDR) lists deca-BDE as a possible human carcinogen based on the development of liver tumors in rats.

PBDEs pose a threat to public health. Firefighters are at particular risk because they are exposed to toxic fumes while on the job. When combusted, PBDEs release a highly corrosive gas known as hydrogen bromine. In a letter to Mark Drygan, president of the Alaska Professional Fire Fighters Association, Richard M. Duffy, Assistant to the General President of the International Association of Fire Fighters (IAFF), on behalf of IAFF writes: "Many studies involving fire fighters exposed to these and other toxic gases during active fire fighting, overhaul, and long term exposure from these chemicals penetrating protective gear, have found that fire fighters have a much greater risk of contracting cancer, heart and lung disease, and other debilitating diseases." In the same letter, Duffy states, "the IAFF believes that the passage of legislation addressing brominated flame retardants (Polybrominated diphenyl ethers (PBDEs) including Penta-, Octa-, and Deca-BDEs) is a step in the right direction for improving the health and safety of our fire fighters and the citizens who are exposed to these."

We do not have to compromise fire safety by phasing out brominated flame retardants because safe and affordable alternatives are available to replace the need for these toxic chemicals in our household products. Industry has already voluntarily phased out the use of penta- and octaBDE, and affordable, less toxic flame retardants are available for all deca-BDE uses. On December 17, 2009 the U.S. Environmental Protection Agency announced that the two U.S. producers of deca-BDE and the largest U.S. importer have committed to end production, importation, and sales of deca-BDE for most used in the United States. According to reports written by the states of Illinois, Maine, and Minnesota, there are affordable alternatives to deca-BDE for consumer electronics, residential upholstered furniture, and mattresses. In fact, many of these alternatives are already being used in the marketplace. For instance, Washington State estimates that roughly 57% of televisions and 95% of computer products do not contain deca-BDE. Furthermore, many companies are taking the lead in using safer alternatives, including Apple, Dell, Sony, Sharp, Samsung, Phillips, Sealy, Serta, Select Comfort, and many others.

In summary, SB 295 presents a viable tool for protecting the health of Alaskan workers, public health, and the environment. We believe that implementation of this bill will not create hardship for local businesses, as there are many viable and economic alternatives. Thank you for your careful consideration of the merits of this bill. We urge the Committee to ensure its passage.

Sincerely,

Pamela K. Miller
Executive Director
Alaska Community Action on Toxics

Colleen Keane
Environmental Health Organizer
Alaska Community Action on Toxics

CC: Co-Chair Senator Joe Paskvan
Senator Fred Dyson
Senator Johnny Ellis
Senator Joe Thomas
Senator Bill Wielechowski

Enclosure

Protect Public Health
SB 295/HB 385 "Flame Retardants and Toxic Chemicals"

Flame retardants are widely used in a variety of products to prevent and slow the spread of fire. While fire retardancy is important, some flame retardants, known as polybrominated diphenyl ethers or PBDEs, used in electronic and other products are leaving a lasting toxic legacy in people and the environment. With cost-effective and equally fire-safe alternatives available, it's time to phase out PBDEs.

- Polybrominated diphenyl ethers, or PBDEs, are a class of flame retardant chemicals added to many consumer products found in the home, office, automobiles, and airplanes.
- The three mixtures used most widely are penta-BDE, octa-BDE, and deca-BDE.
- Commonly found in electronics, such as the plastic casings of TVs and computers, and used in some furniture foams, textiles, and kitchen appliances, industry voluntarily ended production in the United States of the formulations of penta and octa in 2004 after high levels were found in breast milk.
- Over fifty million pounds of the toxic flame retardant decaBDE continue to be built into TVs, mattresses, and other products annually in North America.
- DecaBDE is a developmental toxin and listed as possible human carcinogen.
- Many electronic companies have found safer substitutes and have phased out the use of PBDEs.

The American Public Health Association, the International Association of Fire Fighters, and the Alaska Professional Fire Fighters Association have recommended the phase out of toxic PBDE flame retardants.

ALASKA'S FLAME RETARDANTS AND TOXIC CHEMICALS BILLS – SB 295 & HB 385

- Phases out the manufacture and sale of products containing penta- and octa-BDEs by January 1, 2011.
- Phases out the manufacture and sale of electronic products, furniture, textiles, and mattresses containing deca-BDE by 2011.
- Exempts transportation vehicles; products or equipment for industrial and mining use; products or equipment used in a manufacturing process; electronic wiring; resold items; and items brought into the state before the effective date.
- Empowers Alaska State Department of Environmental Conservation (ADEC) to ban other products containing flame retardants if it is determined that it is harmful to public health or the environment, and if reasonable safe alternatives exist.
- Requires several state departments to complete a review of the risks of PBDEs, possible alternatives, and the findings from other U.S. agencies.
- Requires ADEC to develop a list of "chemicals of concern" that are persistent bioaccumulative toxics, including those that are cancer-causing, mutagenic, developmental or reproductive toxicants, neurotoxic, or endocrine disruptors.

WHAT ARE TOXIC FLAME RETARDANTS?

Polybrominated diphenyl ethers, or PBDEs, are a class of flame retardant chemicals added to many consumer products found in the home, office, automobiles, and airplanes. The three most common commercial classes of PBDEs are penta-BDE, octa-BDE, and deca-BDE. PBDEs are also part of a broader chemical class called polyhalogenated aromatic hydrocarbons (PHAHs) which include other highly toxic chemicals such as PCBs and dioxins. PBDEs are intrinsically hazardous because of their chemical characteristics: (1) they are stable, meaning that they are persistent in the environment and do not break down easily; (2) they are lipophilic, meaning that they accumulate in fatty tissues of living organisms; and (3) they have toxic properties, including the potential to act as endocrine disruptors. Their persistence and fat solubility allow them to both bio-magnify and bio-accumulate, meaning that they build up in the bodies of animals and humans.

Increasing Levels

PBDE levels are increasing at an exponential pace, as they are still largely unregulated in the U.S.

- The highest known concentrations of PBDEs in human populations in the Arctic were found in Yupik women from the Yukon Kuskokwim Delta of Alaska.[1]
- Levels of PBDEs in U.S. women's breast milk are 10-100 times higher than levels in European women.[2,3]
- Concentrations of PBDEs have increased over the years in marine mammals due to atmospheric transport and bioaccumulation.[3]

HEALTH CONCERNS

Developmental Effects: Studies in laboratory animals indicate that neonatal exposure to PBDEs permanently damages learning and memory functions, impairs motor activity, and is linked to permanent behavioral aberrations and hyperactivity.[4,5]

Reproductive Effects: PBDE exposures have been correlated with cryptorchidism, or undescended testes in new born boys,[6] and permanent impairment of sperm development in laboratory animal studies.[5] Exposures have also been associated with the delay of puberty in both male and female laboratory animals and alterations in sexual development and gender-specific sexual behavior.[7]

Cancer: One study suggests that *in utero* exposure to PBDEs is associated with an increased risk of testicular cancer in men.[8] The Agency for Toxic Substances and Disease Registry (ATSDR) lists deca-BDE as a possible human carcinogen based on the development of liver tumors in laboratory animals.[9]

Thyroid Problems: Recent animal studies have shown that PBDE exposure is linked to decreased circulating concentrations of thyroid hormone[5] and to a decrease in thyroid weight in adult offspring.[7]

SAFER ALTERNATIVES ARE AVAILABLE

Alternatives to the use of PBDE flame retardants are available and cost effective. Alternatives include product redesign to eliminate the need for added chemicals. According to reports written by the states of Illinosi, Maine, and Minnesota, there are affordable alternatives to deca-BDE for consumer electronics, residential upholstered furniture, and mattresses. In fact, many of these alternatives are already being used in the marketplace. For instance, Washington State estimates that roughly 57% of televisions and 95% of computer products do not contain deca-BDE.

Many companies are taking the lead in using safer alternatives, including Apple, Dell, Xerox, Ericsson, IBM, Intel, Motorola, Sony, Panasonic, Phillips, Sealy, Serta, Select Comfort, and many others. and others. Here is what the leading companies are saying about eliminating deca-BDE in their products:

"All virgin plastics presently used by Sony are 'deca-free' (Decabromodyphenyl ether). These products meet all relevant fire safety standards."
-Sony Electronics; March. 2006

"We currently avoid the use of BFRs (brominated flame retardants) by using plastics that can be flame retarded with non-halogenated compounds and by using design strategies that reduce the need to use flame retarded plastics at all."
-Dell Computer Corporation; December 2005

"HP eliminated the use of two brominated flame retardants (BFRs) PBB and PBDE...HP has removed the remaining BFRs from the plastic housings of the vast majority of HP products."
-HP; March 2006

"The use of PBDEs in mattresses today – which is limited already – will likely be voluntarily phased out entirely in the near future."
-International Sleep Products Association; November 2003

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Safer Alternatives to Deca

Achieving Fire Safety Without Toxic Chemicals

... We did not see any evidence that flame retardants being used as alternatives to decaBDE do not meet all required fire safety standards.[i] - Illinois Environmental Protection Agency

SB285 would limit the use of Deca in these plastic products:
TVs • Computers • Residential Upholstered Furniture • Mattresses

Current Uses of Deca:

Approximately 80% of Deca used in the United States is in electronics, with the vast majority used in the plastic casings of televisions. The use of Deca in computer monitors is extremely rare. According to Washington State, 95% of computer products are Deca-free."

Textiles comprise the second largest use of Deca in the country. However, the chemical is not currently typically used in residential upholstered furniture and "furniture industry sources suggest that, in 99% of cases, chemical flame retardants will not be needed to meet pending national standards for residential upholstered furniture."[iii]

With regard to mattresses, Deca was previously used by manufacturers. However, the industry has made a shift. "The International Sleep Products Association (ISPA), a trade association representing mattress manufacturers, reports that all its members use fire-resistant barriers that minimize the need for flame retardant chemicals." In addition, manufacturers have uniformly avoided the use of Deca to meet a national flammability standard that took effect in July 2007.[iv]

Current Uses of Deca.

Plastic housing of TVs	Vast majority
Plastic housing of computers	Very rare
Residential upholstered furniture	Not Used
Mattresses or mattress pads	Industry shift away from Deca

Fire Safety Standards for TV Enclosures (Underwriters Laboratories, UL 94)

Underwriters Laboratories sets the safety standards for TVs sold in the United States.

The UL standard for TV Enclosures requires the UL 94 V-0 rating for all plastics within five inches of an ignition source.

This is a vertical burn test where five vertically mounted samples of plastics are exposed to two consecutive 10-second ignitions from an open flame. The UL 94 V-0 rating is one of the most stringent requirements.

- The extinguishment time for each sample after each exposure is 10 seconds.
- The second combustion time for all five samples does not exceed 30 seconds.
- The glowing time per sample does not exceed 60 seconds.
- There were no flaming drips.
- No burning occurred up to the holding clamp.

Deca-free TVs must meet the UL 94 V-0 standard and already do the majority of the market.

95% of Computers are already Deca-free

Source: Washington State DEP. *Washington State Polybrominated Diphenyl Ether (PHDE) Chemical Action Plan: Final Plan.* January 2006.

Meeting Fire Safety Standards

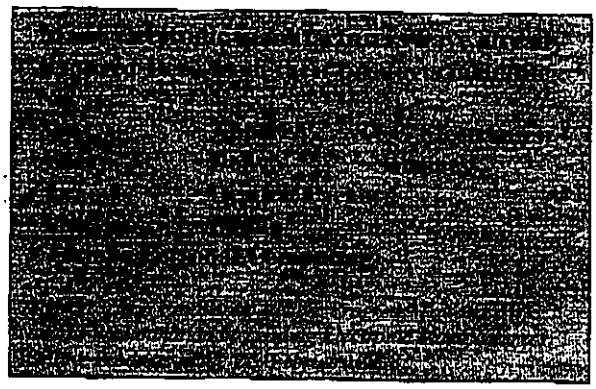
Fire safety standards for televisions, computers, furniture, and mattresses can be achieved without Deca by using non-chemical and chemical substitutes.

Non-chemical alternatives to Deca can include the redesign of a product or the use of materials that are inherently more flame resistant. For example, in electronic equipment, metal components could be used to protect the power supply. And with textiles, easily ignitable fabrics could be replaced with materials that are difficult to ignite or burn more slowly (such as wool).[v]

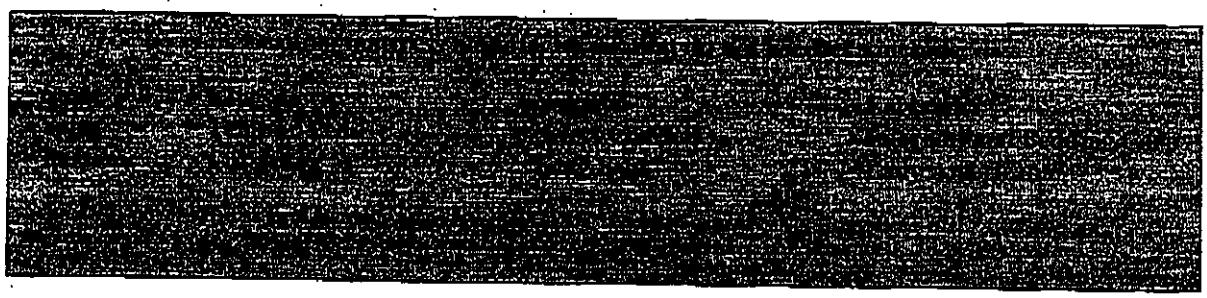
Fire safety standards can also be met by using chemical alternatives to Deca. For example, a phosphorous-based compound called resorcinol bis (diphenyl phosphate) (RDP) is a common substitute for Deca in electronics. According to the Maine Department of Environmental Protection and the Maine Center for Disease Control and Prevention, "RDP presents a significantly lower threat to the environment and human health than decaBDE."[vi]

Affordable Alternatives:

Alternatives to Deca are not only available, but are cost effective. According to reports written by the states of Illinois, Maine, and Minnesota, there are affordable alternatives to Deca for consumer electronics, residential upholstered furniture, and mattresses.



In fact, many of these alternatives are already being used in the marketplace. For instance, Washington State estimates that roughly 57% of televisions and 95% of computer products do not contain Deca.[vii] And as noted above, mattress manufacturers have already shifted away from the use of Deca.



For all applications in which decaBDE currently is used, alternatives without decaBDE are available ... No applications were identified in which decaBDE is the only flame retardant used or in which decaBDE offers unique or exceptional properties. No application was identified in which the use of alternatives requires a compromise in fire safety.[viii]

– Maine Department of Environmental Protection & Maine Center for Disease Control and Prevention

(The information in this factsheet was compiled by Vermont PIRG)

i Illinois Environmental Protection Agency, *Report on Alternatives to the Flame Retardant DecaBDE: Evaluation of Toxicity, Availability, Affordability, and Fire Safety Issues* (Appendix I, p.16), March 2007.

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v The Lowell Center for Sustainable Production, University of Massachusetts Lowell, *Decabromodiphenylether: An Investigation of Non-Halogen Substitutes in Electronic Enclosure and Textile Applications* (p.35), April 2005.

vi Maine Department of Environmental Protection and Maine Center for Disease Control and Prevention, *Brominated Flame Retardants: Third Annual Report to the Maine Legislature* (executive summary), January 2007.

vii Washington State DEP. *Washington State Polybrominated Diphenyl Ether (PBDE) Chemical Action Plan: Final Plan* (p.65). January 2006.

viii Maine Department of Environmental Protection and Maine Center for Disease Control and Prevention, *Brominated Flame* Retardants: Third Annual Report to the Maine Legislature (p.36), January 2007.

American Public Health Association

APHA

Policy Statement Database

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Preventing Human Exposure to Polybrominated diphenyl ether (PBDE) Flame Retardants to Protect Public Health

Policy Date: 11/9/2004
Policy Number: 2004-05

This policy, acknowledging that polybrominated diphenyl ether (PBDE) flame retardant compounds are widely used and chemically similar to PCBs, and noting more recent recognition that PBDEs are environmentally persistent, rapidly bioaccumulate in human tissue including breast milk and function as developmental neurotoxicants in animals, urges proactive steps to reduce human exposure citing especially APHA policy (#200011) encouraging "precautionary action to prevent potential harm to reproductive health, infants, and children, even if some cause and effect relationships have not been established with scientific certainty."1

More specifically, PBDEs are commonly used flame retardants found in foam products, textiles, electrical equipment, building materials and transportation. Penta-BDE, octa-BDE and deca-BDE are three of the most common commercial classes, with varying numbers of bromine atoms per molecule. Chemically, they look very much like PCBs, which were banned in 1976 due to their high toxicity and persistence and now conclusive evidence that they cause neurodevelopmental problems in children.2 Aside from their fire-retardant properties, PBDES are potent toxins that persist in the environment and bioaccumulate in the food chain and in human tissues.3 Like PCBs, PBDEs are lipophilic and have been found in fish, bird eggs and marine mammals as well as in human milk, fat and blood. While PCB levels in fish and breast milk have slowly declined since being banned, PBDE levels are increasing at an exponential rate. A 100-fold increase in total PBDEs was noted in Lake Ontario trout between 1978 and 1998.4 Body burdens of PBDEs in San Francisco Bay Harbor seals increased by a factor of 100 between 1989 and 1998.5 Total PBDE levels in human milk, blood and tissues have increased by a factor of 100 during the past 30 years, doubling about every five years.6 PBDE levels in U.S. women's breast milk are typically 10-100 times higher than levels in European women7,8 and are now approaching concentrations at which health effects have been observed in laboratory animals.9-17 Although human data on health effects are still lacking for PBDEs, ample data on toxicity are available from animal studies. These studies document that PBDEs are toxic to the brain, reproductive system and liver and disrupt thyroid function.18 Effects on thyroid function provide a plausible mechanism for PBDEs' possible adverse effects on child development. Human studies already document adverse effects on intelligence and psychomotor skills in children with disruptions in thyroid levels in the womb

through the second year of life.19-22 One study found that workers exposed to PBDEs experienced higher prevalence of hypothyroidism.23 Concurrent exposure to both PBDEs and PCBs, as from consuming some fatty fish, may present an increased risk since some researchers have found additive or synergistic effects between the two chemicals.24

PBDEs have been detected in household dust,25 food, and in air drawn from a warm TV,26 but the major human exposure pathways have yet to be identified. PBDEs with fewer bromines, such as penta, have the highest potential for bioaccumulation and are typically the most common classes found in humans, fish and other wildlife. Scientists, however, have increasingly been finding deca-BDEs and other higher brominated congeners in biota.27-29 Moreover, it is clear that deca can debrominate and convert to the more bioavailable forms in the environment and potentially during metabolism as well, making them a greater health risk than originally thought.

Global PBDE production totaled 150 million pounds in 1999, over 50 percent of which was used in the Americas.30 Deca-BDE is the most widely used class of BDE at 80 percent of worldwide production.31 Like PCBs, PBDEs flame retardants are now ubiquitous in the environment. The European Chemicals Bureau estimates that 75 percent of penta-BDE emissions will end up in soil and 24.9 percent in surface water and sediment.32 Measured levels of PBDEs in U.S. sewage sludge are 40 times that of European sludge.33

Eliminating most uses of PBDE flame retardants is possible, and a prudent step to protect public health. Concerns about rising levels of PBDEs in the breast milk of Swedish women led to efforts by industrial users in both Sweden and Germany to phase out the use of these chemicals. These actions have led to a decline in PBDE levels in breast milk of Swedish women.34 The European Union has enacted a ban on penta and octa-BDEs and is considering a ban on deca-BDEs as well. The states of California, Hawaii, New York, and Maine have enacted phase-outs of penta and octa-BDEs. Minnesota, Massachusetts, Michigan, Washington and Maryland have proposed similar state-level phase-outs.

Alternatives to the use of PBDE flame retardants are available and cost effective. Alternatives include: product redesign to eliminate the need for added chemicals; use of naturally flame retardant materials like wool and leather or plastics containing sulfur; and use of less toxic alternatives.35 The German Environmental Agency selected red phosphorus, ammonium polyphosphate and aluminum trihydroxide as alternatives with the least adverse environmental impact.36

Some computer and electronics manufacturers like Apple, Ericsson, IBM, Intel, Motorola, Panasonic, Phillips, and Sony are using alternatives. For example, Motorola now uses a halogen-free laminate that is cost effective, while meeting fire safety standards.37 Toshiba has replaced BFR-containing plastic casings in electronic parts with inherently flame-resistant polyphenylene sulfide. IKEA furniture, Crate and Barrel and Eddie Bauer are requesting PBDE-free polyurethane foam from their manufacturer Hickory Springs.

Although global manufacturers of these compounds continue to produce, as well as export, their products to the United States, one of the two U.S. manufacturers of PBDEs, Great Lakes Chemical, has already announced that they will phase out production of penta and octa-BDEs by 2005. The remaining U.S. manufacturer, Albemarle, continues to manufacture deca-BDE. By calling for a reasonable time frame for phase-out of deca-BDEs, impacts on businesses and workers could be minimized. Phasing out these compounds and substituting safer alternatives protects U.S.

manufacturers of PBDEs and companies that use them in their products from potential liability and helps maintain a European market for products requiring flame retardant properties. Since exposure to PBDEs may include an inhalation route of exposure, phasing out the manufacture of these chemicals should better protect the health of workers in industries dealing with PBDEs.

A PBDE phase-out may result in job loss for existing production workers. APHA policy statement 9304 acknowledges potential worker impacts and calls for assistance to workers who are displaced by technological changes.38 New research further supports the need for Work Environment Impact Assessments prior to chemical phase-outs/bans in order to prevent the shifting of risks to workers within the affected industry.39 A PBDE phase-out also provides economic opportunities for workers in industries which make safer alternatives to PBDE flame retardants.40

In light of the aforementioned emerging science on the inherent toxicity and persistence of PBDEs, evidence of adverse health effects on animals and the prevalence and rising levels in fish, biota and human breast milk, immediate action is needed to prevent further environmental contamination and to protect public health.

Therefore, The American Public Health Association hereby:

1. Resolves: That APHA urge state and federal governments to require the use of PBDE flame retardants be phased out in all products manufactured and sold in the United States by a date certain; and

2. Resolves: That APHA urge state and federal governments, in enacting such phase-outs, to consider policies that alleviate short-term economic impacts on the PBDE production workforce, and to also consider economic benefits to workers in industries making safer alternatives; and

3. Resolves: That APHA urge state and federal governments to provide financial incentives for development and use of alternative flame retardants or preferably changes in product design to increase fire resistance without use of chemicals, to assure fire safety, while protecting the public from toxic exposures; that alternative flame retardants be adequately tested for toxicity; and that environmental and health safety must be assured prior to use; and

4. Resolves: That APHA urge state and federal governments to require labeling of chemical flame retardants used in products; and

5. Resolves: That APHA urge state, federal and local governments to regulate the safe disposal of products containing brominated flame retardants and to prohibit land application of sewage sludge until testing can assure that such material does not contain measurable levels of PBDEs; and

6. Resolves: That APHA urge the U.S. Centers for Disease Control and Prevention to expand the national biomonitoring program to include PBDEs and to increase the number of people studied; and

7. Resolves: That APHA urge Congress to increase funding for research on PBDE flame retardants, including monitoring levels of PBDEs in fish, sediments, human milk, blood and tissue, and additional research into exposure routes and human health effects from these exposures.

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Celeste Hodge

From: Sen. Bettye Davis
Sent: Tuesday, March 16, 2010 7:45 PM
To: Celeste Hodge
Subject: FW: please support SB 295

Senator Bettye Davis
Senator
Alaska State Legislature
716 W. 4th Ave, Suite 400
Anchorage, Alaska 99501
907-269-0144 T
907-269-0148 F
Senator_Bettye_Davis@legis.state.ak.us

From: Dee Hunt [mailto:dhunt@gci.net]
Sent: Monday, March 15, 2010 5:42 PM
To: Sen. Bettye Davis
Subject: please support SB 295

Dear Senator Davis:

Please protect public health and the environment by phasing out PBDEs, which are added to plastics, foam products, and textiles to inhibit burning. Safer and economically viable alternatives are available and are already being used by some manufacturers of computers and other products.

PBDEs persist in the environment and bioaccumulate in fish, animals and humans.

I am asking you to support SB 295, which would phase out these toxic flame retardants.

Sincerely,
Dee Hunt

Dee Hunt
25145 Schaff Drive
Chugiak, AK 99567
phone and fax: 907-688-1568
email: dhunt@gci.net

Celeste Hodge

From: Sen. Bettye Davis
Sent: Tuesday, March 16, 2010 7:45 PM
To: Celeste Hodge
Subject: FW: SB295

Senator Bettye Davis
Senator
Alaska State Legislature
716 W. 4th Ave, Suite 400
Anchorage, Alaska 99501
907-269-0144 T
907-269-0148 F
Senator_Bettye_Davis@legis.state.ak.us

-----Original Message-----
From: Bob Mitchell [mailto:mitchell@ptialaska.net]
Sent: Monday, March 15, 2010 4:15 PM
To: Sen. Bettye Davis; Sen. Joe Paskvan; Sen. Fred Dyson; Sen. Johnny Ellis; Sen. Joe Thomas; Sen. Bill Wielechowski
Subject: SB295

Please vote to pass SB295, which is legislation that would protect public health and the environment by phasing out toxic flame retardants.
SB 295 would require the phase out of polybrominated diphenyl ethers (PBDEs). PBDEs are toxic flame retardant chemicals added to plastics, foam products, and textiles to make them difficult to burn. The EPA is concerned that certain PBDEs are persistent, bioaccumulative, and toxic to both humans and the environment. The American Public Health Association and International Association of Fire Fighters have urged the phase out of PBDEs. Safer and economically viable alternatives are available and are already being used by some manufacturers of computers and other products.

Thank you for your consideration.

And special thanks to Senator Wielechowski for introducing the bill.

Bob Mitchell
241 East 23rd Avenue
Anchorage AK 99503
907-274-4459

SB 307

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/10/10

FURTHER: Judiciary

Date of 5-Day Notice: March 11, 2010
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: March 16, 2010

Health and Social Services Committee considered SENATE BILL NO. 307

SB 307 SHELTERS FOR RUNAWAY MINORS

"An Act relating to residential shelters for runaway minors."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title
_____

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
Health	3/12/2010			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Ellis	✓			
	Thomas	✓			
	Pasicvan	X			
	Dyson	X			
CHAIR:	Davis	✓			

5448

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
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Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senate Health and Social Services Committee

SPONSOR STATEMENT

SENATE BILL 307 *"An Act relating to residential shelters for runaway minors"*

SB307 allows emergency residential shelters like the Covenant House to continue to accept federal grant funding. Covenant House Alaska has five programs that include emergency shelter, healthcare, job and educational assistance and transitional living. Covenant House Alaska served nearly 3,000 Alaskan youth in FY2009. Covenant House Alaska has been in Alaska for over 20 years and served literally tens of thousands of youth.

In 2007, Covenant House Alaska was awarded the federal Basic Center Grant (BCG) through the Administration for Children and Families. This competitive, federal grant supplied Covenant House Alaska with $300,000 phased over three years to operate the Crisis Center ($100,000 per year). The Administration for Children and Families recently notified Covenant House Alaska the Crisis Center is technically out of compliance with federal grant requirements stated in the Homeless and Runaway Youth Act.

The Act at 42 U.S.C Section 5712(b)(2)(A) states the shelter can have "a maximum capacity of not more than 20 youth, except where the applicant assures that the State where the center or locally controlled facility is located has a State or local law or regulation that requires a higher maximum to comply with licensure requirements for child and youth serving facilities." Established through the Act, federal regulation 45 CFR 1351.18 (d) states the Basic Center Grant (BCG) may be awarded to facilities with a shelter capacity of 20 beds or less. Covenant House Alaska holds 40 beds.

The Administration for Children and Families (ACF) concedes that states with statutes requiring them to operate a facility over 20 beds will meet the federal requirements. SB307 allows for a simple amendment to AS 47.10.310 – "Licensing of Programs for Runaway Minors" by adding a new subsection to read: "(e) A program for runaway minors that operates a licensed residential shelter in the state shall provide a shelter with a capacity designated in the license issued under AS 47.10.300-47.10.390." This simple amendment will allow emergency residential shelters like Covenant House Alaska to continue competing for the federal Basic Center Grant (BCG).

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB307
() Publish Date:

Identifier (file name): SB307-DHSS-C&L-3-12-10
Dept. Affected: Health & Social Services

Title: Shelters for Runaway Minors
RDU: Public Health
Component: Certification and Licensing

Sponsor: Health & Social Services

Requester: Senate HSS
Component Number: 245

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This statutory change is designed to bring Covenant House Alaska (a shelter for homeless youth) into compliance with federal grant requirements in the Homeless Runaway Youth Act. Federal regulations have a capacity cap of 20 beds, and this will allow Covenant House to operate a 40-bed facility under the terms of their license without jeopardizing their grant. It does not create an increased workload for existing staff; therefore, the Department has determined this will have zero fiscal impact to state operations.

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Officer / Director
Phone 907-269-8126
Division: Public Health
Date/Time 3/11/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/12/2010
DHSS Finance & Management Services

5450

C

Effective: October 8, 2008

United States Code Annotated Currentness
Title 42. The Public Health and Welfare
Chapter 72. Juvenile Justice and Delinquency Prevention (Refs & Annos)
Subchapter III. Runaway and Homeless Youth (Refs & Annos)
Part A. Basic Center Grant Program (Refs & Annos)
→ **§ 5712. Eligibility; plan requirements**

(a) Runaway and homeless youth center; project providing temporary shelter; counseling services

To be eligible for assistance under section 5711(a) of this title, an applicant shall propose to establish, strengthen, or fund an existing or proposed runaway and homeless youth center, a locally controlled project (including a host family home) that provides temporary shelter, and counseling services to youth who have left home without permission of their parents or guardians or to other homeless youth.

(b) Provisions of plan

In order to qualify for assistance under section 5711(a) of this title, an applicant shall submit a plan to the Secretary including assurances that the applicant--

(1) shall operate a runaway and homeless youth center located in an area which is demonstrably frequented by or easily reachable by runaway and homeless youth;

(2) shall use such assistance to establish, to strengthen, or to fund a runaway and homeless youth center, or a locally controlled facility providing temporary shelter, that has--

(A) a maximum capacity of not more than 20 youth, except where the applicant assures that the State where the center or locally controlled facility is located has a State or local law or regulation that requires a higher maximum to comply with licensure requirements for child and youth serving facilities; and

(B) a ratio of staff to youth that is sufficient to ensure adequate supervision and treatment;

(3) shall develop adequate plans for contacting the parents or other relatives of the youth and ensuring the safe return of the youth according to the best interests of the youth, for contacting local government officials pursuant to informal arrangements established with such officials by the runaway and homeless youth center and for providing for other appropriate alternative living arrangements;

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Covenant House Alaska

Crisis Center • Community Services Center • Transitional Living

The Honorable Bettye Davis
State Capitol
Juneau, AK 99801

March 1, 2010

Dear Senator Davis,

Thank you for your long-standing support of Covenant House Alaska (CHA). CHA is the only shelter in Alaska specifically designed for homeless youth. Throughout our five programs including emergency shelter, healthcare, job and educational assistance and transitional living, CHA served nearly 3,000 Alaskan youth in FY09. CHA has been in Alaska for over 20 years and served literally tens of thousands of youth.

CHA was awarded the Basic Center Grant (BCG) through the Administration for Children and Families (ACF) in 2007. This competitive, federal grant supplied CHA with $300,000 phased over 3 years to operate the Crisis Center ($100,000 per year). ACF recently notified CHA that the Crisis Center is technically out of compliance with federal grant requirements stated in the Homeless and Runaway Youth Act. CHA will not be competitive for the new grant cycle starting in September 2010 if Alaska's state statute is not amended to comply with federal requirements.

Established through the Act, federal regulation 45 CFR 1351.18 (d) states that the BCG will be awarded to facilities with a shelter capacity of 20 beds or less. CHA's Crisis Center holds 40 beds. ACF concedes that states with statute requiring them to operate a facility over 20 beds will override the federal requirements. Through consultation with an attorney, CHA proposes the following change in Alaska statute to satisfy ACF's request.

Amendment to AS 47.10.310 to add a new subsection (e):

> (e) A program for runaway minors, which operates a residential shelter in the State of Alaska for runaway or homeless minors and which is required to obtain a license to operate pursuant to AS 47.10.330 – 47.10.390, is required to provide a shelter with the capacity designated in the approved license.

Since CHA is licensed to operated a shelter with 40 beds, this amendment would effectively require CHA to operate a facility that houses over 20 youth.

As the Chair of the Senate Health, Education and Social Services Committee, CHA is seeking your assistance in changing Alaska's statute. Our goal is to have a committee bill introduced this session in order to comply with the federal regulations by September 2010. Please contact me for additional materials if necessary, including ACF's findings.

Thank you for your consideration. Please contact me with any questions.

Sincerely,

Deirdre A. Cronin

Although a change in regulations may satisfy federal requirements, CHA is pursuing a change in statute as a primary means to satisfy the grant requirements. Through consultation with an attorney, CHA proposes the following change in Alaska statute to satisfy ACF's request.

Amendment to AS 47.10.310 to add a new subsection (e):

> (e) A program for runaway minors, which operates a residential shelter in the State of Alaska for runaway or homeless minors and which is required to obtain a license to operate pursuant to AS 47.10.330 – 47.10.390, is required to provide a shelter with the capacity designated in the approved license.

Since CHA is licensed to operated a shelter with 40 beds, this amendment would effectively require CHA to operate a facility that houses over 20 youth. Our goal is to make this change to statute during the 2010 Legislative Session.

Similarly, CHA will be pursuing a change in regulations simultaneously. Pursuing a change in regulations will both compliment our legislative changes, as well as serve as a back-up if the statutory changes are not completed in the 2010 Legislative Session.

A change in regulation would likely be an addition to 7 AAC 57.030. A new subsection could be added to the end of 7 AAC 57.030 that stated something to the following effect:

Upon issuance of a license to a program for runaway minors authorizing operation of any type of residential shelter in the State of Alaska for runaway or homeless minors within the meaning of AS 47.10.330-47.10.390, the program receiving the license is required to provide a shelter with the capacity designated in the approved license.

As the Commissioner of Health and Social Services, CHA wants to ensure you are adequately briefed on our goals to amend Alaska's statute and/or regulations and actively pursue the BCG next fall. We hope you will be supportive of our efforts.

Thank you for your consideration. Please contact me with any questions.

Sincerely,

Deirdre A. Cronin

Deirdre A. Cronin
Executive Director

HHS publishes annually in the Federal Register a program announcement of grant funds available under the Runaway and Homeless Youth Program Act. The program announcement states the amount of funds available, program priorities for funding, and criteria for evaluating applications in awarding grants. The announcement also describes specific procedures for receipt and review of applications. An applicant should:

(a) Obtain a program announcement from the Federal Register or from one of HHS's 10 Regional Offices in Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, San Francisco, and Seattle;

(b) Obtain an application package from one of HHS's Regional Offices; and

(c) Submit a completed application to the Grants Management Office at the appropriate Regional Office.

[43 FR 55635, Nov. 28, 1978, as amended at 48 FR 29202, June 24, 1983]

§ 1351.18 What criteria has HHS established for deciding which Runaway and Homeless Youth Program grant applications to fund?

top

In reviewing applications for a Runaway and Homeless Youth Program grant, HHS takes into consideration a number of factors, including:

(a) Whether the application meets one or more of the program's funding priorities; (see §1351.12)

(b) The need for Federal support based on the number of runaway or otherwise homeless youth in the area in which the runaway and homeless youth project is or will be located;

(c) The availability of services to runaway or otherwise homeless youth in the area in which the runaway and homeless youth project is located;

(d) Whether there is a minimum residential capacity of four and a maximum residential capacity not to exceed 20 youth with a ratio of staff to youth sufficient to assure adequate supervision and treatment;

(e) Plans for meeting the best interests of the youth involving, when possible, both the youth and the family. These must include contacts with the families. This contact should be made within 24 hours, but must be made no more than 72 hours following the time of the youth's admission into the runaway and homeless youth project. The plans must also include assuring the youth's safe return home or to local government officials or law enforcement officials and indicate efforts to provide appropriate alternative living arrangements.

(f) Plans for the delivery of aftercare or counseling services to runaway or otherwise homeless youth and their families;

(g) Whether the estimated cost to the Department for the runaway and homeless youth project is reasonable considering the anticipated results;

(h) Whether the proposed personnel are well qualified and the applicant agency has adequate facilities and resources;

(i) Whether the proposed project design, if well executed, is capable of attaining program objectives;

(j) The consistency of the grant application with the provisions of the Act and these regulations.

§ 1351.19 What additional information should an applicant or grantee have about a Runaway and Homeless Youth Program grant?

top

(a) Several other HHS rules and regulations apply to applicants for or recipients of Runaway and Homeless Youth Program grants. These include:

(1) The provisions of 45 CFR part 74 pertaining to the Administration of Grants;

(2) The provisions of 45 CFR part 16, Departmental Grants Appeal Process, and the provisions of Informal Grant Appeal Procedures (Indirect Costs) in volume 45 CFR part 75;

(3) The provisions of 45 CFR part 80 and 45 CFR part 81 pertaining to nondiscrimination under programs receiving Federal assistance, and hearing procedures;

(4) The provisions of 45 CFR part 84 pertaining to discrimination on the basis of handicap;

(5) The provisions of 45 CFR part 46 pertaining to protection of human subjects.

(3) award nonprofit corporations or municipalities grants for the establishment or operation of licensed programs for runaway minors;

(4) adopt regulations for the administration of AS 47.10.300 — 47.10.390, including regulations providing for the coordination of services to be provided by licensed programs for runaway minors and by the department. (§ 4 ch 144 SLA 1988; am § 35 ch 126 SLA 1994; am § 8 ch 107 SLA 1998)

Collateral references. — 47 Am. Jur. 2d, Juvenile Courts and Delinquent and Dependent Children, § 36.

Sec. 47.10.310. Licensing of programs for runaway minors. (a) A person may not operate a program for runaway minors in the state without a license issued under this section. A person who violates this subsection is guilty of a violation.

(b) The department may license a program for runaway minors under AS 47.10.300 — 47.10.390 only if the program

(1) is operated by a corporation or a municipality; and

(2) meets the requirements of (c) of this section.

(c) A program for runaway minors shall

(1) explain to a minor who seeks assistance from the program the legal rights and responsibilities of runaway minors and the services and assistance provided for runaway minors by the program and by the state or local municipality;

(2) upon admission of a minor to the program, attempt to determine why the minor is a runaway and what services may be necessary or appropriate for reuniting the minor with the minor's family;

(3) provide or help arrange for the provision of services necessary to promote the health and welfare of a minor in the program and, if appropriate, members of the minor's family; services may include, but are not limited to, the provision of food, shelter, clothing, medical care, and individual, group, or family counseling;

(4) within one state working day after admission of a minor to the program inform the department of a minor in the program

(A) who claims to be the victim of child abuse or neglect, as defined in AS 47.17.290;

(B) whom an employee of the program has cause to believe has been a victim of child abuse or neglect; or

(C) whom an employee of the program has reason to believe is evading the supervision of the department, the person to whom the department has entrusted supervision, or the minor's legal guardian;

(5) be operated with the goal of reuniting runaway minors with their families, except in cases in which reunification is clearly contrary to the best interest of the minor; and

(6) maintain adequate staffing and accommodations to ensure physical security and to provide crisis services to minors residing in a facility operated by the program; a program that, as determined by the department, regularly receives state money in an amount that exceeds one-fourth of the program's costs shall maintain semi-secure portions of its facilities in a proportion that meets regulations established by the department; residents under 18 years of age shall be segregated from residents who are 18 years of age or older.

(d) A program for runaway minors may provide services for the protection of the health and welfare of a person under 21 years of age who is in need of the services and who is without a place of shelter in which supervision and care of the person are available. (§ 4 ch 144 SLA 1988; am § 17 ch 33 SLA 1994; am § 8 ch 120 SLA 1996; am § 9 ch 107 SLA 1998)

(e) . . .

NOTES TO DECISIONS

Cited in R.J.M. v. State, 946 P.2d 855 (Alaska 1997).

SCR

1

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
Phone (907) 269-0250
Fax (907) 269-0249

SENATOR LESIL MCGUIRE

Co-Chair
Senate Resources Committee

Chair
Senate Special Committee on Energy
Senate Special Committee on World Trade, Technology & Innovation

Member
Senate Judiciary Committee
Joint Armed Services Committee

MEMORANDUM

To: Senator Bettye Davis
Chair, Senate Health & Social Services Committee

From: Senator Lesil McGuire

Date: January 30, 2009

Re: Hearing Request: SCR 1: Brain Injury Awareness Month 2009

I respectfully request that SCR 1 *A Resolution relating to establishing March 2008 as brain injury awareness month* be scheduled for a hearing in the Senate Health & Social Services Committee at your earliest convenience. Attached you will find the most current version of the resolution, a sponsor statement, and all backup information.

If you have any questions or concerns, please feel free to contact me personally or my staff, Trevor Fulton, at x3579. Thank you for your time and consideration.

Update 2/10/09

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
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Fax (907) 465-6592

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Co-Chair
Senate Resources Committee

Chair
Senate Special Committee on Energy
Senate Special Committee on World Trade, Technology & Innovation

Member
Senate Judiciary Committee
Joint Armed Services Committee

SENATOR LESIL MCGUIRE

SPONSOR STATEMENT

SCR 1: *BRAIN INJURY AWARENESS MONTH: MARCH 2008*

SCR 1 aims to raise awareness about traumatic brain injuries and the impact they have on Alaskans and their families.

A traumatic brain injury (TBI) is when a blow or jolt hits the head hard enough it causes the brain to move within the skull or the skull breaks and the brain is directly hurt. When this happens, the injury disrupts the normal functioning of the brain. A traumatic brain injury can result in both short-term and long-term problems that involve impairment of cognitive abilities, physical functioning, or both.

Brain injury is very complex because no two injuries are the same. How each person may react to the same type of trauma is unknown. The cause, location and severity also are factors in how a person will react to a brain injury.

The State of Alaska is number one per capita for brain injuries and TBI is one of the leading causes of death of young people in the state. Over 800 TBIs are reported annually and an estimated 12,000 Alaskans have suffered a TBI. It is unknown how many people suffer from traumatic brain injuries (TBI) who do not receive medical assistance.

These injuries are often life altering and consequently place a tremendous strain on victims and their families. Victims often live with permanent disabilities and the tragedy of TBI is exacerbated by the fact that most TBIs are preventable.

The Brain Injury Association of America recognizes March of each year as Brain Injury Awareness Month. SJR 1 comports with national recognition by making March 2009 Traumatic Brain Injury Awareness Month in Alaska.

Because TBI incidence in Alaska is on the rise, raising TBI awareness is more important now than it has ever been. TBIs are one of the most common injuries incurred in military combat today and as injured military personnel return home to Alaska the rate of TBIs is increasing sharply -- with no signs of slowing.

According to a task force on traumatic brain injury created by the Army Surgeon General, as many as one in five U.S. combat troops who fought in Iraq or Afghanistan leave with signs they may have had a TBI. The Walter Reed Army Medical Center reports that 60% of arriving service members from Iraq have a TBI from blasts, severe falls, and motor vehicle accidents. TBI screening at the National Naval Medical Center shows that 83% of wounded Marines treated at that facility have some form of temporary or permanent brain damage.

Rising TBI rates in Alaska is another reason why it is so important to bring attention to this silent epidemic. So please join us in support of brain injury awareness, prevention, and treatment by supporting SCR 1.

STATE OF ALASKA

Executive Proclamation
by
Sarah Palin, Governor

An estimated 5.3 million Americans currently live with disabilities resulting from traumatic brain injury (TBI). Every year, 80,000 individuals experience the onset of long-term disability following a brain injury. Brain injury can affect a person cognitively, physically, emotionally, and behaviorally. Consequences can include short and long-term memory loss, double or low vision, headaches or migraines, fatigue, increased anxiety, depression and mood swings, and impulsive behavior.

The three leading causes of brain injury are motor vehicle accidents, violence, and falls. Falls are the leading cause of brain injury in the elderly. The risk of brain injury is higher in adolescents, young adults, and people older than 75 years. After one brain injury, the risk for a second injury is three times greater, after the second injury, the risk for a third injury is eight times greater.

The effects of brain injury are devastating emotionally and financially to families. The cost of brain injury in the United States is estimated to be $48.3 billion annually.

The Alaska Department of Health and Social Services, Division of Behavioral Health, the lead state agency for TBI, in close collaboration with the Alaska Traumatic Brain Injury Advisory Network, the Division of Public Health, the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Governor's Council on Disabilities and Special Education, and the Alaska Commission on Aging are all working together toward the prevention, treatment, and rehabilitation of traumatic brain injury in Alaska.

Public awareness of the extent, consequences, and causes of brain injury is critical to the prevention of these injuries and will enhance the recovery process for persons with brain injury.

NOW, THEREFORE, I, Sarah Palin, Governor of the State of Alaska, do hereby proclaim March 2007 as:

Traumatic Brain Injury Awareness Month

in Alaska, and encourage everyone to remember those with brain injuries and be more informed about traumatic brain injury.

Dated: March 8, 2007

Sarah Palin, Governor
who has also authorized the seal of the State of Alaska to be affixed to this proclamation.

5459

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SCR1**
() Publish Date:

Identifier (file name): SCR1-LEG-COU-2-11-09
Title: Relating to establishing March 2009 as Brain Injury Awareness Month.
Sponsor: Senator Lesil McGuire
Requester: Senate HESS Committee

Dept. Affected: Legislature
RDU: Legislative Council
Component: Council and Subcommittees
Component Number: 783

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*
This legislation has zero fiscal impact on the Legislative Affairs Agency.

Prepared by: Karla Schofield, Deputy Director — Phone 465-6626
Division: Legislative Affairs Agency — Date/Time 2/11/09 12:32 PM
Approved by: Pamela Varni, Executive Director — Date 2/11/2009
Legislative Affairs Agency

(Revised 9/10/2008 OMB)

5460

Testimony for SCR 1

Jill Hodges, Executive Director, Alaska Brain Injury Network

Nancy Michaelson, mother of TBI survivor

SCR1 "Resolution Relating To Establishing March 2009 As Brain Injury Awareness Month"
Testimony given to the Senate Health and Social Services Committee, February 11, 2009
Nancy Michaelson

Good afternoon, Honored Chair and Committee members,

Thank you for letting me comment to you today on SCR1, a Resolution that is near and dear to my heart.

My husband and I live in our home with our 25 year old son Aren who 6 years ago became permanently disabled with brain injury. He was fortunate enough to get admitted to Craig Rehabilitation Hospital in Denver, Colorado.

Why do I say "fortunate enough"? Because Aren had serious medical issues that needed specialized care from a full team of doctors, and he was able to get that while participating daily in a rehab program especially designed for brain injury patients.

But, even more than that, within the first 20 hours there, we were met with the attitude that Aren had widespread damage so we had a lot of work to do and we'd better get started.

I cannot stress to you enough the differences in this attitude from what we experienced here at home both before we went to Craig for rehab and after we returned.

So, yes, we were lucky to go outside to a specialty brain injury rehab center for the following over-riding reason: the "Hopeful Outlook." Hope -- for Aren's future and our future as a family; for the life he and we can have regardless of the status of his cognition or abilities. We came home with the realization that we can fight for, move towards, and support quality of life for persons with brain injury regardless of their stage of injury. We learned appreciation for an ability to look outside the box of traditional physical rehabilitation therapy and care programs to find approaches that work with persons with brain injury, always keeping in mind the unique challenge of the delicate balance between physical abilities and cognitive realities. Insurance policies cover these approaches and there are places these therapies happen in the US, why not in Alaska?

To be honest with you, when we returned to Alaska and visited our son's Rehab doctor and staff -- he is mainly immobile and largely incommunicative -- we told them we were "ecstatic" to have Aren at home with us. We were met with incredulous and even insulting comments.

We attribute this to **our** outlook upon returning from the brain injury rehab center and our acceptance that the only life we have with our son is what it will be with brain injury, regardless of what progress he makes. We also attribute these negative comments to a lack of general awareness in Alaska about brain injury and of the wide range of capabilities of brain injury survivors. High needs and lower-level function survivors like Aren sit in a wheelchair and look like they can't understand anything to the untrained eye, until you tell them just the right joke, or talk to them about politics, or take them sledding. Other survivors may walk, talk, drive, teach art, but not be able to balance a checkbook, answer a telephone, or remember the routine you go through before you go to bed at night.

We have encountered problems since we got back in Alaska getting rehab medical or therapy

care. Most of the problems had to do with the fact that Aren got his original treatment Outside...or had his pain pump implanted there to help control his spasticity.

I fear for those numerous returning Vets who may only face the same problems at the very same time Alaskans are offering them a hero's welcome home.

What about how families are affected by brain injury? Indeed, Aren's brain injury has not only disabled him for the rest of his life, but has changed his sister's life -- and that of her new, young family -- forever. Aren will have high needs forever, will probably never walk up to her to hug her or thump her on the head again, and will require Guardianship management after we are gone. This kind of psychological and emotional reality can and usually does break families. In our family, Aren's care totally consumes our daily schedule and our finances. (I lost my job after his injury since I had to be home caring for him.)

Known as "the quiet epidemic", sometimes brain injury is not so silent. There are sleepless nights and crying from pain that Aren may or may not be able to identify or communicate to us. And there is occasional sobbing. Universally, depression is a side effect of brain injury. Thankfully, Aren has not often shown signs of this.

But you know what? Above everything else, we remain thankful just to be able to be together as a family, to have the life we **do** have.

This is where you come in.

We believe Alaskans deserve a local rehabilitation option that can give them the chance to get on the road to whatever recovery is possible and to learn to live life to its fullest potential even after surviving brain injury. But before we get there:

AWARENESS -- of the large numbers of Alaskans who suffer brain injuries annually,

AWARENESS -- of the wide scope of their rehabilitation needs,

AWARENESS -- of the impact of brain injury on families, and

AWARENESS -- that many brain injuries can be prevented.

YOU can help all of these become reality when you pass this resolution. We, the Michaelson family, commend the introduction of SCR1 and heartily thank you for your vote to declare March 2009 Brain Injury Awareness Month.

Sincerely,

Nancy Michaelson 7799 N Palmer Fishhook Rd, Palmer, AK 99645

amsa®

It Takes More Than Medical School to Make a Physician

Twelve Months of Disability Awareness

There are a number of disability-related awareness months, weeks and days. Promoting one or several of these days is a great way to increase the awareness of disability-related issues at your school. Where available, contact information is given. Call or write the appropriate organization to request promotional kits, posters and other available information. Remember: *Disabilities is more than just meets the eye!* Make sure others around you know this as well.

Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec

JANUARY

Mental Wellness Month

Thryroid Disease Awareness Month

National Birth Defects Prevention Month
March of Dimes Birth Defects Foundation
1275 Mamaroneck Ave, White Plains, NY 10605
(914) 997-4600

National Glaucoma Awareness Month
Prevent Blindness America
500 East Remington Rd, Schaumburg, IL 60173
(800) 331-2020 / (847) 843-2020

FEBRUARY

National Eating Disorders Screening Program

National Wise Mental Health Consumer Month

National American Heart Month

National Women's Heart Health Day

National Have-A-Heart Day: Feb. 14

American Heart Association
7272 Greenville Ave, Dallas, TX 75231
(800) AHA-USA

Low Vision Awareness Month
Prevent Blindness America
500 East Remington Rd, Schaumburg, IL 60173
(800) 331-2020 / (847) 843-2020

National Cardiac Rehabilitation Week
American Association of Cardiovascular and Pulmonary Rehabilitation
7611 Elmwood Ave, Ste 201, Middleton, WI 53562

(608) 831-6989

National Burn Awareness Week
Shriners Burn Institute
3229 Burnet Ave, Cincinnati, OH 45229
(513) 872-6000

MARCH

Hemophilia Month
National Hemophilia Foundation, Soho Building
110 Greene St, Ste 303, New York, NY 10012
(800) 42-HANDI

Mental Retardation Awareness Month
The Arc
500 East Border St, Ste 300, Arlington, TX 76010
(817) 261-6003

National Chronic Fatigue Syndrome Awareness Month
National Chronic Fatigue Syndrome and Fibromyalgia Association
PO Box 18426, Kansas City, MO 64133
(816) 313-2000 / (816) 524-6782 (Fax)

National Kidney Month
National Kidney Foundation
30 East 33rd St, New York, NY 10016
(800) 622-9010 / (212) 889-2210

Pulmonary Rehabilitation Week
American Association of Cardiovascular and Pulmonary Rehabilitation
7611 Elmwood Ave, Ste 201, Middleton, WI 53562
(608) 831-6989

American Diabetes Alert
American Diabetes Association
Duke St, Alexandria, VA 22314
(800) DIABETES

APRIL

Cancer Control Month
American Cancer Society
National Headquarters
1599 Clifton Rd NE, Atlanta, GA 30329-4251
(800) ACS-2345 / (404) 320-3333

Counseling Awareness Month
American Counseling Association
5999 Stevenson Ave, Alexandria, VA 22304
(703) 823-9800

National Autism Awareness Month
Autism Society of America
7910 Woodmont Ave, Ste 650, Bethesda, MD 20814-3015
(800) 3-AUTISM (parent information and referral calls only)
(800) 329-0899 (fax-on-demand, quick response)
(301) 657-0881 / (301) 657-0869 (fax)

National STD Awareness Month
American Social Health Association
PO Box 13827, Research Triangle Park, NC 27709
(919) 361-8400 / (919) 361-8425 (Fax)

National Minority Cancer Awareness Week
Cancer Information Service
NCI Office of Cancer Communications
Building 31, Room 10A16

9000 Rockville Pike, Bethesda, MD 20892
(800) 4-CANCER / (301) 402-2594

WalkAmerica
March of Dimes Birth Defects Foundation
1275 Mamaroneck Ave, White Plains, NY 10605
(914) 997-4573

MAY

Asthma and Allergy Awareness Month
Asthma and Allergy Foundation of America
1125 15th St NW, Ste 502, Washington, DC 20005
(800) 7-ASTHMA / (202) 466 7643

Better Hearing and Speech Month
American Speech-Language-Hearing Association
10801 Rockville Pike, Rockville, MD 20852
(800) 638-8255 / (301) 897-8682

Breathe Easy Month
American Lung Association
1740 Broadway, New York, NY 10019ñ4374
(800) LUNG-USA / (212) 315-8700

Hepatitis Awareness Month
Hepatitis Foundation International
30 Sunrise Terrace, Cedar Grove, NJ 07009
(973) 239-1035 / (973) 857-5044 (Fax)

Huntington's Disease Awareness Month
Huntingdon's Disease Society of America, Inc.
140 West 22nd St, Sixth Floor, New York, NY 10011-2420
(800) 345-4372 / (212) 242-1968
(212) 243-2443 (Fax)

National Arthritis Month
Arthritis Foundation
1330 West Peachtree St, Atlanta, GA 30309
(800) 283-7800 / (404) 872-7100

National Digestive Diseases Awareness Month
Digestive Disease National Coalition
507 Capitol Court NE, Ste 200, Washington, DC 20002
(202) 544-7497

National High Blood Pressure Month
National Heart, Lung, and Blood Institute Information Center
PO Box 30105, Bethesda, MD 20824-0105
(301) 251-1222 / (301) 251-1223 (Fax)
nhlbiic@dgsys.com

National Melanoma/Skin Cancer Detection and Prevention Month
American Academy of Dermatology
PO Box 681069, Schaumburg, IL 60168
(847)330-0230 ext. 343 / (847)330-0050 (Fax)

National Mental Health Month
National Mental Health Association
1021 Prince St, Alexandria, VA 22314-2971
(800) 969-6642 / (703) 684-7722
(703) 684-5968 (Fax)

National Neurofibromatosis Month
National Neurofibromatosis Foundation
120 Wall Street, 16th Floor, New York, NY 10005
(800) 323-7938 / (212) 344-6633
(212) 747-0004 (Fax)

National Stroke Awareness Month
National Stroke Association
96 Inverness Dr East, Ste I, Englewood, CO 80112-5112
(800) STROKES

National Trauma Awareness Month
American Trauma Society
8903 Presidential Parkway, Ste 512, Upper Marlboro, MD 20772-2656
(800) 556-7890 / (301) 420-4189

Tuberous Sclerosis Awareness Month
National Tuberous Sclerosis Association
8181 Professional Place, Ste 110, Landover, MD 20785
(800) 225-6872 / (301) 459-9888

National Suicide Awareness Week
American Association of Suicidology
4201 Connecticut Ave NW, Ste 310, Washington, DC 20008
(202) 237-2280 / (202) 237-2282 (Fax)

National Mental Health Counseling Week
American Mental Health Counselor Association
801 North Fairfax St, Ste 304, Alexandria, VA 22314
(800) 326-2642 / (703) 548-4775 (Fax)

Childhood Depression Awareness Day
National Mental Health Association
1021 Prince St, Alexandria, VA 22314-2971
(800) 969-6642 / (703) 684-7722
(703) 684-5984 (Fax)

National Anxiety Disorders Screening Day
National Mental Illness Screening Project
308 Seaview Ave, Staten Island, NY 10305
(718) 351-1717 / (718) 667-8893 (Fax)

National Melanoma/Skin Cancer Detection and Prevention
American Academy of Dermatology
PO Box 681069, Schaumburg, IL 60168
(847) 330-0230, ext 343 / (847) 330-0050 (Fax)

National Alcohol and Other Drug-Related Birth Defects Week
National Council on Alcoholism and Drug Dependence, Inc.
12 West 21st Street, New York, NY 10010
(212) 206-6770

National Osteoporosis Prevention Week
National Osteoporosis Foundation
1150 17th Street NW, Ste 500, Washington, DC 20036
(202) 223-2226

National Stuttering Awareness Week
Stuttering Foundation of America
3100 Walnut Grove Rd, Ste 603, Memphis, TN 38111-0749
(800) 992-9392 / (901) 452-7343
(901) 452-3931 (Fax)
stuttersfa@aol.com

JUNE

National Hernia Awareness Month

National HIV Testing Day

National Scleroderma Awareness Month
United Scleroderma Foundation
PO Box 399, Watsonville, CA 95077-0399
(800) 722-HOPE / (408) 728-2202
(408) 728-3328 (Fax)

outreach@scleroderma.com

National Aphasia Awareness Week
National Aphasia Association
156 Fifth Ave, Ste 707, New York, NY 10010
(800) 922-4622 / (212) 989-7777 (Fax)
klein@aphasia.org

National Headache Awareness Week
National Headache Foundation (NHF)
428 West St. James Place, 2nd Floor, Chicago, IL 60614-2750
(800) 843-2256 / (773) 525-7357 (Fax)

Helen Keller Deaf-Blind Awareness Week
Helen Keller National Center
111 Middle Neck Rd , Sands Point, NY 11050
(516) 944-8900, ext. 325 / (516) 944-8637 (TTY)
(516) 944-7302 (Fax)

JULY

Hemochromatosis Screening Awareness Month
Hemochromatosis Foundation
PO Box 8569, Albany, NY 12208
(518) 489-0972

AUGUST

Spinal Muscular Atrophy Awareness Month
Families of Spinal Muscular Atrophy
Libertyville, IL 60048
(800) 886-1762 /(847) 367-7620
(847) 367-7623 (Fax)

SEPTEMBER

Leukemia Society Month
The Leukemia and Lymphoma Society
1311 Mamaroneck Ave., White Plains, NY 10605
(212) 573-8484
http://www.leukemia-lymphoma.org

Prostate Cancer Awareness Week
Prostate Health Council
American Foundation for Urological Disease
1128 North Charles St, Baltimore, MD 21201
(800) 822-5277

National Cholesterol Education Month
National Heart, Lung, and Blood Institute Information Center
PO Box 30105, Bethesda, MD 20824-0105
(301)251-1222 / (301)251-1223 (Fax)
nhlbiic@dgsys.com

National Pediculosis Prevention Month
National Pediculosis Association
PO Box 610189, Newton, MA 02161
(617) 449-NITS

National Sickle Cell Month
Sickle Cell Disease Association of America
200 Corporate Pointe, Ste 49, Culver City, CA 90230-7633
(800) 421-8453 / (310) 216-6363

Ovarian Cancer Awareness Month
The National Ovarian Cancer Coalition
PO Box 4472, Boca Raton, FL 33429-4472

(888) OVARIAN
ovca@aol.com

National Rehabilitation Week
National Rehabilitation Awareness Foundation
PO Box 71, Scranton, PA 18501-0071
(717) 341-4637 / (717) 341-4331 (Fax)

Hearing Aid Awareness Week
International Hearing Society
20361 Middlebelt Rd, Livonia, MI 48152
(800) 521-5247

National 5-A-Day Week
Cancer Information Service
NCI Office of Cancer Communications
Building 31, Room 10A16
9000 Rockville Pike, Bethesda, MD 20892
(800) 4-CANCER / (301) 402-8594 (Fax)

National Reye's Syndrome Week
National Reye's Syndrome Foundation
PO Box 829, Bryan, OH 43506
(419) 636-2679 / (419) 636-3366 (Fax)
reyessyn@mail.bright.net

Childhood Cancer Awareness Month
National Childhood Cancer Foundation
http://www.nccf.org

OCTOBER

Breast Cancer Control Month
American Cancer Society
National Headquarters
1599 Clifton Rd NE, Atlanta, GA 30329-4251
(800) ACS-2345 / (404) 320-3333

Celiac Sprue Awareness Month
Celiac Sprue Association/United States of America
PO Box 31700, Omaha, NE 68131-0700
(402) 558-0600

Healthy Lung Month
American Lung Association
1740 Broadway, New York, NY 10019-4374
(800) LUNG-USA
(212) 889-3370 New York
(202) 682-5864 Washington, DC

National Breast Cancer Awareness Month
Cancer Information Service
Office of Cancer Communications
Building 31, Room 10A16
9000 Rockville Pike, Bethesda, MD 20892
(800) 4-CANCER / (301) 402-8594 (Fax)

National Campaign for Healthier Babies Month
March of Dimes Birth Defects Foundation
1275 Mamaroneck Ave, White Plains, NY 10605
(914) 997-4600

National Liver Awareness Month
American Liver Foundation
1425 Pompton Ave, Cedar Grove, NJ 07009
(800) GO-LIVER / (973) 256-2550

National Lupus Awareness Month
National Lupus Foundation of America

1330 Piccard Drive, Ste 200, Rockville, MD 20850-4303
(800) 558-0121 (English) / (800) 558-0231 (Spanish)
(301) 670-9292

National Physical Therapy Month
American Physical Therapy Association
1111 North Fairfax St, Alexandria, VA 22314
(703) 706-3248 / (703) 684-7343 (Fax)

National Spina Bifida Prevention Month
Spina Bifida Association of America
4590 MacArthur Blvd NW, Ste 250, Washington, DC 20007-4226
(800) 621-3141 / (202) 944-3285
(202) 944-3295 (Fax)

National Spinal Health Month
American Chiropractic Association
1701 Clarendon Blvd, Arlington, VA 22209
(800)986-4636 (for orders only) / (703)276-8800

Rett Syndrome Awareness Month
International Rett Syndrome Association
9121 Piscataway Rd, Suite 2B, Clinton, MD 20735
(800) 818-RETT / (301) 856-3334
(301) 856-3336 (Fax)
irsa@paltech.com

Sudden Infant Death Syndrome Awareness Month
SIDS Alliance
1314 Bedford Ave, Ste 210, Baltimore, MD 21208
(800) 221-SIDS / (410) 653-8226
(410) 653-8709 (Fax)

American Heart Walk
American Heart Association
7272 Greenville Ave, Dallas, TX 75231
(800) AHA-USA1 / (301) 990-8900

Mental Illness Awareness Week
American Psychiatric Association
1400 K Street NW, Washington, DC 20005
(202) 682-6220

National Depression Screening Days
National Mental Illness Screening Project
308 Seaview Ave, Staten Island, NY 10305
(718) 351-1717 / (718) 667-8893 (Fax)
http://www.nmisp.org

National Hepatitis Awareness Week
American Liver Foundation
1425 Pompton Ave, Cedar Grove, NJ 07009
(800) 223-0179 / (201) 256-2550

National Red Ribbon Celebration
National Family Partnership
11159B South Town Square, St. Louis, MO 63123
(314) 845-1933

National Breast Cancer Awareness Month
National Breast Cancer Awareness Month
c/o Foresight Communications
PO Box 3156, Chicago, IL 60654-3156
or
The Susan G. Komen Breast Cancer Foundation
@ (800) IM AWARE
or
National Cancer Institute's Cancer Information Service
(800) 4-CANCER
http://cancernet.nci.nih.gov / http://rex.nci.nih.gov
or

American Cancer Society
1599 Clifton Rd, NE, Atlanta, GA 30329
(800) ACS-2345 / (404) 320-3333
http://www.cancer.org

National AIDS Awareness Month
Pharmacists Planning Service, Inc.
101 Lucas Valley Rd #210, San Rafael, CA 94903
(415) 479-8628 / (415) 479-8608 (Fax)
ppsi@aol.com

World Mental Health Day
World Federation for Mental Health
1021 Prince St, Alexandria, VA 22314
(703) 838-7525 / (703) 684-5968 (fax)
wfmh@erols.com

National Psoriasis Awareness Month
The National Psoriasis Foundation
6600 SW 92nd Ave, Ste 300, Portland, OR 97223
Tara Rolstad / Matthew Merenda
Voice: (800) 723-9166 / Fax: (503) 245-0626
E-mail: tara@npfusa.org
http://www.psoriasis.org/pressrel/psorawar100897.html

National Brain Injury Awareness Month

Pastoral Care Week

NOVEMBER

Diabetic Eye Disease Month
Prevent Blindness America
500 East Remington Rd , Schaumburg, IL 60173
(800) 331-2020 / (847) 843-2020

National Alzheimer's Awareness Month
Alzheimer's Association
919 North Michigan Ave, Ste 1000, Chicago, IL 60611-1676
(800) 272-3900 / (312) 335-8700
(312) 335-8882 (TDD) / (312) 335-1110 (Fax)

National Diabetes Month
American Diabetes Association
1660 Duke Street, Alexandria, VA 22314
(800) 232-3472 / (703) 549-1500

National Epilepsy Month
Epilepsy Foundation of America
4351 Garden City Drive, Landover, MD 20785
(800) EFA-1000 / (800) 213-5821 (publications)
(301) 459-3700

National Brain Aneurysm Awareness Week
Brain Aneurysm Foundation
66 Canal Street, Boston, MA 02114
(617) 723-3870 / (617) 723-8672 (Fax)

National Home Care Month

National Hospice Month

DECEMBER

World AIDS Day
American Association for World Health
1825 K Street NW, Ste 1208, Washington, DC 20006
(202) 466-5883

National Aplastic Anemia Awareness Week
Aplastic Anemia Foundation of America, Inc.
PO Box 613, Annapolis, MD 21404
(800) 747-2820

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SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER:

Date of 5-Day Notice: 2/4/09
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/11/09

Health and Social Services Committee considered SENATE CONCURRENT RESOLUTION NO. 1

SCR 1 BRAIN INJURY AWARENESS MONTH: MARCH 2009

Relating to establishing March 2009 as Brain Injury Awareness Month.

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
LEG	2/11			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	X			
	PASKVAN	X			
CHAIR: Betty Davis	DAVIS	X			

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
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Fax (907) 269-0249

SENATOR LESIL MCGUIRE

Co-Chair
Senate Resources Committee

Chair
Senate Special Committee on Energy
Senate Special Committee on World Trade, Technology & Innovation

Member
Senate Judiciary Committee
Joint Armed Services Committee

MEMORANDUM

To: Senator Bettye Davis
Chair, Senate Health & Social Services Committee

From: Senator Lesil McGuire

Date: January 30, 2009

Re: Hearing Request: SCR 1: Brain Injury Awareness Month 2009

I respectfully request that SCR 1 *A Resolution relating to establishing March 2008 as brain injury awareness month* be scheduled for a hearing in the Senate Health & Social Services Committee at your earliest convenience. Attached you will find the most current version of the resolution, a sponsor statement, and all backup information.

If you have any questions or concerns, please feel free to contact me personally or my staff, Trevor Fulton, at x3579. Thank you for your time and consideration.

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
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Co-Chair
Senate Resources Committee

Chair
Senate Special Committee on Energy
Senate Special Committee on World Trade, Technology & Innovation

Member
Senate Judiciary Committee
Joint Armed Services Committee

SENATOR LESIL MCGUIRE

SPONSOR STATEMENT

SCR 1: *BRAIN INJURY AWARENESS MONTH: MARCH 2008*

SCR 1 aims to raise awareness about Traumatic Brain Injuries and the impact they have on Alaskans and their families.

Traumatic brain injury (TBI) is damage to the brain that results when the head is hit, strikes a stationary object, or is violently shaken. Alaska is the number one state per capita for brain injuries and TBI is one of the leading causes of death of young people in the state. Over 800 TBIs are reported annually and an estimated 12,000 Alaskans have suffered a TBI.

These injuries are often life altering and consequently place a tremendous strain on victims and their families. Victims often live with permanent disabilities and the tragedy of TBI is exacerbated by the fact that most TBIs are preventable.

The Brain Injury Association of America recognizes March of each year as Brain Injury Awareness Month; this resolution would comport with national recognition by making March 2009 Traumatic Brain Injury Awareness Month in Alaska.

Because TBI incidence in Alaska is on the rise, raising TBI awareness is more important now than it has ever been. TBIs are one of the most common injuries incurred in military combat today and as injured military personnel return home to Alaska the rate of TBIs is increasing sharply -- with no signs of slowing.

According to a task force on traumatic brain injury created by the Army Surgeon General, as many as one in five U.S. combat troops who fought in Iraq or Afghanistan leave with signs they may have had a TBI. The Walter Reed Army Medical Center reports that 60% of arriving service members from Iraq have a TBI from blasts, severe falls, and motor vehicle accidents. TBI screening at the National Naval Medical Center shows that 83% of wounded Marines treated at that facility have some form of temporary or permanent brain damage.

Rising TBI rates in Alaska is another reason in a long list of very good reasons to bring attention to this silent epidemic. So please join us in support of brain injury awareness, prevention, and treatment by supporting SCR 1.

SCR

12

ALASKA STATE LEGISLATURE

Interim:
716 West 4th Avenue
Anchorage, Alaska 99501-2133
Phone: (907) 269-0199
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Senator_Kevin_Meyer@legis.state.ak.us

Session:
Alaska State Capitol
Juneau, Alaska 99801-1182
Phone: (907) 465-4945
Fax: (907) 465-3476
Toll Free: (866) 465-4945

SENATOR KEVIN MEYER
SENATE DISTRICT O

SPONSOR STATEMENT FOR SCR 12

"Proclaiming September 9, 2010, as Fetal Alcohol Spectrum Disorders Awareness Day."

SCR 12 would proclaim September 9, 2010 as Fetal Alcohol Spectrum Disorders Awareness Day (FASD).

Alaska has the highest known incidence of FASD in the United States. This is a condition caused by prenatal exposure to alcohol, which can result in permanent brain damage, birth defects, learning disabilities, behavioral problems and most tragically, the loss of individual potential.

While FASD affects all racial and socioeconomic groups, it is a 100% preventable condition. FASD Awareness Day is observed internationally on September 9th. This serves as a reminder on the ninth day of the ninth month of the year that during the nine months of pregnancy a woman should abstain from alcohol.

SCR 12 would observe FASD Awareness Day by promoting the awareness of the effects of prenatal exposure to alcohol.

Celeste Hodge

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Wednesday, February 03, 2010 10:13 AM
To: Celeste Hodge
Subject: RE: SCR12 - Proclaiming September 9, 2010 as Fetal Alcohol Spectrum Disorders Awareness Day

FISCAL NOTE NOT NEEDED

No note needed. Thanks for checking.
w.

Wilda J. Laughlin
Legislative Liaison, Dept. of Health and Social Services
Phone (907) 465-1613
Fax (907) 465-3068
Cell (907) 723-3802

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From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Wednesday, February 03, 2010 8:42 AM
To: Laughlin, Wilda J (HSS)
Subject: RE: SCR12 - Proclaiming September 9, 2010 as Fetal Alcohol Spectrum Disorders Awareness Day

If theirs is none, will I still need a completed fiscal form showing zero dollars? Thanks.

Celeste Graham-Hodge, Legislative Administrator
Office of Senator Bettye Davis - AK State Legislature
State Capitol, Rm 30, Juneau, AK 99801
T (907) 465-4906, F (907) 465-3756
716 W. 4th Ave., #400, Anchorage, AK 99501
T(907) 269-0144, F(907) 269-0148
Celeste_Hodge@legis.state.ak.us

From: Laughlin, Wilda J (HSS) [mailto:wilda.laughlin@alaska.gov]
Sent: Wednesday, February 03, 2010 8:41 AM
To: Celeste Hodge
Subject: RE: SCR12 - Proclaiming September 9, 2010 as Fetal Alcohol Spectrum Disorders Awareness Day

Hi Celeste—thanks for checking. I don't think there's a fiscal impact, but I'll double check as well.
w.

Wilda J. Laughlin
Legislative Liaison, Dept. of Health and Social Services
Phone (907) 465-1613
Fax (907) 465-3068
Cell (907) 723-3802

This e-mail, including attachments, is intended for the use of the person or entity to which it is addressed and may contain CONFIDENTIAL or privileged information that is protected by

TEN THINGS YOU SHOULD KNOW ABOUT FAS

1. Drinking during pregnancy can cause permanent damage to a developing fetus.

2. FAS is one of the most common causes of mental retardation, and is the only cause that is entirely preventable.

3. According to recent State of Alaska DHSS surveillance data, more than 126 children are born at risk for FASD each year in Alaska.

4. Prenatal exposure to alcohol can cause brain damage and other permanent birth defects.

5. Obtaining an FAS diagnosis can improve an individual's ability to function in the world, and may reduce secondary disabilities like depression and school failure.

6. FASD is found in all races and all socio-economic groups – wherever women drink alcohol FASD exists.

7. There is no safe level of alcohol consumption during pregnancy.

8. Women should stop drinking prior to trying to conceive – alcohol can cause damage to a developing fetus even before a woman knows she is pregnant.

9. FASD is 100 percent preventable.

10. With the right diagnosis, support and understanding, many individuals with FASD are living happy and full lives.

From State of Alaska, Office of Fetal Alcohol Syndrome FAQ
http://www.hss.state.ak.us/fas/info/faqs.htm

Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update

Prepared for:

The Advisory Board on Alcoholism and Drug Abuse
Department of Health & Social Services

Prepared by:

McDowell Group

Juneau • Anchorage

December 2005

5480

Alaska, as well as the daily rate information for each facility. There were an estimated 219,400 total nursing home and long-term treatment care bed days in Alaska for all during 2003, while cost per day of care averaged $328 per day, with a range of $213 to $625 per day. The cost of Alaska nursing home care for all illnesses and injuries during 2003 was approximately $71.9 million. Based on estimates published in the NIDA/NIAAA (1998) study, approximately 1 percent of the nation's nursing home care costs can be attributed to alcohol abuse-specific illnesses. The research team applied 1 percent to total nursing home and long term care costs in Alaska during 2003.

Results

Estimated pharmaceutical costs related to alcohol abuse in Alaska during 2003 were approximately $23.0 million. Alcohol abuse-related nursing home care days totaled 2,194 in Alaska during 2003. Costs from these visits amounted to approximately $719,000.

Fetal Alcohol Spectrum Disorders

Prenatal exposure to alcohol can cause specific birth defects which may include physical, mental, behavioral, and learning disabilities. Many children with fetal alcohol disorders are not identified until they reach school age or later. Individuals with alcohol-related effects may have difficulties with attention, memory, and problem solving. Heart, liver, and kidney defects are also common, as well as vision and hearing problems.[13] Alcohol-related effects that fall within the broad category of fetal alcohol spectrum disorders (FASD) include:

- fetal alcohol syndrome (FAS),
- partial FAS (PFAS),
- fetal alcohol effects (FAE),
- alcohol-related neurodevelopmental disorder (ARND),
- and other alcohol-related birth defects (ARBD).[14]

During the past ten years, a number of FAS prevalence rates have been established. Studies by the Centers for Disease Control and Prevention indicate a national rate from 0.2 to 1.5 cases per 1,000 births across various populations.[15] Other studies, including those focusing on specific high-risk populations such as Native Americans, other minorities and families living in poverty have indicated rates from 0.5 to 5.0 per 1,000 live births. Clearly, the data is varied and limited.

In establishing a clear number of infants born each year in the United States with Fetal Alcohol Syndrome, the CDC estimates between 1,000 and 6,000 children will be born with FAS each year – a preventable birth defect and disability.

Beginning in 1997, Alaska was one of five states comprising the CDC's Fetal Alcohol Syndrome Surveillance Network (FASSNet), a program established to provide consistent and comparable FAS prevalence rates. Participating states included Arizona, Colorado, New York, Wisconsin and Alaska (however, FAS rates for Wisconsin are not available). At 1.5 per 1,000 live births, Alaska has a significantly higher rate of children born with FAS than other states in the FASSNet program. In

[13] National Organization on Fetal Alcohol Syndrome, *What is FAS/FASD?*, www.nofas.org/faqs.aspx?id=9
[14] US Department of Health and Human Services, SAMHSA Fetal Alcohol Spectrum Disorders Center for Excellence. *The Language of Fetal Alcohol Spectrum Disorders.*
[15] *FAS: Guidelines for Referral and Diagnosis*, CDC, 2004.

addition, Alaska data showed an estimated FAS prevalence rate of 4.8 per 1,000 live births among Alaska Natives. CDC data indicates FAS prevalence rates ranging from 0.3 per 1,000 in Arizona and Colorado to 0.4 in New York.

CDC estimates that other prenatal alcohol-related conditions, such as ARND and ARBD, occur approximately three times as often as FAS.[16] Within the wider category of FASD (which would include individuals with FAS), the US is estimated to have about 10 cases per 1,000 live births.[17]

Alaska's estimated rate of all births impacted by prenatal alcohol exposure is 16.3 cases per 1,000 births, based on the 1995 to 1999 birth years. While these alcohol-related effects are closely associated with FASD, these rates are not directly comparable to national FASD rates of 10 per 1,000 live births due to differences in diagnoses and reporting at the state and national levels. Based on 16.3 cases per 1,000 and the number of live births from 1995 to 1999, approximately 160 infants are born each year in Alaska with FAS and other effects from maternal alcohol use during pregnancy. Of those, approximately 15 are born with Fetal Alcohol Syndrome (FAS).

FAS vs. FASD

It is important to remember that the information being used to determine the economic costs of care and service delivery to individuals with Fetal Alcohol Syndrome is only a small portion of the overall impact of prenatal exposure to alcohol and the resulting birth defects and disabilities. Beginning in 2000, the State of Alaska began extensive efforts to improve and expand the ability to appropriately diagnose individuals prenatally exposed to alcohol. In 2005, Alaska has a broad and regionally diverse network of diagnostic teams across the state.[18] Data collected from these teams indicate that from July 2000 through March 2005 teams have conducted 755 FASD diagnostic assessments. Of this number, 76 (10.0 percent) were diagnosed with FAS or atypical FAS; 378 (49.9 percent) were diagnosed with Static Encephalopathy; 251 (32.2 percent) were diagnosed with Neurobehavioral Disorder; and 50 (6.6 percent) were found to have no evidence of organic brain damage.

What this data indicates is that the costs associated with all alcohol-related births are much higher than those estimated just for individuals with FAS. And, as noted in the break-through research of Dr. Ann Streissguth in 1996 (Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome [FAS] and Fetal Alcohol Effects [FAE]), individuals with FAE (what is now referred to as FASD) are more likely to develop secondary disabilities and need more services than those with Fetal Alcohol Syndrome and the associated facial dysmorphology. For Alaska and the economic costs associated with all fetal alcohol spectrum disorders, the costs could be as much as 80 percent higher than indicated for FAS alone.

Economic Cost of Fetal Alcohol Syndrome

The cost of caring for and providing appropriate services to a person with FAS can be significant. These costs may include neonatal care for low birth weight to special speech therapy, behavioral management, or residential care for adults with FAS. Lifetime costs for care for children born in 2003 with FAS are estimated below. However, these costs are excluded from the total health care costs for 2003, as the component of that expenditure in 2003 alone cannot be determined.

[16] CDC, *Tracking Fetal Alcohol Syndrome*, www.cdc.gov/ncbddd/fas/fassurv.htm
[17] National Organization on Fetal Alcohol Syndrome, *What are the Statistics and Facts about FAS and FASD?*, www.nofas.org/faqs.aspx?id=12
[18] For information on available services go to http://health.hss.state.ak.us/fas/teams/default.htm).

Methodology

To estimate the economic costs from FAS, the research team first determined the number of live births with FAS in Alaska. The Alaska Department of Health and Social Services has closely monitored incidence of FAS in the state since 1998, as part of a U.S. Centers for Disease Control (CDC) monitoring program called the Fetal Alcohol Syndrome Surveillance Network (FASSNet), the ongoing Alaska FAS Surveillance Project and the Alaska Birth Defects Registry. The development of 13 community-based FASD diagnostic teams across Alaska has also assisted in the collection of data related to both FAS and other alcohol-related disabilities included in the FASD umbrella definition.

The Alaska FAS Surveillance Project data collection system is based on reports to the Alaska Birth Defects Registry, and uses medical chart data points to identify children with FAS or other prenatal alcohol-related conditions. DHSS staff consider the surveillance program to be highly rigorous. Alaska clinicians and case workers use a diagnostic process developed by researchers at the University of Washington Fetal Alcohol Syndrome Diagnostic and Prevention Network. Reporting of birth defects to the state registry is mandated by Alaska law. While Alaska's FAS surveillance system is believed to capture the majority of prenatal alcohol-related cases, it is possible that underreporting could make the incidence rate even higher.

For birth years 1995 to 1999, the incidence rate of FAS in Alaska is 1.5 per 1,000 live births.[19] This was the highest rate of the five states that were involved in developing the CDC FASSNet system. (The lowest rate was 0.3 FAS cases per 1,000 births.) However, the incidence of all prenatal alcohol-related conditions, including such conditions as alcohol-related birth defects (ARBD) and alcohol-related neurodevelopmental disorder (ARND), as well as FAS, is 16.3 per 1,000 live births. This incidence rate is assumed to be consistent in birth year 2003.

To estimate FAS costs in Alaska, the research team relied on data published in Health Professions Education Partnership Act of 1998 (Senate Bill 1754). The cost of treating an individual with FAS over his or her lifetime was estimated to be at least $1.4 million in 1995. These costs could include neonatal intensive care, medical and surgical services (not related to neonatal care), special speech therapy, behavioral management, and residential care. Medical and surgical service might include rectifying or monitoring hearing loss or cleft palate surgery. Residential services include special education, home care, speech therapy or institutional care. The 1995 data was adjusted for inflation using the Bureau of Labor Statistics Consumer Price Index for medical care. Additionally, costs of providing care were adjusted by the Alaska differential for cost of living (65 percent in 2003). The resulting total lifetime costs (in 2003 dollars) for providing services to an individual with FAS are estimated at $3.1 million.

The total cost for providing services to an individual with FAS born in Alaska during 2003 was estimated by multiplying the lifetime costs by the number of FAS births during that period.

Results

Table 18 presents estimated costs for FAS births in Alaska during 2003. During that period, Alaska had about 15 FAS births. Total economic costs resulting from services to all individuals with FAS in Alaska totaled approximately $47.0 million.

[19] *Susan Merrick, FAS Surveillance Project Manager, Alaska Department of Health and Social Services, personal communication, July 2005.*

Table 18
Lifetime Costs of Medical and Residential Services for Children Born with FAS in 2003

	Incidence and Costs
Alaska births in 2003	10,084
FAS incidence per 1,000 live births	1.5
FAS births	15
Lifetime FAS cost	**$47,037,000**

Source: Birth data from the Alaska Bureau of Vital Statistics. McDowell Group, based on FAS data from Alaska Department of Health and Social Services; and Health Professions Education Partnership Act of 1998, S. 1754, 108d Congress (1998).

AIDS and HIV Costs

Intravenous drug abuse among individuals who share unhygienic needles is a significant cause of AIDS and HIV. Although AIDS and HIV no longer require extensive inpatient medical care, both result in high medical expenses worth measuring separately from the hospital and outpatient costs presented above (NIDA/NIAAA, 1998).

Methodology

The State of Alaska Department of Health and Social Services Epidemiology Section compiles data on HIV and AIDS diagnoses in the state. While the section does not track individuals with HIV and/or AIDS diagnoses, it does compile cumulative counts of the number of diagnoses in the state since the first known HIV diagnosis. Of the known cases of HIV and/or AIDS, 13 percent are associated with intravenous drug use. In addition, the Epidemiology Section tracks known deaths. The section does not track the whereabouts of diagnosed individuals, and as a result no data exists regarding the number of HIV/AIDS patients who may have moved away from Alaska. For the purposes of these estimates the research team assumes that 100 percent of diagnosed individuals remain in the state, though it is recognized that this may not be the case. Additionally, we assume that 100 percent of the known deaths occurred among individuals who had been diagnosed with AIDS, although data is not available on specific cause of death.

Two steps were used to calculate other drug-related AIDS and HIV medical costs. First, AIDS and HIV costs were estimated by applying annual medical expenses from the NIDA/NIAAA (1998) study to the number of known Alaska AIDS and HIV patients in 2003. Cost data was adjusted for inflation and the cost of health care in Alaska using the same sources and methods previously reported. Annual medical expenses for each Alaska HIV patient were estimated at $30,600, while medical expenses for each AIDS patient were $68,200.

The second step was to determine the percent of AIDS and HIV medical expenses that can be attributed to other drug abuse. The Epidemiology Section reported that approximately 13 percent of AIDS and HIV cases were attributed to intravenous drug abuse. This attribution rate was then applied to medical costs for AIDS and HIV patients.

Based on the data from the Alaska Division of Public Health, a total of 597 individuals with HIV or HIV/AIDS lived in Alaska in 2003. Of those, an estimated

Senator Kevin Meyer
Alaska State Capitol
Juneau, AK 99801-1182

February 8, 2010

RE: SCR 12 Fetal Alcohol Spectrum Disorders Awareness Day Proclamation

Dear Senator Meyer,

I am writing this letter in support of Senate Concurrent Resolution No. 12 proclaiming September 9, 2010, as Fetal Alcohol Spectrum Disorders Awareness Day. I was planning to provide testimony by phone, but unfortunately, I am unable to break away from work.

Over the past 22 years as a behavioral health clinician I have witnessed firsthand the devastating consequences of prenatal alcohol and FASD for Alaska's families and communities.

Alaska unfortunately has the highest known rates of FAS/FASD in the United States. As you know, Alaska also ranks high in many other statistics such as domestic violence, sexual assault, and suicide. One of the secondary consequences of prenatal alcohol is that those with an FASD without adequate support often experience significant mental health problems, are at greater risk for suicide, and are frequently exploited and victimized.

Your efforts towards keeping FASD awareness active, and on the forefront of people's minds, will make a difference for Alaska's families and communities. This will happen by communicating the importance of awareness and taking action to prevent future FASD, as well as provide interventions for those who are already impacted.

Thank you for your efforts. If I can answer any questions, or be of help, please let me know.

Respectfully,

Michael Baldwin

5340 Tudor Top Circle
Anchorage, AK 99507
907-250-7736

Advisory Board on Alcoholism and Drug Abuse

abada amhb

Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

February 8, 2010

Senator Kevin Meyer
Alaska State Capitol
Juneau, Alaska 99801

Re: SCR 12 — FASD Day

Dear Senator Meyer,

The Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board express their appreciation and support for your resolution declaring September 9, 2010 Fetal Alcohol Spectrum Disorders Day. As you know, fetal alcohol spectrum disorders are 100% preventable. Raising awareness and recognition of this fact will help prevent more Alaskan children from being born affected by prenatal alcohol exposure.

Even more importantly, it will raise awareness of the special, and often very individual, needs of individuals diagnosed with fetal spectrum disorders. Too often the services and supports they need to thrive – at home, at school, and in their communities – are not available. By designating a day to focus on the unique issues of fetal alcohol spectrum disorders and their impact on Alaska, we can not only support Alaskans with FASD but also prevent future Alaskans from experiencing FASD.

Thank you for your continued work on this important issue.

Sincerely,

Debi Keith, Chair
AMHB

James Duncan, Chair
ABADA

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/10

FURTHER: Rules

Date of 5-Day Notice: 2/4/10
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/9/10

Health and Social Services Committee considered SENATE CONCURRENT RESOLUTION NO. 12

SCR 12 FETAL ALCOHOL SPECTRUM DISORDERS DAY

Proclaiming September 9, 2010, as Fetal Alcohol Spectrum Disorders Awareness Day.

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
S. HSS	2/8			✓	1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Thomas	✓			
	ELLIS	✓			
	PASKVAN	X			
	Dyson	X			
CHAIR:	DAVIS	X			

5487

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SCR 12
(S) Publish Date: 2/10/10

Identifier (file name):
Title: SCR 12 FETAL ALCOHOL SPECTRUM DISORDERS DAY
Sponsor: Senator Meyer
Requester: (S) Health and Social Services Committee

Dept. Affected:
RDU
Component
Component Number

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Prepared by: Celeste Hodge, Committee Aide — Phone 465-4906
Division: Senate Health & Social Services Committee — Date/Time
Approved by: Senator Bettye Davis — Date 2/8/2010
Senate Health & Social Services Committee, Chair

(Revised 11/6/2009 OMB)

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VOICES for FASD

2010 LEGISLATIVE PRIORITIES

Governor Parnell has included in his FY11 Mental Health Budget funding for services for children diagnosed with Fetal Alcohol Spectrum Disorder (FASD), treatment for pregnant women and peer navigation. Also, Senator Kevin Meyer has introduced a resolution (SCR 12) proclaiming September 9, 2010 as FASD Awareness Day.

Support Services for Children with FASD, Treatment for Pregnant Women, Peer Navigation, and FASD Awareness Day

Increased Access to FASD Treatment Services in Rural Alaska
$228,600 (in the FY11 Mental Health Budget, HB 302)
This funding will build services in communities with active FASD diagnostic teams so that children diagnosed with FASD can receive appropriate therapies and services as close to home as possible – with priority given to rural communities. Services could include occupational therapy, speech therapy, physical therapy, education supports and specialized mental health services. This funding will: 1) allow for immediate access to services upon diagnosis, avoiding more costly out-of-state Residential Psychiatric Treatment Center (RPTC) care that can be needed when appropriate services are not available; 2) increase the availability of services in the home community; and 3) pay for services that are not reimbursed by Medicaid. This model is similar to the model used to provide individualized services to youth with severe emotional disturbance (SED) in the Bring the Kids Home initiative.

Substance Abuse Treatment for Pregnant Women
$500,000 (in the FY11 Mental Health Budget, HB 302)
This funding will increase the number of treatment beds available for residential and/or intensive outpatient substance abuse treatment for pregnant women — followed by aftercare. This increment addresses the limited capacity to serve pregnant women in Alaska. The average wait between assessment and admission is 23.3 days (almost an entire month of the pregnancy). Only 54% of the women who are estimated to have needed substance abuse treatment to prevent harm to their children *in utero* received care in FY08. The intent is to prioritize this funding as follows: 1) expand residential treatment capacity for pregnant women statewide (to alleviate the need to travel to Anchorage/Fairbanks); 2) encourage the expansion of existing family-style treatment models where children can reside at the facility with the mother in treatment; 3) expand intensive outpatient treatment capacity for pregnant women statewide so that when space in a residential or a family-style program is not available, a pregnant woman who needs and seeks treatment can receive it; and 4) expand aftercare resources.

Peer Navigator Program
$175,000 (in the FY11 Mental Health Budget, HB 302))
The Parent and Youth Navigator project allows parents and youth to be hired to assist their peers in navigating the service delivery system for youth experiencing serious emotional disturbance (SED). A significant number of these youth experience co-occurring disorders,

such as an FASD, and the mental health service delivery system does not always appropriately respond to the needs of these youth. Navigation services can be key to helping youth and families identify and access appropriate services. Grant funding would also be available for volunteer coordination to develop a volunteer youth advisory group, with grant funding for travel and per diem for volunteer youth and volunteer chaperones. This group would meet to educate various groups about issues from their perspective. Parent/peer navigation and parent and youth input in policymaking is important to ensure that increased in-state capacity is developed to be as responsive to the needs of youth and parents as possible. Grantees will be required to report outcomes such as number of parents involved, results of the interaction, and effectiveness of services.

SCR 12 Proclaiming September 9, 2010, as Fetal Alcohol Spectrum Disorders Awareness Day

Senator Kevin Meyer's resolution proclaims September 9, 2010, Fetal Alcohol Spectrum Disorders Awareness Day. Alaska has the highest known incidence of FASDs in the United States. FASDs affect all racial and socioeconomic groups. The disabilities associated with FASDs cause untold emotional stress to individuals and families and cost taxpayers millions of dollars over an affected individual's lifetime. Observing Fetal Alcohol Spectrum Disorders Awareness Day will promote awareness of the effects of prenatal exposure to alcohol and of the fact that there is no known safe level of alcohol consumption during pregnancy. It, will help to prevent FASDs, increase identification of children with FASDs, and improve the lives of those affected by fetal alcohol spectrum disorders.

VOICES for FASD

FASD in Alaska Corrections

A 2006 evaluation by the University of Alaska Anchorage (UAA) Behavioral Health & Research Services, reported the following results based on surveys distributed to personnel at each of Alaska's correctional institutions:

- Estimated percentage of the inmates on current caseload who may have FAS = 27%
- Percentage of Corrections staff who have referred an inmate for FAS screening or diagnosis = 25%
- Percentage of Corrections staff who say they have the appropriate skills and knowledge to deal with alcohol abuse among the inmates or offenders on their caseload = 56%
- Percentage of Corrections staff who say they have the appropriate skills and knowledge to deal with offenders or inmates who have FASD = 55%
- Percentage of Corrections staff who say they have the support of their administration to deal with inmates or offenders on their caseload who have FAS = 56%
- Percentage of Corrections staff who say the current social service programs within the correctional system are appropriate for inmates or offenders on their caseload who have FAS = 30%
- Percentage of Corrections staff who say the current educational service programs within the correctional system were appropriate for the inmates or offenders on their caseload who have FAS = 35%
- Corrections respondents had an average of 9-10 year experience working in corrections in Alaska.

Source: *FAS Knowledge, Attitudes, Beliefs and Behavior (KABB): 2006 Survey of Alaskan Professionals.* Behavioral Health Research and Services, FAS Evaluation, University of Alaska Anchorage. http://bhrs.uaa.alaska.edu/pdf/reports/FAS/FAS_KABB_FINAL_Report.pdf

Sponsored by the Alaska Mental Health Trust Authority, Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse

VOICES for FASD

Alaska FASD Talking Points

- FASDs are a range of disabilities caused when a developing fetus is exposed to alcohol.
- The term FASD is not in itself a clinical diagnosis, but describes the full range of disabilities that may result from prenatal alcohol exposure, including Fetal Alcohol Syndrome (FAS), Fetal Alcohol Syndrome (FAS), Partial Fetal Alcohol Syndrome (PFAS), Alcohol-Related Neurodevelopmental Disorder (ARND), Static encephalopathy (alcohol exposed) and Neurobehavioral Disorder (alcohol exposed).
- This lifelong disability can include learning disabilities, problems with memory, heart and kidney problems, impulsiveness, poor judgment, mental retardation and severe emotional disturbance (SED).
- FASD is the most common known cause of cognitive disabilities.
- Alaska has the highest per capita rate of FASD in the United States.
- A person with an FASD without support has at high risk of becoming an alcoholic, suffering from depression, serving time in jail, or becoming homeless.
- FASDs are a leading cause of preventable and permanent birth defects in the United States.
- With early diagnosis, knowledge, and support – our homes, schools and communities can become better equipped to support a person with FASD and minimize or prevent secondary disabilities.

Sponsored by the Alaska Mental Health Trust Authority, Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse

Anchorage Council on FASD (ACFASD)

Fetal Alcohol Spectrum Disorders

- 90% of kids and Adults with Fetal Alcohol Spectrum Disorders (FASD) do not have intellectual disabilities (I.Q. below 70 points), but may still have central nervous system damage that severely affects their ability to live successful, independent lives unless they receive appropriate supports.
- Over 90% of individuals with FASD will also be diagnosed with a mental health disorder during their lifetime.
- Fetal Alcohol Syndrome (FAS) is the diagnosis given only when short height, low weight, small head circumference, certain specific facial features and central nervous system damage all occur.
- It's important to note that the features most people notice about this disorder (the facial characteristics) develop early during the first trimester of pregnancy, possibly even before a woman knows she is pregnant. Severity of the facial differences does not tell us how badly the brain has been affected; only that alcohol exposure happened very early in the prenatal history.
- Prenatal alcohol exposure alters the way the brain of a person with FASD develops, potentially causing a wide range of difficulties in learning and memory, impulse and emotional control. They often have trouble making connections that seem obvious to us.
- People with FASD may appear to understand everything you say, but may not be able to follow through with directions they are given.
- Quite often behavior is what tells us something is different about the way the brain of a person with FASD thinks and understands the world.
- They may not process information very well, especially verbal information.
- Memories and learning skills are intermittent – sometimes available and sometimes not.
- Understanding cause and effect of their actions may be difficult if not be possible.
- They can have difficulty learning from their mistakes - throughout their lifespan.
- Impulse control may not be among their skills.
- They forget, but that also means everyday is a new day and starts with a clean slate.

PEOPLE DO NOT OUTGROW FASD. THEY WILL LIVE WITH THE CONSEQUENCES OF THEIR PRENATAL EXPOSURE TO ALCOHOL FOR LIFE.

THE ROLE OF THE COMMUNITY IN SUPPORTING INDIVIDUALS WITH FASD

- Kids ***and*** adults with FASD need lots of structure in school, day program or job settings.
- Adapt the physical environment to address sensitivities to noise, sound, smells, textures, lighting. These types of changes work for everybody, not just for people with neurological differences.
- Give simple ONE-step directions. Be willing to repeat MULTIPLE times.
- Use the same words when you repeat directions. (i.e. don't replace "coat" with "jacket")
- Think STAGE not AGE – they may be developmentally behind their peers and be more comfortable playing with younger children. (Do NOT mistake this for potentially good babysitters – you wouldn't leave a 7yr old in charge of another 7yr old.)
- As adults they may continue to behave in an immature way. Adapt materials and programs to meet them where they are developmentally.
- Avoid unstructured or free-time.
- They may have poor executive functioning (sequencing) skills – SHOW THEM – and be willing to show anew every day.
- They may have difficulty leading groups or activities. Provide an assistant or let them co-lead.
- They can be eager and enthusiastic – channel that enthusiasm to work for you when others seem bored or indifferent.
- Rewards and corrections should be done immediately after the action occurs – remember the memory issues.
- Each individual has something they are good at – be the detective who discovers each one's unique talent or strength!

For more information or to schedule FASD trainings please contact Cheri Scott at cheris@stonesoupgroup.org or 907-561-3701

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The brain is the organ most sensitive to prenatal alcohol damage. [Dr. Edward P. Riley lecture, September 25, 2002]

Damage to the brain from alcohol exposure can have an adverse affect on behavior. Alcohol exposure appears to damage some parts of the brain, while leaving other parts unaffected. Some children exposed to alcohol will have neurological problems in just a few brain areas. Other exposed children may have problems in several brain areas. The brain dysfunction is expressed in the form of inappropriate behaviors. Their behavior problems should be viewed with respect to neurological dysfunction. Although psychological factors such as abuse and neglect can exacerbate behavior problems in FASD, we are looking primarily at behavior that is organic in origin. To better understand FASD behavior issues, shift perspective from thinking the child "won't" to "can't." (Diane Malbin, MSW, Trying Differently Rather Than Harder,)

Sometimes the person's behavior is misinterpreted as willful misconduct (Debra Evensen, www.fasalaska.com), but for the most part, maintaining good behavior is outside of the child's control, especially in stressful or stimulating situations. Behavior problems in children with FASD are often blamed on poor parenting skills. While good parenting skills are required, even alcohol exposed children raised in stable, healthy homes can exhibit unruly behavior. The most difficult behaviors are seen in children who were prenatally exposed to alcohol and who also suffer from Reactive Attachment Disorder.

Most children with FASD have some attachment issues, may display inappropriate sexual behaviors, show poor judgment, have difficulty controlling their impulses, are emotionally immature, and need frequent reminders of rules. As a result, many will require the protection of close supervision for the rest of their lives.

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Fetal Alcohol Spectrum Disorders (FASD)

Alcohol causes more damage to the developing fetus than any other substance, including marijuana, heroin, and cocaine. (Institute of Medicine, 1996)

"Soft Signs"

(Psychological signs of FASD brain damage)

- Immature social development: overly friendly to strangers
- Emotional lability:
- Poorly developed conscience:
- Lack of consistent impulse control:
- Inability to learn from consequences
- Good expressive language skills
- Talented in art, music or mechanics.
- Attention deficits: not always hyperactive, but easily distracted by external stimuli
- Short-term memory deficits
- Inappropriate social interactions
- Difficulty managing money:
- Poor concept of time
- Grandiose ideas and unrealistic life goals, distorted perceptions
- Poor judgment
- Vulnerability and naiveté

"The greatest obstacle our children with fetal alcohol disorders must overcome is chronic frustration from not being able to meet the unrealistic expectations of others." – Dr. Calvin Sumner, nationally recognized expert.

Fasstar Information Series Brochure 0408B1

FASD and the Brain

(Photo courtesy of Sterling Clarren, MD)

Brain of a baby with no alcohol exposure

Brain of baby with heavy alcohol exposure

How Prenatal Alcohol Exposure Affects Development of the Brain

By Teresa Kellerman

Fasstar Enterprises
Fetal Alcohol Syndrome: Support, Training, And Resources

www.fasstar.com

FASD and the Brain

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Alcohol is a "teratogen" (substance that is toxic to the baby's developing brain). Damage can occur in various regions of the brain. The areas that might be affected depend on which areas are developing at the time the alcohol is consumed. Since the brain and the central nervous system are developing throughout the entire pregnancy, the baby's brain is always vulnerable to damage from alcohol exposure.

The regions of the brain that might be affected by prenatal alcohol exposure include:

Frontal Lobes – this area controls impulses and judgment. The most noteworthy damage to the brain probably occurs in the prefrontal cortex, which controls what are called the **Executive Functions**.

Corpus Callosum - passes information from the left brain (rules, logic) to the right brain (impulses, feelings) and vice versa; related to attention deficits, psychosocial function, and verbal learning.

Basal Ganglia – involved in cognitive function; affects spatial memory and behaviors like perseveration and the inability to switch modes, work toward goals, and predict behavioral outcomes, and the perception of time.

Hypothalamus - controls appetite, emotions, temperature, and pain sensation

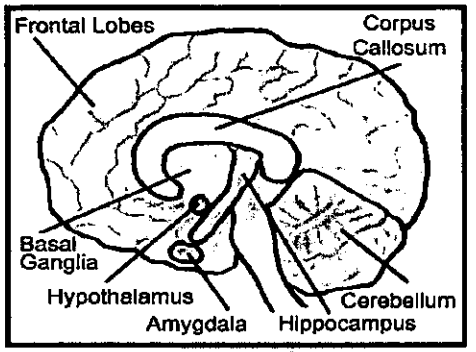
Amygdala – central part of emotional circuitry, senses danger, fear and anxiety; plays major role in recognizing faces and facial expressions, social behavior, aggression, and emotional memory; critical for stimulus-reinforcement association learning.

Hippocampus - plays a fundamental role in spatial and verbal memory retrieval; damage can cause chronic stress, anxiety, and depression; dysfunction is related to symptoms of schizophrenia.

Cerebellum – controls balance, coordination and movement; impacts learning and cognitive skills.

The hypothalamus, amygdala, and hippocampus are part of the **limbic system**, regulating emotions, social and sexual behavior, fight or flight" response, and empathy.

Fetal Alcohol Spectrum Disorders (FASD)



Executive Functions of the Prefrontal Cortex

Effects of alcohol exposure on behaviors related to executive functions of the prefrontal cortex:

- inhibitions: socially inappropriate behavior
- problem solving: inability to figure out solutions spontaneously
- sexual urges: inability to control sexual impulses, especially in social situations
- planning: inability to apply consequences from past actions
- time perception: difficulty with abstract concepts of time and money
- internal ordering: like files out of order, difficulty processing information
- working memory: storing and/or retrieving information
- self-monitoring: needs frequent cues, requires "policing" by others
- verbal self-regulation: needs to talk to self out loud, needs feedback
- motor control: fine motor skills more affected than gross motor
- regulation of emotion: moody "roller coaster" emotions, may withdraw or lash out
- motivation: apparent lack of remorse, need external motivators
- judgment – inability to make wise decisions

Alcohol Exposure by Trimester:

1. During the first trimester, as shown by the research of Drs. Clarren and Streissguth, alcohol interferes with the migration and organization of brain cells. [Journal of Pediatrics, 92(1):64-67]

2. Heavy drinking during the second trimester, particularly from the 10th to 20th week after conception, seems to cause more clinical features of FASD than at other times during pregnancy, according to a study in England. [Early-Human-Development; 1983 Jul Vol. 8(2) 99-111]

3. During the third trimester, according to Dr. Claire D. Coles, the hippocampus is greatly affected, which leads to problems with encoding visual and auditory information (reading and math). [Neurotoxicology And Teratology, 13:357-367, 1991]

Not all damage from alcohol exposure is seen on brain scans, as lesions might be too small to be detected, yet large enough to cause significant disabilities.

Children do not need to have full Fetal Alcohol Syndrome (FAS) to have significant difficulties due to prenatal exposure to alcohol. According to research done by Drs. Joanne L. Gusella and P.A. Fried, even light drinking (average one-quarter ounce of absolute alcohol daily) can have adverse affects on the child's verbal language and comprehension skills. [Neurobehavioral Toxicology and Teratology, Vol. 6:13-17, 1984] Drs. Mattson and Riley in San Diego have conducted research on the neurology of prenatal exposure to alcohol. Their studies show that children of mothers who drank but who do not have a diagnosis of FAS have many of the same neurological abnormalities as children who have been diagnosed with full FAS. [Neurotoxicology and Teratology, Vol. 16(3):283-289, 1994]

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About the Arctic FASD RTC

In 2008, the Centers for Disease Control and Prevention awarded the *Center for Behavioral Health Research and Services* a three-year grant to develop a Fetal Alcohol Spectrum Disorders Regional Training Center to acquaint a broad range of health and allied healthcare professionals and students with prevention, referral, identification, and treatment of Fetal Alcohol Spectrum Disorders. Four similar centers are operating elsewhere in the country.

Contact Information

Arctic FASD RTC staff can be reached at (907) 561-2880 or via email at
⇒ arcticfasdrtc@uaa.alaska.edu

Please visit our website for more information about FASD, our work in the community, and upcoming trainings and workshops at:

www.uaa.alaska.edu/arcticfasdrtc

UAA

UAA is an AA/EO employer and educational institution.

Arctic FASD Regional Training Center
Center for Behavioral Health Research & Services
University of Alaska Anchorage
P.O. Box 241626
Anchorage, AK 99524-1626

UAA UNIVERSITY of ALASKA ANCHORAGE

Arctic FASD Regional Training Center

Our mission is to educate health and allied healthcare providers and students about FASD prevention, identification and screening, referral, and treatment

Funded through the Centers for Disease Control and Prevention. Grant # CDC 1U84DD000439

What is FASD?

Fetal Alcohol Spectrum Disorders (FASDs) are permanent birth defects caused by the consumption of alcohol during pregnancy.

FASDs affect all areas of an individual's life including:

- problems with memory, motivation, speech language, and attention
- cognitive deficits that affect understanding consequences of behavior, concepts of time, and planning
- damage to the central nervous system and learning disabilities

Some facial characteristics of FASDs include widely spaced eyes, small eye openings, and thin upper lip.

FASDs are not limited to any specific population; they cross all social and cultural boundaries.

FASDs are 100% preventable!

Objectives

The **Arctic FASD Regional Training Center (RTC)** will:

- train physicians, nurses, psychologists, speech and language therapists, social workers, and other professionals as well as students in these health and allied health-care professions on topics related to FASD prevention and interventions
- help assure that health and allied healthcare providers have basic knowledge about FASD prevention, referral, identification, and treatment as they encounter at-risk groups
- raise awareness of FASDs, develop resources related to FASD education, and disseminate resources to professionals, educators, and members of the public

Education and Training

The Arctic FASD RTC is in the process of developing an educational curriculum targeting the specific needs of health and allied healthcare professionals who work with pregnant woman or individuals with FASD.

The Arctic FASD RTC educational curriculum is aligned with the Centers for Disease Control and Prevention's (CDC) seven FASD Core Competencies and will be tailored to the specific needs of our region's communities.

FASD Competencies

The CDC notes seven competency areas necessary for all health and allied health-care professionals. These competencies include:

- historical, biomedical, and clinical background of fetal alcohol syndrome (FAS) and other disorders related to prenatal exposure to alcohol, known collectively as FASDs
- services aimed at preventing alcohol-exposed pregnancies in women of childbearing age through screening and brief interventions for alcohol use
- concepts and models of addiction for women of childbearing age, including those who are pregnant, to provide appropriate prevention services, referral, and case management
- effects of alcohol on the developing embryo and fetus
- screening, diagnosing, and assessing infants, children, adolescents, and adults for FASDs
- long-term case management and coordination for persons with FASDs
- ethical, legal, and policy issues related to FASDs

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What is FASD?

[illegible] has the highest per capita rate of Fetal [illegible] Spectrum Disorder (FASD) in the [illegible]. This lifelong disability is caused when [illegible] developing fetus is exposed to alcohol.

[illegible] range of lifelong disabilities that [illegible] include learning disabilities, depression, [illegible] with memory, heart and kidney [illegible], impulsiveness, and poor judgment. [illegible] is also the most common known cause [illegible] mental retardation. A person with an FASD [illegible] support has a high risk of becoming [illegible] alcoholic, suffering from depression, [illegible] time in jail, or becoming homeless.

[illegible] early diagnosis, knowledge, support, [illegible] passion and hope - our homes, schools and [illegible] communities can become better equipped to [illegible] support a person with FASD and minimize or [illegible] prevent secondary disabilities.

Sponsored in part by:

[illegible] Council ○ Tlingit Haida Indian Tribes of [illegible] ○ Juneau FASD Diagnostic Clinic ○ Alaska [illegible] of Behavioral Health ○ Northern Light [illegible] Church ○ Advisory Board on Alcoholism [illegible] Drug Abuse ○ Alaska Mental Health Board ○ [illegible] Mental Health Trust Authority ○ Office of [illegible] Children's Services ○ Juneau Youth Services ○ [illegible] Human Services ○ Juneau Catholic [illegible] ○ Catholic Community Service ○ [illegible] Church of the Nativity ○ Resurrection Lutheran [illegible] ○ Glory Hole ○ Arctic FASD Regional Training Center ○ SEARHC

Alaska Mental Health Board
Advisory Board on Alcoholism and Drug Abuse
431 N. Franklin St. Suite 200
Juneau, Alaska 99801

Fetal Alcohol Spectrum Disorder (FASD)
Southeast Alaska Regional Conference

"Embracing the Reality, Celebrating the Passion, and Creating the Hope"

Dates: February 18-20, 2010
Location: Centennial Hall, Juneau, Alaska

No Registration Fee
Please register by January 29

FASD Southeast Alaska Regional Conference

Presenters include:

Dr. Sterling Clarren is the Robert A. Aldrich Professor of Pediatrics and past Head of the Division of Congenital Defects at the University of Washington School of Medicine in Seattle, Washington. He is currently the medical doctor for UAW FAS Diagnostic and Prevention Network clinic and is the Director of Inpatient Services for Children's Hospital and Regional Medical Center.

Carolyn Hartness is a consultant and educator working with FASD issues since 1991. She has served on teams that address FASD issues — including the FASD Diagnostic and Prevention Network at the University of Washington, Northwest Portland Area Indian Health Board's FASD Tribal Project, and FAS Center for Excellence. She has also created successful prevention and intervention models used in correctional facilities.

Kathryn Kelly has been the Project Director for the FASD Legal Issues Resource Center at the University of Washington since 2001. The project provides assistance to judges, attorneys, parents, advocates and others in cases of individuals with FASD in Juvenile and Adult Criminal Court. She is also project director of FASD and King County Drug Court.

Barbara Day Max is the executive director of Agape, an alcohol and drug treatment program in Washington. Agape is currently partnering with the Washington State Division of Alcohol and Substance Abuse and the University of Washington to open the Parent-Child Assistance Program (PCAP) providing extensive case management services in a home visitation model.

Deb Evenson is the executive director of FAS Alaska Consultant and Training Services, and has worked as a master teacher and behavior specialist for over 35 years. She is a pioneer in discovering practical solutions that work with youth and families affected by FASD and co-director of the Alaska Affiliate to the National Organization on Fetal Alcohol Syndrome (NOFAS).

Kee Warner is the founder and Executive Director of Whitecrow Village FASD Society and has been involved with FASD initiatives for over 20 years. She is past chair of Canadian Federation for Invisible Disabilities and has received awards for her work improving the lives of people with FASD. Currently, she is program consultant and clinical supervisor for the British Columbia Ministry of Health Structured for Success program.

Cheri Scott is the Parent Navigator Training Coordinator for the Stone Soup Group in Anchorage. She is the mother of an adopted son with FASD and certified trainer for Parent Navigators and FAS 101.

Judge Mike Jeffrey is the Superior Court judge in Barrow and a strong advocate from the bench for more enlightened and compassionate treatment of people with FASD.

Jennifer Jackson is a parent of an adopted child with FASD, consultant, and author of "Silent No More" a book of poetry that describes living with FASD.

Morgan Fawcett was born with FASD. He is an international speaker, composer and performer on the Native American flute. In his presentations, which include performances on the flute, he speaks authentically about his disabilities.

Arctic FASD Regional Training Center provides education and training on Fetal Alcohol Spectrum Disorders to Alaskan communities and is a major resource in helping Alaskans cope with FASD.

Additional presenters include: Judge Patricia Collins, Genevieve Casey, Sandy Fiscus, Gil Lucero, Gail Tharpe-Lucero, Vance Sanders, Geri Mata, Charlene "Lena" Takeuchi, Margaret, Vorlyk, Father Thomas Weiss, Teri Tibbett, and the Juneau Diagnostic Clinic Team.

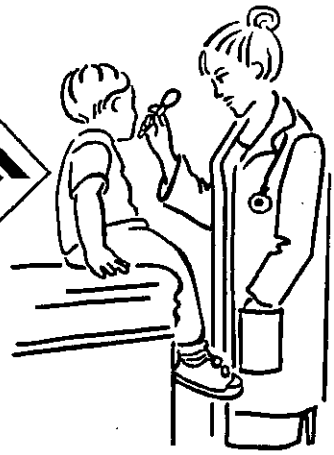
Workshops include:

[illegible] FASD ○ Diagnosis: Cutting Edge ○ Medicine ○ Community Strategies That Work to [illegible] Community Support and Involvement ○ Parent Navigating ○ Early Childhood Development and FASD ○ FASD: Teens and Sexuality ○ Giving a Name to Pain ○ The Successful Advocate: How to Work with the System and How to Have the System Work For You ○ Educate Yourself, Family and Community ○ Traditional Tlingit Healing and Values ○ Healing Circle ○ Strategies in Dealing with a Person with an FASD in a Justice System ○ Supervising Those in the Workplace with an FASD ○ Effective Community Advocacy ○ FASD Prevention ○ 3M Project ○ Design for Success: Creating a More Relaxing and Friendly Space for Living and Working with FASD ○ Why Case Managers: The Key to Better Living Skills and The Hope of Success ○ Homelessness and FASD ○ How an FASD Diagnosis is Made ○ and more

For more information, please visit:
www.ccthita.org/2010fasdconference.html
For questions about registration, please contact
Donna James at (907) 463-7169.

5500

Understanding Fetal Alcohol Spectrum Disorders
Getting a Diagnosis



Jean is a recovering alcoholic. Her daughter has been to the hospital 10 times for heart and kidney problems. At 2, she can't walk or talk.

Katie is 5. She has no friends, throws tantrums, and can't read like other kids. Her teacher says she can't sit still or pay attention. Her birth mother drank on the weekends. Her adoptive mother is upset.

Dana is in substance abuse treatment. Her 13-year-old daughter has been suspended from school three times and has no friends. The school psychologist isn't sure what's wrong.

These children have baffling problems. Even a psychologist is stumped. Since the birth mothers drank alcohol, the children might have various types of fetal alcohol spectrum disorders (FASD).

What Are Fetal Alcohol Spectrum Disorders?

FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, behavioral, mental, and/or learning disabilities with possible lifelong implications. FASD is not a diagnostic term. It refers to several conditions.

The most well-known diagnosis is fetal alcohol syndrome (FAS). Signs of FAS include distinct facial features (smooth philtrum [groove between nose and upper lip], thin upper lip, small eye openings), growth deficiencies, and central nervous system (CNS) defects. The Institute of Medicine has identified three other diagnoses[1]:

- Partial FAS: facial anomalies and other symptoms without all the signs of FAS
- Alcohol-related neurodevelopmental disorder (ARND): CNS defects and behavior problems or cognitive deficits (e.g., speech delays, hyperactivity)
- Alcohol-related birth defects (ARBD): damage to organs, bones, or muscles

How Can I Recognize FASD?

Only trained professionals can make a diagnosis. Teachers or relatives may identify a problem, but they cannot diagnose an FASD.

Signs that may indicate the need for assessment include:

- Sleeping, breathing, or feeding problems
- Small head or facial or dental anomalies
- Heart defects or other organ dysfunction
- Deformities of joints, limbs, and fingers
- Slow physical growth before or after birth
- Vision or hearing problems
- Mental retardation or delayed development
- Behavior problems
- Maternal alcohol use

Why Is Diagnosis Important?

Because most people with FASD have no visible signs of alcohol exposure, their problems may be wrongly blamed on poor parenting or on other disorders. Early diagnosis and intervention contribute to positive long-term outcomes.[2] Accurate diagnosis can:

- Help the person receive appropriate services.
- Aid communication among clinicians, caregivers, educators, and families.
- Provide better self-awareness and understanding by family members.

WHAT YOU NEED TO KNOW

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

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How Is FASD Detected?

An expert trained to assess birth defects and FASD can make a diagnosis. Ideally, a team diagnoses the specific disorder. The team may include:

- Geneticist
- Developmental pediatrician
- Neurologist
- Dysmorphologist (physician specializing in birth defects)
- Education consultants
- Psychologists, psychiatrists, and social workers
- Occupational therapists
- Speech and language specialists

Tests usually include a complete physical (height, weight, vision, hearing, cardiogram, etc.), evaluation of the face, and an IQ test (e.g., WISC, WAIS). Occupational therapy, speech, neurologic, and psychiatric evaluations are used to check for:

- Cognitive deficits, such as memory problems, or developmental delay
- Executive functioning deficits, such as problems following multistep directions
- Motor delays or deficits, such as clumsiness or tremors
- Attention deficits and hyperactivity
- Poor social skills, such as interrupting others and misreading cues
- Behavior problems, such as aggression or not finishing tasks

Examples of specific tests clinicians use include Conners Rating Scales,[3] Vineland Adaptive Behavior Scales,[4] and Children's Memory Scale.[5]

Where Can I Go for a Diagnosis?

Depending on your community, you might go to a developmental pediatrician, an FASD clinic, a genetics clinic, or another specialist. The National Organization on Fetal Alcohol Syndrome (NOFAS) maintains a Web-based directory of FASD services at www.nofas.org/resource/directory.aspx.

How Do I Prepare for an Assessment?

It will help to record your child's history and behavior and make copies of any written reports. Bring the documents and photos of your child at various ages. Areas to note include:

- History of prenatal alcohol exposure
- Child's growth pattern
- Physical characteristics, such as atypical facial features
- Medical history, such as illnesses, surgeries, and vision or hearing problems
- Signs of CNS damage or behavior problems, such as memory problems or poor impulse control

What Do I Do With the Results?

Your child may be eligible for various services. A targeted treatment plan will help improve outcomes. Sharing the assessment results with your child's school can help in identifying appropriate services and teaching strategies. Your child might qualify for an individualized education plan, including services such as speech therapy and counseling.

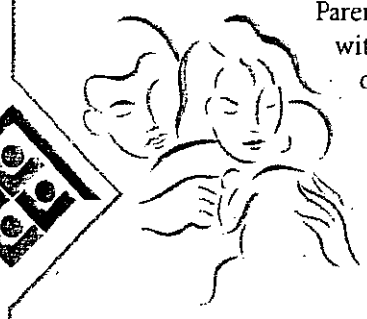
You can also contact the department of social services or developmental disabilities services to ask what support is available. It might also be possible to obtain financial support, such as Supplemental Security Income. Finally, it is important to share the information with your child's pediatrician and other health care providers to help obtain appropriate medical and mental health services.

References

1. Stratton, K., Howe, C., & Battaglia, F. (Eds.). (1996). *Fetal alcohol syndrome: Diagnosis, epidemiology, prevention, and treatment.* Institute of Medicine, Washington, DC: National Academy Press.
2. Streissguth, A. P., Barr, H. M., Kogan, J., & Bookstein, F. (1996). *Understanding the occurrence of secondary disabilities in clients with fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE).* Final Report. Seattle, WA: Fetal Alcohol and Drug Unit, University of Washington School of Medicine.
3. Conners C.K. *Conners' Rating Scales—Revised.* North Tonawanda, NY: Multi-Health Systems.
4. Sparrows, S.S.; Balla, D.A.; and Cicchetti, D.V. *Vineland Adaptive Behavior Scales.* Circle Pines, MN: AGS Publishing.
5. Cohen, M. *Children's Memory Scale.* San Antonio: Harcourt Assessment.

If you're pregnant, don't drink. If you drink, don't get pregnant.
For more information, visit fascenter.samhsa.gov or call 866-STOPFAS.

Adopting and Fostering Children With Fetal Alcohol Spectrum Disorders



Parenting has been called the toughest but most fulfilling job in the world. Parenting children with special needs, such as fetal alcohol spectrum disorders (FASD), brings its own set of challenges.

Many parents of children with an FASD are adoptive or foster parents. Some knew about FASD when they welcomed their children into their family, while others did not. In any case, information is the key to success in raising children with an FASD.

Learning about FASD can help parents understand how their children are affected, which parenting strategies work best, and how to get services and support. For people who want to adopt or foster a child with an FASD, knowing the facts can help them make an informed decision.

What Is FASD?

"FASD" is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), alcohol-related neurodevelopmental disorder (ARND), and alcohol-related birth defects (ARBD). In the United States, FASD occurs in about 10 per 1,000 live births, or about 40,000 babies per year.[1]

There is little information available about FASD and adoption or foster care. One study of children in foster care in Washington State revealed a rate of FAS 10 to 15 times higher than in the general population, suggesting that children in foster care are more likely to have an FASD.[2] Estimates for international adoptions vary by country. In Russian orphanages, the rate of FAS alone has been estimated at 1 to 10 per 100.[3]

Meeting the Challenges Associated With FASD

Brain damage and physical defects are the primary disabilities associated with FASD. Lifelong behavioral or cognitive problems may include:

- Mental retardation
- Learning disabilities
- Hyperactivity
- Attention deficits
- Problems with impulse control, social skills, language, and memory

These challenges can lead to other problems called secondary disabilities, which may include:

- Disrupted school experience
- Alcohol and substance abuse
- Mental illness
- Dependent living
- Problems with employment
- Inappropriate sexual behavior
- Involvement in the criminal or juvenile justice system
- Confinement (prison or inpatient treatment for mental health or substance abuse problems)[4]

A child with an FASD is likely to need services throughout his or her life and may never be able to live independently. The lifetime cost for one child with FAS can be $2 million.[5]

Despite their challenges, children with an FASD have a number of strengths. For example, they tend to be caring, creative, determined, and eager to please.[6] They also respond well to structure, consistency, concrete communication, and close supervision. With a supportive home, an early diagnosis, and appropriate services, many children with an FASD can avoid secondary disabilities and reach their full potential.[4]

WHAT YOU NEED TO KNOW

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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Gathering Information

Many children who have an FASD lack an accurate diagnosis and their problems may not be clear. Prospective parents may request a copy of a child's complete medical and family history. However, because records may not tell the whole story, they may also ask specific questions about:

- Possible prenatal exposure to alcohol or drugs
- The physical and mental health of the mother and any siblings
- The developmental history of the child, including possible delays
- Independent evaluations from a physician

Most States require adoption and foster care agencies to share information with prospective parents about the health and social history of the child and birth parents. Some States require more information sharing than others, but few specifically address alcohol.[7] Full investigation and disclosure is best for everyone so that placements are successful, parents are prepared, and children get the help they need.

Conclusion

Parenting offers many rewards, despite its hurdles. Those who choose to become a parent or caregiver to a child with an FASD experience great joy along with the challenges. The child can benefit from a stable, loving home with parents and caregivers who understand his or her needs. Ultimately, adoptive and foster parents can change the outlook for individuals with an FASD, one day at a time.

Tips for Adopting or Fostering Children Prenatally Exposed to Alcohol or Other Drugs

1. Work with informed professionals in quality adoption agencies.
2. Explore your feelings about alcohol and drug abuse, particularly among pregnant women.
3. Discuss the child's background with your social worker so that you have a realistic picture of the birth parents' substance use and related lifestyle.
4. Ask for written summaries of the child's diagnoses, medical complications, treatment services, and necessary followup care.
5. Ask for information on services and resources to meet the child's needs, including eligibility for adoption subsidies and Medicaid.
6. Find out how to reduce the impact of the child's biological risks by providing a nurturing, responsive, and healthy caregiving environment.
7. Recognize that you must be prepared for and able to tolerate the uncertainties that are part of adopting a child prenatally exposed to drugs or alcohol.
8. Resist negative stereotypes of children prenatally exposed to drugs or alcohol, which ignore the individuality of each child and the role of a healthy environment.
9. Recognize the importance of timely identification of problems and early intervention.

Adapted from Edelstein, S. 1995. *Children With Prenatal Alcohol and/or Other Drug Exposure: Weighing the Risks of Adoption.* Washington, DC: CWLA Press.

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6. Teaching Students With Fetal Alcohol Syndrome/Effects: A Resource Guide for Teachers. Ministry of Education, Government of British Columbia, 1996. http://www.bced.gov.bc.ca/specialed/fas
7. U.S. Department of Health and Human Services. Administration for Children and Families. National Adoption Information Clearinghouse. 2003 Adoption State Statutes Series Statutes-at-a-Glance: Collection of Family Information About Adopted Persons, Birth Parents, and Adoptive Parents. http://naic.acf.hhs.gov/general/legal/statutes/collection.pdf

Stop and think. If you're pregnant, don't drink.

For more information, visit **fasdcenter.samhsa.gov** or call 866-STOPFAS.

www.stopalcoholabuse.gov

Substance Abuse and Mental Health Services Administration
A Life in the Community for Everyone
U.S. Department of Health and Human Services

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5504
DHHS Publication No. (SMA) 07–4254
Printed 2007

Independent Living for People With Fetal Alcohol Spectrum Disorders

In the film "Big," a 13-year-old is stuck in an adult body. He has to get a job, find a home, and pay his own bills. The film is a fantasy, but these tasks can be a scary reality for adults with fetal alcohol spectrum disorders (FASD).

WHAT YOU NEED TO KNOW

What Are Fetal Alcohol Spectrum Disorders?

FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

FASD is not a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), alcohol-related neurodevelopmental disorder (ARND), and alcohol-related birth defects (ARBD). Each year, as many as 40,000 babies are born with an FASD. Hundreds of thousands of adults have these disorders.

Most adults with an FASD look like you or me, but they have cognitive problems that make it hard to live independently. In particular, their social development is stunted and they have poor judgment. Their behavior is unpredictable from one day to the next and can get them into serious trouble.

Many people with an FASD do not understand how impaired they are, which puts them at even greater risk. They have a strong desire to be "normal." Most appear normal to others, raising unreasonable expectations and setting the stage for failure.

FASD may be associated with substance abuse, unemployment, and jail time. With appropriate support, such negative outcomes can be avoided.[1]

What Is Independent Living?

Independent living refers to the ability to function in a community without support. However, many people hire others to help repair their cars, cut their grass, and fix broken windows. In collaboration with a spouse, friends, and paid service providers, people can run their households more efficiently. Thus, "interdependent living" is a more accurate term than independent living.

Can People With an FASD Live Independently?

A supportive community is important for everyone, but it is essential for people with an FASD. They need a strong circle of support made up of family members, mentors, social workers, job coaches, and others who understand the realities and limitations of FASD.

Parents or guardians of children with an FASD should start planning early for the transition to adulthood, when eligibility for many services will end.

Most adults with an FASD will need more help than others to meet the more routine demands of work and home. Areas where assistance may be important include employment, money management, housing, and social skills. Many require close supervision to help them make day-to-day decisions and stay safe.

In a 1996 study of adults with an FASD conducted by the University of Washington:

- 50 percent had trouble finding a job.
- 60 percent had trouble keeping a job.
- 18 percent achieved independent living, but most had employment problems.
- About 80 percent had trouble managing money and making decisions.[1]

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The box shows the percentages who require help with other daily tasks.

- Getting social services, 70%
- Getting medical care, 66%
- Having relationships, 56%
- Shopping, 52%
- Cooking meals, 49%
- Staying out of trouble, 47%
- Structuring leisure time, 47%
- Keeping clean, 36%
- Using public transportation, 24%[1]

How Can People With an FASD Support Themselves?

Appropriate training and assistance can help many people with an FASD find and hold jobs. Job training for persons with an FASD should begin during high school, with the student's education team taking the lead in planning the transition from school to work.

The Federal Rehabilitation Services Administration may be able to help with job placement and support services such as job coaches. States and private organizations, such as the Arc, may also offer assistance.

The key to successful employment for individuals with an FASD is an employer who understands FASD, has reasonable expectations, and can provide a supportive environment. Helpful strategies include:

1. Using concrete language
2. Establishing consistency and routine
3. Providing ongoing training
4. Reviewing job expectations frequently
5. Helping to interpret the wishes and actions of other employees and customers

People with an FASD often find it difficult to access financial benefits. Many States base eligibility for developmental disabilities benefits on IQ. Many people with an FASD have normal IQs and do not qualify. They may be eligible for Social Security Disability Insurance or Supplemental Security Income from the Federal Government if they can meet the strict definition of disability needed to qualify.

Individuals with an FASD typically lack skills managing money. They may receive a paycheck or benefits check and immediately spend it, rather than budgeting for rent and other expenses. Consulting a lawyer about designating a "representative payee" can help. The payee can be a family member, case manager, or other person who receives an individual's checks, pays their expenses, and provides spending money on a daily or weekly basis.

What About Housing?

Housing for adults with an FASD may be hard to find. Those who meet certain criteria may be eligible for Federal housing programs such as public housing, housing vouchers, Section 811 for persons with disabilities, and rural housing programs. States, localities, and nonprofit organizations also may offer housing, but their eligibility criteria and accessibility vary widely.

Supportive housing that offers help with tasks such as cleaning, grocery shopping, and bill paying would be ideal, but few programs are designed for people with an FASD. Group homes for individuals with mental retardation or mental illness may be an option. However, they can be a poor fit for people with an FASD, who may function at a higher level than their housemates or have different needs. Independent living with services may work for persons who do not need constant supervision.

Resources

- Rehabilitation Services Administration, www.ed.gov/about/offices/list/osers/rsa/index.html?src=mr
- Job Accommodation Network, U.S. Department of Labor, www.jan.wvu.edu/sbses/vocrehab.htm
- National Council on Independent Living, 703-525-3406, ncil@ncil.org, www.ncil.org
- U.S. Department of Housing and Urban Development, www.hud.gov
- "F.A.S.: When the Children Grow Up," www.knowledgenetwork.ca/know_tool/fas/resources/documentary/index.html

Reference

1. Streissguth, A., and Kanter, J., eds. 1997. *The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities.* Seattle: University of Washington Press.

If you're pregnant, don't drink. If you drink, don't get pregnant.

For more information, visit fascenter.samhsa.gov or call 866-STOPFAS.

SCR

13

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/24/10

FURTHER:

Date of 5-Day Notice: March 11, 2010
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: March 16, 2010

Health and Social Services Committee considered SENATE CONCURRENT RESOLUTION NO. 13

SCR 13 SUPPORTING SENIOR CAREGIVERS

Supporting senior caregivers and encouraging the Department of Health and Social Services to provide additional education on the effects of aging and the importance of senior caregivers.

and recommends:

[ ] be **replaced** with [ ] **SCS** or [Y] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title
_____
HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
Health	3/12/10	~~✓~~		✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	✓			
	THOMAS	✓			
	PASKVAN	X			
	DYSON	X			
CHAIR:	DAVIS	✓			

5508

Alaska State Legislature

Senator Con Bunde
Senate District P
Senate Minority Leader / Senate Republican Caucus
Member: Senate Labor & Commerce Committee

Sponsor Statement

SCR 13

"Supporting senior caregivers and encouraging the Department of Health and Social Services to provide additional education on the effects of aging and the importance of senior caregivers."

Alaska's senior population is growing. The number of Alaskans 65 years of age or older is expected to increase by nearly 60 percent in the next 20 years and the population of those 85 years or older is projected to double by 2050. Per capita, Alaska has the fastest growing 85 and over population in the entire nation.

While advances in medicine, technology, and assisted living practices are enabling seniors to live longer, more productive, and more comfortable lives than ever before, the fact remains that many of our aging loved ones will at some point require some form of caregiving. In fact, more than 25 percent of all seniors need some level of assistance with their daily activities.

It is critical that we as a state are prepared to meet and manage the needs of our aging population.

By supporting senior caregivers and encouraging the Department of Health & Social Services to provide additional education on the effects of aging and the importance of senior caregivers, SCR 13 draws attention to the changing demographics of aging in Alaska and the critical role played by senior caregivers.

Sen.Con.Bunde@legis.state.ak.us 907-465-4843 Juneau 907-269-0181 Anchorage 1-800-892-4843

SENATE CONCURRENT RESOLUTION NO. 13

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY SENATORS BUNDE, McGuire

Introduced: 2/24/10
Referred: Health and Social Services

A RESOLUTION

Supporting senior caregivers and encouraging the Department of Health and Social Services to provide additional education on the effects of aging and the importance of senior caregivers.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS, every day, an estimated 23 ~~17~~ people in Alaska turn 60; and

WHEREAS an estimated ~~79,847~~ 52,620 people, or ~~11~~ 7.5 percent of the state's population, are 65 years of age or older; and

WHEREAS the population in the state that is 65 years of age or older is expected to increase by ~~59~~ 155 percent in the next 20 years to 134,391 in 2030; and

WHEREAS the population in the state that is 85 years of age or older is projected to reach 12,476 in 2030 ~~and double to 24,952 by 2050~~; and

WHEREAS approximately ~~6,364~~ 5,700 people who are 65 years of age and older and 7,190 people who are 55 years of age and older in the state have Alzheimer's disease or a related disorder, and it is estimated that 14,170 people will have Alzheimer's disease or a related disorder by 2030; and

CS FOR SENATE CONCURRENT RESOLUTION NO. 13(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS BUNDE, McGuire

A RESOLUTION

Supporting senior caregivers and encouraging the Department of Health and Social Services to provide additional education on the effects of aging and the importance of senior caregivers.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS, every day, an estimated 23 people in Alaska turn 60; and

WHEREAS an estimated 52,620 people, or 7.5 percent of the state's population, are 65 years of age or older; and

WHEREAS the population in the state that is 65 years of age or older is expected to increase by 155 percent in the next 20 years to 134,391 in 2030; and

WHEREAS the population in the state that is 85 years of age or older is projected to reach 12,476 in 2030; and

WHEREAS approximately 5,700 people who are 65 years of age or older and 7,190 people who are 55 years of age or older in the state have Alzheimer's disease or a related disorder, and it is estimated that 14,170 people will have Alzheimer's disease or a related disorder by 2030; and

WHEREAS 70 percent of people with Alzheimer's disease or a related disorder live at home and need assistance with activities of daily living; and

WHEREAS more than 25 percent of all seniors need some level of assistance with activities of daily living; and

WHEREAS, in order to address the surging population of seniors who have significant needs for in-home care, the field of senior caregiving will continue to grow; and

WHEREAS an estimated 14,539 adults in the state provide care to individuals with Alzheimer's disease or a related disorder, which equates to an estimated 12,000,000 hours and an approximated value of $140,000,000 each year; and

WHEREAS an estimated 96,800 adults in the state provide care to adult relatives or friends, and an estimated 1,595 adults provide paid senior care to nonrelatives; and

WHEREAS the longer seniors are able to provide for themselves, the less the public payment systems supported by state and federal governments are burdened;

BE IT RESOLVED that the Alaska State Legislature

(1) recognizes senior caregiving as a profession;

(2) supports the private home care industry and the efforts of family caregivers statewide by encouraging individuals to provide care to family, friends, and neighbors;

(3) encourages accessible and affordable care for seniors;

(4) will review state policies and support current state programs that address the needs of seniors and senior caregivers;

(5) encourages the Department of Health and Social Services to continue to provide additional education on the effects of aging and the importance and availability of senior caregivers to meet personal needs.

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(5) encourages the Department of Health and Social Services to continue to provide additional education on the effects of aging and the importance and availability of senior caregivers to meet personal needs.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SCR013
() Publish Date:

Identifier (file name): SCR013-DHSS-SDSA-3-12-10
Dept. Affected: Health & Social Services

Title: Supporting Senior Caregivers
RDU: Senior and Disabilities Services
Component: Administration

Sponsor: Bunde

Requester: Senate HSS
Component Number: 2663

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Senate Concurrent Resolution 13 supports senior caregivers and encourages the Department of Health and Social Services to provide additional education on the effects of aging and the importance of senior caregivers. There are no foreseeable costs.

Prepared by: Rebecca Hilgendorf, Director
Phone 907-269-2083
Division: Division of Senior and Disabilities Services
Date/Time 3/10/10 4:36 PM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/12/2010
DHSS Finance & Management Services

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February 26, 2010

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SCR 13 (Bunde)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SCR 13, authored by Senator Con Bunde and co-sponsored by Senator Lesil McGuire.

SCR 13 puts a spotlight on the changing demographics of aging in Alaska and the critical role played by family caregivers.

The fastest growing age group in America is the eighty-five plus. Per capita, Alaska has the fastest growing eighty-five plus in the entire nation.

The eighty-five plus are the age group most likely to need some assistance with activities of daily living. The majority of this assistance is rendered by family caregivers.

Many Alaskan families will find themselves in a caregiving mode as our population ages. AARP supports the recommendation in SCR 13 that encourages the Department of Health and Social Services to provide education about caregiving to all of us and to support the efforts of family caregivers to take care of older relatives and friends.

Without family caregivers, government would face increasing demands for paid assistance for older citizens. This would significantly impact the Medicaid long term care program as well as the personal care attendant program.

Family caregivers don't "dump" their responsibilities on government. They step up to the plate and provide assistance as they are able. We often find caregivers in their 70's and 80's caring for older parents as well as frail spouses and siblings.

With a little help and support, Alaska can do much to help these caregivers continue to assist their family members. This is a legitimate and appropriate service for state and local government to render to those citizens who give so much of themselves.

We should shine a spotlight on these caregivers, recognize their efforts, and provide whatever education we can to help them maintain the independence of their family members and their own health and well-being.

AARP recommends an "AYE" vote on SCR 13.

Jennie Chin Hansen, President
William D. Novelli, Chief Executive Officer

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Con Bunde

Alzheimer's
Resource of Alaska

February 26, 2010

Senator Con Bunde
State Capitol, Room 423
Juneau, AK 99801

Anchorage &
Statewide Services
1750 Abbott Road
Anchorage, AK 99507
phone 907-561-3313
fax 907-561-3315
Toll-free in Alaska
800-478-1080

Fairbanks Services
565 University Ave.
Suite 2
P.O. Box 72791
Fairbanks, AK 99707
phone 907-452-2277
fax 907-457-3376

Juneau Services
3100 Channel Drive
Suite 19
Juneau, AK 99801
phone 907-586-6044
fax 907-586-6044

Mat-Su Valley Services
Trinity Barn Plaza
P.O. Box 4406
Palmer, AK 99645
phone 907-746-3413
fax 907-746-3413

www.alzalaska.org

Dear Senator Bunde,

On behalf of the Alzheimer's Resource of Alaska and the individuals we serve, I would like to thank you for introducing Senate Concurrent Resolution n.13 supporting caregivers of Alaska seniors.

Seniors choose to remain in their home and their community, with help from family, for as long as possible. Family caregivers are honoring their elder's wishes; more than 70% of people with Alzheimer's disease and related dementias (ADRD) live at home where they are cared for by family and friends. However, the demands of caregiving can come at a high cost to the caregiver's own physical and mental wellbeing. Caregiver stress is becoming a major health risk for caregivers.

Education and support services give caregivers tools and skills that enable them to maintain families' independence and are an effective mechanism for families to continue caring for a loved one in their own home and community. Families assume most of the responsibility for the care of the older family member while working, caring for children and holding other responsibilities. In the later stages, when some people with ADRD move to an assisted living facility or nursing home many family caregivers continue to assist with financial and legal affairs, medical care and emotional support. Some even continue to help with bathing, dressing and personal care needs.

Education for caregivers is a key component in the statewide infrastructure of senior care. Research shows that education and support services for the family caregivers can maintain this informal care longer and delay placement of the elder by an average of 1 ½ years. State funding simply leverages the enormous contributions by families making education and support services highly cost-effective. We must increase our support of this informal, unpaid, caregiving network.

Thank you again for introducing SCR N. 13.

Sincerely,

Dulce Nobre
Executive Director

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

March 1, 2010

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

Subject: Support for SCR 13, Senior Caregivers

Dear Chair Davis:

The Alaska Commission on Aging (ACoA) supports SCR 13, a bill that recognizes the important role of family and professional caregivers who care for older Alaskans, some of whom have Alzheimer's disease and related dementias (ADRD), by providing the assistance they need to remain in their homes and communities for as long as possible. The number of older Alaskans with Alzheimer's disease and related disorders is projected to nearly double within the next decade, based on national age-based prevalence rates, and quadruple by 2030. Fifty-eight percent of residents at the Pioneer Home have ADRD (Pioneer Home, January 2010 report). SCR 13, authored by Senators Con Bunde and Lesil McGuire, also highlights Alaska's demographic aging transition.

For the second year in a row, Alaska is the state with the fastest growing population of older adults age 65 years and older. Between 1998 and 2008, the number of Alaska seniors grew by over 50%, which is more than four times the national average.

The growth of the older Alaskan population is occurring at both ends of the senior age continuum – among the youngest seniors (age 60 to 64 years) many of whom moved to Alaska during the 1970s pipeline era, and the "oldest old," those age 85 years and older who are the most frail, the most prone to Alzheimer's disease and related disorders, and most in need of long-term support services. The graying of Alaska's population is creating substantial shifts for workforce, particularly in the health care and long-term support service sectors as demand increases and providers are becoming of retirement age.

Alaska's emphasis on caregiving performed by family and professional home- and community-based (HCBS) providers has made a significant difference in seniors' ability to remain at home; this is apparent in the increased average age of admission to the Pioneer Homes from 76 in 1998 to 86 in 2008. As a result of caregiver efforts, older Alaskans are able to continue living at home and in their communities, where they most desire to be, and spend fewer years in nursing homes when this care is most appropriate. Rates for a semi-private room in a nursing home will rise by 192% over the next twenty years, increasing from $187,815 (in 2008) to $549,662 by 2030 (Genworth Financial 2008 Cost of Care Study).

The majority of caregiving for persons with ADRD is performed by loved ones. In Alaska, there are approximately 14,539 unpaid ADRD caregivers who have contributed an estimated 12,550,265 hours of unpaid care that is valued at $139,307,943 (Alzheimer's Association 2009). Without family caregivers, the state would be paying far more for Medicaid long-term support services.

ACoA supports SCR 13 and its recommendations to regularly review state policies and programs to ensure they address the needs of Alaska seniors and their caregivers and for the Department of Health and Social Services to provide education about the aging process and the importance of senior caregivers. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879), should you have any questions regarding our position. Thank you for your consideration.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

Cc: Senator Joe Paskvan, Vice Chair
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Con Bunde

AUTHENTICATED U.S. GOVERNMENT INFORMATION GPO

One Hundred Eleventh Congress of the United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Tuesday, the sixth day of January, two thousand and nine

Concurrent Resolution

Whereas 8,000 people in the United States turn 60 years old every day;

Whereas an estimated 35,900,000 people, 12.4 percent of the population, are 65 years of age and older;

Whereas the United States population age 65 and older is expected to more than double in the next 50 years to 86,700,000 in 2050;

Whereas the 85 and older population is projected to reach 9,600,000 in 2030 and double again to 20,900,000 in 2050;

Whereas it is estimated that 4,500,000 people in the United States have Alzheimer's disease today;

Whereas it is estimated that number will increase to between 11,300,000 and 16,000,000 by 2050;

Whereas 70 percent of people with Alzheimer's disease and other dementias live at home, and these individuals are examples of individuals who need assistance in their homes with their "activities of daily living";

Whereas currently over 25 percent of all seniors need some level of assistance with their "activities of daily living";

Whereas in order to address the surging population of seniors who have significant needs for in-home care, the field of senior caregiving will continue to grow;

Whereas there are an estimated 44,000,000 adults in the United States providing care to adult relatives or friends and an estimated 725,000 nonfamily private paid senior caregivers;

Whereas both unpaid family caregivers and paid caregivers work together to serve the daily living needs of seniors who live in their own homes;

Whereas the Department of Labor estimated that paid caregivers for the year 2006 worked a total of 835,000,000 hours, and the projected hours of paid senior caregivers are estimated to increase to 4,350,000,000 hours by 2025; and

Whereas the longer a senior is able to provide for his or her own care, the less burden is placed on public payment systems in State and Federal governments: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That Congress—

(1) recognizes caregiving as a profession;

(2) supports the private home care industry and the efforts of family caregivers nationwide by encouraging individuals to provide care to family, friends, and neighbors;

JOIN NFCA's Community

Free for caregivers

Who are America's Family Caregivers?

Suzanne Mintz on YouTube | Suzanne Mintz Interview on Women's Radio

Rosalyn Carter said it best: "There are only four kinds of people in the world – those who have been caregivers, those who are currently caregivers, those who will be caregivers and those who will need caregivers". Caregivers are needed for family members of all ages. With appropriate information and support, family caregivers can help their loved ones across the lifespan.

So, who are family caregivers ... It's a complicated question and answers may vary depending upon whom you ask. Physicians may give an answer different from social workers and researchers may undoubtedly quote statistics. However, if you really want to know who America's family caregivers are, you need to ask them directly.

America's family caregivers are *family, friends, partners, and neighbors*. To better understand the experience and the meaning of being a family caregiver go to The National Family Caregiver Story Project. The NFCA Story Project is a collection of first-person accounts by family caregivers. It is the gateway to becoming part of a growing group of family caregivers who have reached out to share their thoughts, feelings and find solace in the words of others. As you read the stories of America's family caregivers you may find yourself nodding in recognition and find the answers to Who are America's Caregivers?

Research and Statistics:

NFCA Research and Reports have focused largely, but not exclusively, on those family caregivers who provide significant levels of care. One aspect of our research has sought to better understand how to communicate effectively with family caregivers, since so many are uncomfortable with calling themselves anything other than a spouse, a parent, or a loving adult child.

There is an extensive body of family caregiver research available on many different aspects of the caregiving experience. You can find out more about the financial, physical and emotional impact of family caregiving as well as information on family caregivers at work and in the healthcare system in the Caregiver Statistics section of this site.

Suzanne Mintz on YouTube

Listen to Suzanne Mintz, President/CEO of NFCA, talk about family caregivers. Click here for the video on YouTube.

In-Home Care Services

"I got to a point where I didn't like driving or running errands by myself. Now, thanks to my CAREGiver Susan, I don't put off getting the things I need and I actually enjoy getting out."

- *Ruth, Florida*

Senior Home Care Services

Everyone shares similar concerns about health care for our parents, grandparents and loved ones as they reach retirement age and beyond. Perhaps your mother gets confused and can't keep her doctor appointments and medications straight. Or your dad seems depressed and doesn't enjoy fishing anymore. Maybe your grandmother suffering from Alzheimer's needs regular attention while you're at work. That's when Home Instead Senior Care can come into the home and be the caregiver for you. Learn more about how Home Instead Senior Care can help you care for the senior in your life.

Are you seeing that your loved ones need home care as they age? Have you thought about a nursing home or assisted living facility but want to keep them in their home for as long as possible? Are you starting to wear out because of the impact the senior care you're providing is having at work and with your family members? Do you fear for a loved one's safety?

Home Instead Senior Care can help with compassionate, home senior care services delivered right in your loved one's home. Whether a few hours a day or long-term care 24 hours a day, a CAREGiver can assist you. All CAREGivers are thoroughly screened, extensively trained, insured and bonded, matched to your preferences, professional and reliable

Home Instead Senior Care Means Exactly That

Share Video: Twitter Facebook Email Embed

Home Instead Senior Care's mission is to enable seniors to live happy, healthy, and independent lives in their homes. As the industry leader for in-home, non-medical care, Home Instead's CAREGivers help turn clients' ordinary days into extraordinary experiences. Hear what actual clients have to say about how Home Instead has improved their lives.

Become a part of the North American Home Instead Senior Care family of franchises

International Franchise Opportunities

Media Room

Home Instead, Inc demonstrates commitment to quality care through our proprietary PEAQ program, -Pursuing Excellence by Advancing Quality. In fact, we commissioned J.D. Power and Associates to routinely survey CAREGivers and clients to ensure consistent delivery of high quality service.

We understand that making the decision to use outside help for caring for an elderly loved one is difficult. That's why we provide a wealth of senior care resources and Alzheimer's and dementia care resources for you to consider.

Home Instead Senior Care offers a wide variety of services, which may grow to include activities and support that are unique to you and your elderly loved one's needs.

Senior Services include the following and more - all tailored to meet your needs:

Companionship Services

- Offer elderly companionship and conversation
- Provide respite care
- Monitor diet and eating
- Check food expirations
- Assist with evening and tuck-in
- Stimulate mental awareness
- Assist with entertaining
- Answer the door
- Reminisce about the past
- Assist with clothing selection
- Care for houseplants
- Provide reminders for appointments
- Discuss current and historical events
- Participate in crafts
- Play games and cards
- Supervise home maintenance
- Record and arrange recipes
- Oversee home deliveries
- Prepare grocery lists
- Clip coupons for shopping
- Monitor TV usage
- Mail bills and letters
- Buy magazines, papers and books
- Rent and play movies
- Plan visits, outings and trips
- Visit neighbors and friends
- Read religious materials
- Maintain calendar
- Maintain family scrapbook
- Record family history

Home Helper Services

- Provide Alzheimer's Care
- Assist with laundry and ironing
- Take out garbage
- Aid with morning and wake-up
- Arrange appointments
- Provide medication reminders
- Aid with reading
- Assist with walking
- Write letters and correspondence
- Organize mail
- Change linens
- Plan, prepare and clean up meals
- Make beds
- Dust furniture
- Drop off and pick up dry cleaning
- Pick up prescriptions
- Organize and clean closets
- Assist with pet care
- Shop for groceries and supplies
- Prepare future meals
- Escort to appointments
- Accompany to lunch or dinner
- Escort for shopping and errands
- Attend plays and concerts
- Escort to religious services
- Attend club meetings and sporting events
- Aid with airport tasks

Personal Services

Assistance with:

- Eating
- Grooming
- Dressing
- Bathing
- Incontinence
- Cognitive impairment
- Mobility
- Medication reminders

Services vary by location.

To download and print our brochures, click here.

HB

2

5524

SENATE COMMITTEE REPORT

DATE: 3/25/09

FURTHER:

DATE TURNED IN TO OFFICE: 4/6/09

Health and Social Services Committee considered CS FOR HOUSE BILL NO. 2(HSS)

HB 2 BIRTH CERTIFICATE FOR STILLBIRTH

"An Act relating to the issuance of a certificate of birth resulting in a stillbirth."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
DHS	2/18			✓	1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME:	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS			✓	
	Thomas	✓			
	Dyson	✓			
	Parkin			X	
CHAIR: Betty Davis	DAVIS	✓			

5525

ALASKA STATE LEGISLATURE

Rep. Carl Gatto

MEMORANDUM

TO: Senator Betty Davis Chair, Senate Health and Social Services Committee
FROM: Rep. Carl Gatto
DATE: March 25, 2009
RE: Request for Hearing

Enclosed is the committee packet for CSHB 2 "*An Act relating to the issuance of a certificate of birth resulting in stillbirth.*" I have included a sponsor statement, the most recent version of the bill, attached fiscal note, and other supplemental material.

Please schedule a committee hearing before the Senate Health and Social Services Committee at your earliest convenience. I appreciate your time and look forward to your reviewing this bill.

Please contact my staff member Sandra Wilson at 465-3163 with any questions or comments regarding this request.

Thank you

Alaska State Legislature

Interim:
600 E. Railroad Ave
Wasilla, AK 99654

Phone: (907) 376-3725
Fax: (907) 376-4768

Session:
Alaska State Capitol, Rm 108
Juneau, AK 99801-1182

Phone: (907) 465-3743
Fax: (907) 465-2381
Toll Free: (800) 565-3743
Rep_Carl_Gatto@legis.state.ak.us

Representative Carl Gatto

Chair, House Military and Veteran Affairs Committee
District 13 - Palmer

SPONSOR STATEMENT
CSHB 2 (HHS)

"An Act relating to the issuance of a certificate of birth resulting in stillbirth."

HB 2 brings closure to parents who have suffered the loss of a stillborn child by giving them a Birth Certificate reflecting that they had a child who was stillborn. To paraphrase one parent of a stillborn child: being able to receive a Birth Certificate for my daughter would make me feel complete in that it would acknowledge that my daughter existed, even if it was only for a short while. This is true not only for her but also heard from other parents that have suffered this loss.

Under current law parents of stillborn children receive a fetal death certificate. HB 2 allows parents the option of requesting a certificate of birth for their stillborn child. This birth certificate is optional, and if the parents choose to receive a Birth Certificate they have the option of naming their child.

There are twenty-six states that now offer parents of stillborns the option of obtaining a Birth Certificate for their child. I urge your support for CSHB 2 (HHS).

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

January 22, 2009

SUBJECT: Sectional Summary (HB 2 (Work Order No. 26-LS0003\A)

TO: Representative Carl Gatto
Attn: Sandra Wilson

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Establishes a process for the bureau of vital statistics to issue a certificate of birth resulting in a stillbirth at the request of a parent of the stillborn child. Requires the bureau to transmit the certificate to the local registrar for filing with the fetal death certificate.

JMM:lmb
09-002.lmb

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 002
() Publish Date:

Identifier (file name): HB002-DHSS-BVS-02-18-09
Dept. Affected: Health & Social Services
Title: Birth Certificate for Stillbirth
RDU: Public Health
Component: Bureau of Vital Statistics
Sponsor: Gatto
Requester: House HSS
Component Number: 961

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

HB002 would require the Bureau of Vital Statistics (BVS) to issue, upon the request of a parent, a "certificate of birth resulting in a stillbirth" for an intrauterine fetal death occuring after 20 complete gestational weeks. These certificates would cost $20 each. Approximately 50 stillbirths are recorded in Alaska annually. Based on response in other states passing similar legislation, it is expected most families would request such a certificate. The division has adequate budget authorization to receive these additional receipts, resulting in a zero fiscal note - even though there will be a cost to the requestor similar to other certificates. (Continued on P. 2)

Prepared by: Beverly Wooley, Director
Phone 269-8126
Division: Public Health
Date/Time 1/23/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/18/2009
DHSS Finance & Management Services

5529

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. HB002

ANALYSIS CONTINUATION

Minimal programming and administrative time will be neccessary to issue such certificates - amounting to an estimated $1,000 annually. Assuming 50 certificates are issued each year at $20 each, costs will be covered by the fee. The BVS budget is funded primarily by receipt supported services; all certificates issued - birth, death, fetal death - require a $20 fee.

January 20, 2009

To the Alaska Legislature

In Support of HB 2
This is the Story of Daniel Gavin Sheppard,

My name is Chauna and in 2002, I became pregnant for the first time in my life at the age of 32. We were overjoyed and considered this a miracle baby after being diagnosed with Fertility problems.

I walked on air with happiness, eating healthier, drinking extra water and taking every breath with my precious baby in mind. That summer we purchased a larger car, a crib and swing, stocked up on diapers of various sizes, and dozens of outfits, We went to child birth classes and even did relaxation exercises at home to prepare for labor. I never missed a doctor appointment and even switched doctors so I could get higher quality care. We got ultrasound videos and pictures. I really enjoyed feeling his regular kicking, rolling and occasional hic ups.

Daniel was due on November 26th, 2002. It was that morning that after a bit of poking and juice drinking that I couldn't seem to wake my son. My doctor sent me to the maternity ward where using a Doppler speaker they couldn't hear a heartbeat. At that point we had an ultrasound where we could not see any heart movement in those tiny, clearly visible, ribs on the tv screen. It was the most painful reality of my life to know my baby had died.

I was induced at apx 2:30pm that day. We went through 17 hours of labor that including an epidural, pain and nausea medication, IV's and 2 hours of pushing. Daniel Gavin was born weighing 7lb 14oz and 19 inches long at 7:30am on November 27, 2002.
His warm, soft, beautiful body was placed on my chest where my husband and I cuddled and kissed and loved him even more than the day before. The nurse bathed him. We dressed him and friends and family came to hold him as well. I distinctly remember one dear friend rocking him just like he was any other baby. The hospital took foot prints and cut a lock of hair for us to keep. They also gave us two camera's to take pictures of our beautiful boy. We were so lucky to be able to keep him with us for 12 hours. We sang to him and prayed before we had to let him go and begin the long painful journey of grief.

The next day the hospital gave us a generic card with his name and birthday on it written in marker and told us that we won't get a birth certificate because he never took a breath. This was a harsh blow after all we had been through. After all, I had given birth to Daniel and he was certainly born.

We drove home from the hospital on Thanksgiving Day with an empty car seat, empty arms and broken hearts.

As sad as this was, we still love Daniel so much, he will always be a part of our family. We do things on his birthday and other times of the year to show him our love. Though we never saw his eyes or heard him cry, my son Daniel is such a gift and we are so thankful for him. There never has been a day when I thought I wasted 9 months carrying him or a time when I wish he never existed. Never, ever... I wish the State of Alaska would not treat him as such.

In 1892 American Author Mark Twin said, "Favored above Kings and Emporers is the stillborn child." I wish stillbirth and the experience of having to deliver a dead baby was respected in this manner today.

This tragedy strikes everywhere. According to the Center for Positive Outcomes in Pregnancy in Washington DC, there are more than 39,000 stillbirths in the U.S. every year.

Historically, we share this horrific experience with John Quincy Adams, Rutherford Hayes, Ernest and Pauline Hemingway, and John and Jackie Kennedy, whose stillborn daughter is buried with her parents and siblings.

Ask any woman why she would endure the pain and agony of giving birth and she will tell you because of the 'reward' at the end...it is 'all worth it' we frequently hear. But what about the silent births- the women who get no reward for all their hard work...

I am writing this today asking you for your support...Please pass HB 2.

Sincerely,

Chauna Sheppard
4032 Reka Drive #K-1
Anchorage, AK 99508
(907) 333-7650
chauna18@hotmail.com

Sandra Wilson

From: Hoyt Family [mehoyt@mtaonline.net]
Sent: Tuesday, January 20, 2009 7:30 PM
To: Sandra Wilson
Subject: RE: Hello

Sandra,

HB 2, to create a 'Birth Certificate resulting in a Still Birth' would make me and a lot of people feel complete. My daughter was still born at 36 weeks and we had a large funeral for her. The idea that the state will only accept the fact that she died is so heart breaking. How can a person die with out being born? Having that piece of paper in my hand would bring closure to the entire grieving process. This would validate that my little girl was once here and apart of our lives.

Thanks so much for bringing this bill forward.

Michelle Hoyt
Project Linus - Alaska Chapter
Providing Security thru Blankets

-----Original Message-----
From: Sandra Wilson [mailto:Sandra_Wilson@legis.state.ak.us]
Sent: Tuesday, January 20, 2009 4:44 PM
To: Carletta Gemmell; Chauna Sheppard; Colleen; Dayna Murphy; Dina Banez; Gretchen Mangrobang; Kaylene Johnson; Lynnette Haas; Michelle Hoyt; Rhonda Crawford; Sandy Thomas; WesCin Yuill
Subject: Hello

Hello everyone. Today was the first day of session and I am preparing the packet that will accompany our request for hearing. I need updated letters of support. You can either write new ones or use the same ones as last year but I need them to reflect the new bill number for this bill which is HB 2. The sooner you can get these to me the sooner I will get a request in. Again I thank everyone for being willing to take the time and send me these letters.

Sincerely,

Sandra Wilson
Staff to Rep. Carl Gatto
907-465-3163
Sandra_wilson@legis.state.ak.us

All of our Family & Friends -

Our son, Declan Murphy Stich, was stillborn Thursday, December 6th at 3:22pm. He was a beautiful 4 pounds 15 ounces and 18.5 inches, just the right size for a baby of 37 weeks.

It was discovered at Dayna's Wednesday morning checkup that Declan's heart had stopped beating. He must have passed away between midnight and nine o'clock, because we both felt his movements the night before. We decided to induce her labor on Wednesday night. Dayna's labor was short and Declan's delivery was without complication. Dayna is healthy and beginning the process of recovery.

We were able to keep Declan with us for several hours after his birth. He was so perfect - absolutely perfect with no sign of distress or problem. We will cherish those precious few moments with our special little boy forever. We took photographs of our own, but we also had a photographer from Now I Lay Me Down To Sleep (a volunteer organization) take images for us so we may share this experience with everyone. We've attached several select pictures from our camera, and we understand if anyone is uncomfortable or uneasy viewing these. The camera does not do Declan justice, he looked very much like a normal sleeping baby.

We are, of course, completely distraught. However, our memories of the time we did have with Declan are raising our spirits. The hospital staff did some wonderful molds of his feet and cut a lock of his hair, so we do have some very physical momentos of him.

Many people have asked about his name. Declan is a VERY Irish name meaning "Full of goodness". The most famous bearer of the name Declan was St. Declan, an early Irish saint who preached in Ireland prior to the arrival of St. Patrick.

I wish I had an explanation as to why Declan has died so unexpectedly, but hopefully a limited autopsy and the results of a large battery of tests will shed some light. However, most fetal deaths like this simply have no explanation. Dayna's pregnancy was completely normal and without complication, and there were no indications that anything like this could happen. We do hope to determine if there may be problems with future pregnancies or if there is a genetic disorder that could have caused a problem.

While we will grieve for Declan and the life we've lost with him, we both feel that life must now move on. We understand that many of you will have questions or want to talk about what has happened, please don't hesitate to speak with us. It has probably been just as hard, or even harder, experience for all of you that don't have the details or latest news. We appreciate your grief for our loss and hope that this email and future conversations with us can assuage the anguish that you may feel.

We would like to thank everyone that has called, emailed, sent flowers, provided a meal, or even just given us space during these past few days. We would particularly like to show our appreciation for the professional services provided by the nursing staff at Providence Hospital (Marcie & Tricia), Dr. Allison Gibbs & Midwife Tonya Kirk from

Anchorage Women's Clinic, photography by Janna Maile (http://www.photoartsak.com) from The Now I Lay Me Down To Sleep Foundation, Evergreen Mortuary (http://www.evergreenfuneral.com), and Dayna's brother Matt for fabricating Declan's urn.

We ask that anyone who feels a need to make a contribution on behalf of our experience please consider a donation to The Now I Lay Me Down to Sleep Foundation. The web page for donations is: http://www.nowilaymedowntosleep.org/pageDisplay.php?page=42

While we've tried to include everyone that we touch in our daily lives as a recipient of this email, we don't have addresses for many friends or acquaintances. Please forward this to anyone that you feel needs to receive it, and we apologize if anyone receives this message more than once.

All our love - Steve & Dayna
--
Steve Stich
Dayna Murphy
8040 Fairwood Cir
Anchorage, AK 99518
907-770-9132

Mayme Ohnemus

P.O. Box 754
Cooper Landing, Alaska 99572
Phone & Fax: (907) 595-1214

February 22, 2009

Representative Carl Gatto
E. Railroad Ave.
Wasilla, Alaska 99654

Phone: 376-3704

Fax: 376-6180

RE: HB 2: Stillbirth Certificate

Dear Representative Gatto:

Thank you for sponsoring HB 159 Stillbirth Certificate last year and for sponsoring HB 2 this year. I sent you some information October 16, 2008 regarding the loss of our granddaughter, Evynn Nicole Ohnemus. My daughter-in-law shared her desire to obtain a Stillbirth Certificate for our granddaughter Evynn Nicole Ohnemus born March 5, 2006. She received a note about HB 2 and asked me to contact you since I am planning to be in Juneau February 26th.

I'm so proud Amber asked me to speak on behalf of our family. She wants me to relay the pain and anguish we have suffered during the time of losing our sweet baby; tell you how the flame went out of our lives upon her death and about the huge void we have had in our lives from that loss three years ago.

Our nineteen month old grandson has rekindled the flame in our lives and continues to give us a lot of joy. We're expecting another grandbaby in July and life feels good again. Evynn's spirit is with us always and we miss her. It's important, especially to her mother and father that Evynn Nicole Ohnemus is treated with the greatest respect. She lived and she died. A Stillbirth Certificate is a small thing to ask for a family that suffered the greatest of losses, their baby.

Thank you reintroducing the bill for parents to be able to obtain a Stillbirth Certificate. This is very important to the healing process for the families of stillborn babies. Thank you for this opportunity to share our story. I urge Representatives and Senators to give 100% support for HB 2.

Sincerely,

Mayme Ohnemus

Mayme

Enclosed: I am enclosing a letter from my daughter-in-law and the information I sent before including letter, picture page and a copy of This N That, written for the Sexy Seniors soon after the loss of our granddaughter - my husband and I couldn't bear to talk about our loss for several weeks but our friends and families deserved to know why we were grieving. They also shared in our loss.

February 21, 2009

Sandra Willson, staff
Carl Gatto
Juneau, Alaska

RE: HB 2 Certificate of Still Birth

To Whom It May Concern:

Thank you for sponsoring HB 2 again this year.

My name is Amber Mullican-Ohnemus. Three years ago my husband and I lost our daughter to stillbirth at 43 wks. There was no apparent cause of death. I was very disappointed the bill failed last year. It is an amazingly hard issue to deal with for me and my whole family. When we found out Evynn would not get a birth certificate it made things even harder to deal with since it seemed she was not considered alive at all. She was a wanted and planned for child. She was alive for 10 months until that gut wrenching day in March 2005. She deserves the dignity of having a birth certificate just as much as children who die of any cause minutes or even days after their births. It would mean a lot to me and my family to have a certificate of still birth to place in her baby book The death certificate we got was so cold and hurtful it felt like she never existed in life only death.

Please, think of all of the lives you can help change for the better by providing this meaningful certificate. You may not be able to bring back our children but you can at least let us have peace with knowing they mattered and were acknowledged.

Thank you for your support on this issue,

Sincerely,

Amber W. Mullican-Ohnemus, B.S.N., R.N., CNOR.

P.O. Box 1442
Soldotna, AK 99669
907-260-4922

Sandra Wilson

From: WesCin Yuill [wesyuill@mtaonline.net]
Sent: Sunday, January 25, 2009 4:19 PM
To: Sandra Wilson
Subject: Re: Hello Again

I live in Palmer , AK. My son and daughter-in-law live in Wasilla. They had a daughter that was stillborn in Aug. of 2007. Could you help me with what information I should include in a letter and who I should write the letter to . Thank you. Cindy Yuill

Sandra Wilson wrote:

> Hello once again. I am working on contacting local governments to get
> them to pass resolutions in support of HB 2. What I would like for
> those of you who live here in Alaska to do is to write a letter to the
> editor getting the word out about this legislation. Also I am trying
> to determine where in the state everyone is from so I can have an idea
> how broad the support for this legislation is. So if you could just
> send me quick notes letting me know where you are located. Also if you
> need any ideas as to where to start with a letter I would be happy to
> help with that as well.
>
>
>
> Sincerely,
>
>
>
> Sandra Wilson
>
> Staff to Rep. Carl Gatto
>
> 907-465-3163
>
> Sandra_wilson@legis.state.ak.us
>
>
>

Sandra Wilson

From: Dayna Murphy [dayna@syllo.com]
Sent: Tuesday, February 24, 2009 4:59 PM
To: Sandra Wilson
Subject: HB 2

Attachments: Letter.txt

Letter.txt (4 KB)

Hi Sandra,

We emailed a little last year when I first found your information on line. I would like you to add our story to the pile you must have. Attached is a copy of the letter we sent out to friends and family after the loss of our son.

We would love to have recognition for our son. Something that shows he was here and present. His baby book has some very cherished keepsakes (some of his hair, his foot prints, molds of his feet, etc) but to have a birth certificate to include would mean a lot. It would give us one more thing tied to him. We had so little time with him that anything is welcome, especially something that has him name.

Since his passing, life has been different. Your perspective on situations changes after losing a child. I remember the first time I left the house alone after he passed away. Something very physical was missing. I had no child with me nor did I have a belly. It was a horrible feeling and I was close to tears in the store. I don't think you ever get over losing a child however you move on. We think about him all the time and keep pictures of him in our home. Our most favorite are of his hand and feet taken by a photographer associates with the Now I Lay Me Down to Sleep foundation.

We are expecting our second child, a girl, in three weeks. We are so ready for her to be here, the constant stress of worry if she is alright is hard to take.
We are so envious of couples who coast through pregnancies and have no idea what the other side of it is like; we wish that we could be naive. We have learned that pregnancy is something you have no control over--you are along for the ride.

We hope that the outcome in the next few weeks will be a better one.

Thank you for your work on this issue. We look forward to hearing about the outcome.

--
Dayna Murphy
Syllogistics LLC
Office 907-770-9134
Fax 907-770-6399
dayna@syllo.com http://www.syllo.com
200 W34th Ave #1074
Anchorage, AK 99503

Newsweek

A Vast and Sudden Sadness

Each year thousands of families experience stillbirth. As science seeks causes, parents use photography to honor their babies and cope with their grief.

Claudia Kalb
NEWSWEEK
From the magazine issue dated Feb 9, 2009

Marirosa Anderson was still sweating from a workout when her cell phone rang at 8:20 p.m. on Nov. 11, a particularly cold night in northern Virginia. Anderson had planned to spend the evening with her husband and two small children. Then she saw the caller-ID number. She took a deep breath, readied herself and answered the phone. Karen Harvey, a labor-and-delivery nurse at Inova Fairfax Hospital, gave her the rundown. A baby was about to be delivered by C-section and the parents wanted photographs. Could she come right over?

Anderson threw on jeans and a sweatshirt, grabbed her camera bag and ran out the door. At the hospital, Harvey led her to a quiet room where Laurie Jackson and her husband, Michael, were waiting. Laurie's pregnancy had been easy and enjoyable, filled with the happy buzz of baby showers and the lovely air of expectation. But during a routine check that Tuesday afternoon—just three days before her due date—the Jacksons were given the incomprehensible news that their baby no longer had a heartbeat. The night before, Laurie had felt the baby kicking. Now she and Michael were confronting the impossible: saying hello and goodbye to their firstborn child at the very same time.

Anderson introduced herself, then took out her camera, turning her attention to a perfect little girl who lay still in a bassinet, peaceful in a white cotton blanket with pink and blue stripes. "She's precious," Anderson said. Then she started to shoot. The baby's face. Click. Her tiny hands. Click. Her little pink feet. Click. Now it was time for the three of them. Laurie cradled her baby girl in the crook of her elbow, Michael leaned in next to her. Together they studied their daughter's face—her mouth resembled Laurie's family, the rest was pure Michael—they whispered to each other, they came together as a family. Their baby girl weighed six pounds, seven ounces and she was 19 inches long. They named her Brenna Rose.

Pregnancy is supposed to be the most wonderful time, brimming with anticipation, kicking with newness and life. But as novelist Elizabeth McCracken writes in "An Exact Replica of a Figment of My Imagination," a recent memoir about the death of her first baby, "this is the happiest story in the world with the saddest ending." Stillbirth happens more often than we imagine—10 times more often than sudden infant death syndrome, or SIDS, a condition most every parent knows about and dreads. Every year some 26,000 babies die during or after the 20th week in their mothers' womb (a loss before that is considered a miscarriage) or die during birth. In at least half of all cases, doctors have no idea what went wrong. The impact is impossible to measure. Mothers, fathers, brothers, sisters, grandparents, aunts, uncles, cousins and friends—all must figure out how to absorb the vast and sudden sadness, to grieve and, in many instances, to reconcile with a God who has shaken their faith to its core.

Decades ago, stillborn babies were whisked away from their parents to morgues; doctors and nurses pretended nothing happened, mothers were medicated with Valium, parents suffered their sorrow alone. It was in the late 1970s and early 1980s that the medical and psychological thinking about stillbirth began to evolve when researchers started studying the impact of a baby's death and parents began telling their stories. From silence and detachment came acknowledgment and

remembrance. Today nurses encourage parents to hold the babies. Molds of hands and feet are created. Locks of hair are collected. And photographs are taken. Not just the clinical snapshots that nurses have been capturing for years, but striking and sensitive portraits that have burgeoned since the formation of a group called Now I Lay Me Down to Sleep in 2005.

Volunteer photographers who belong to the group, including Anderson, take pictures of stillborn babies—and babies expected to die soon after birth—for their parents at no cost. The idea was born from the life of Maddux Haggard, who was 6 days old and on life support in Colorado when his parents, Cheryl and Mike, decided they wanted pictures of their baby and contacted Sandy Puc', a local photographer well known for her beautiful baby portraits. After that photo session four years ago, Cheryl Haggard and Puc' founded Now I Lay Me Down to Sleep, which has since grown to 7,000 photographers, most of them professionals, across the globe.

Photographing the dead may seem strange, even morbid, especially in our American culture so uncomfortable with death. Those feelings are only intensified when the dead are the newly born or just hours or days old. "We associate giving birth with life, with the future, with the defiance of death," says Irving Leon, a psychologist at the University of Michigan Medical Center in Ann Arbor who specializes in reproductive loss. "To have that smashed, violated so powerfully, it's something people don't want to look at, both literally and metaphorically."

Postmortem photography, though, has a long and treasured past. In the 19th century, when people died at home, families spent much of their savings on expensive silver daguerreotypes depicting their loved ones after they had passed away. Now I Lay Me Down to Sleep is a modern-day incarnation of this "memento mori" photographic genre (Latin for "remember your death"). Memories facilitate grieving, says Leon, which is critical to long-term healing. Holding a baby, talking to her and photographing her—all create memories that help parents cope with a devastating loss.

Parents who are hesitant about holding their babies often change their minds toward the end of a shoot, realizing that they'll have no other chance to embrace their child. And the sessions bestow a quiet time for mothers and fathers to treasure and honor their babies without any interruption from nurses or doctors. In years past, parents didn't expect all of their children to live. Today babies are dreamed about and dwelt on, and the deep attachment that develops between parents —especially mothers—and their unborn children starts earlier than ever before. At eight weeks, a baby's heartbeat can be seen on ultrasound; parents now find out gender and assign names months before their babies are born. All this has intensified the grief reactions many women feel after they suffer not just a stillbirth, but a miscarriage too, says Leon.

Studies show that mothers benefit from bonding with their stillborn babies. Joanne Cacciatore, a researcher at Arizona State University, studied 3,000 women and found that those who had the chance to see and hold their babies had fewer symptoms of depression and anxiety. This benefit may be temporarily reversed during a subsequent pregnancy. And nobody should be pressured to hold their babies. But more than 80 percent of women who did not regretted the lost opportunity. Cacciatore, whose fourth baby, Cheyenne, died in 1994, calls this a period of "ritualization," a time for parents to honor their child and to feel some semblance of control during an emotionally chaotic time. Holding a stillborn baby allows women to connect and then separate themselves from their babies after months united in the same body. And it gives parents the chance to create positive memories, rather than live with the unknown: What did she feel like? Whose nose did she have? Was she peaceful?

Doctors, nurses and social workers who encounter stillbirth have come to know this, and their thinking about how to care for patients has evolved enormously. Elisabeth Kübler-Ross's seminal 1969 book, "On Death and Dying," exposed the impact of loss and the long and intricate process of grieving. Parents of stillborn babies started talking about what it felt like to lose their children; physicians and psychologists began challenging the hush-hush approach. Michele Schwarzmann, director of maternal child health at Mercy Medical Center in Baltimore, can't forget the first stillbirth she witnessed in the 1970s. " 'Michele, you can't cry, you have to be strong'," she remembers her supervisor telling her. A decade later, Schwarzmann says she was finally allowed to express her sadness: "I sobbed for every baby I never got to cry over."

Stillbirth is in many ways a medical mystery. Despite its gravity, it has been largely overlooked. Even today, researchers don't know the true incidence of stillbirth nor do they fully understand why it happens. In some cases, doctors can identify a cause—a prenatal infection that travels from mother to baby, a genetic anomaly, a placental abruption, an umbilical-cord accident. But in at

least half of all cases—more than 10,000 a year—they can't pinpoint the problem. "Over the last 50 years, we've put a lot of research and clinical energy into preventing sick babies from dying after birth and a lot of energy into premature babies," says Dr. Robert Silver, an Ob-Gyn at the University of Utah School of Medicine. "We haven't put the same energy into stillbirth."

All that became clear at a workshop held by the National Institute of Child Health and Human Development (NICHD) in 2001. "We realized that we needed to do a study that was larger than anything undertaken in this country," says Dr. Catherine Spong, chief of NICHD's Pregnancy & Perinatology Branch. With NICHD funding, Silver and other researchers began collecting data on more than 500 stillbirths at five sites around the country. Now they're analyzing the information. The hope is that the new information will help researchers sort out how to reduce a woman's risk for stillbirth, identify problems in advance so that couples can prepare for a loss and, ultimately, save lives.

No matter how good the science gets, however, some number of babies will continue to die and parents will continue to grapple with the shock. Not long after joining Now I Lay Me Down to Sleep in 2007, photographer Jennifer Clark got a call from a hospital near Salt Lake City. The parents, Melina and Tom Anderson (unrelated to Marirosa Anderson), had three other children—a son, Jack, then 6, and two daughters, Amy, 4, and Mae, 2—and they were excited about welcoming their fourth, another girl, named Ella. At 39 weeks, however, the baby's heartbeat started dropping precipitously and Melina had to have an emergency C-section under general anesthesia. Melina remembers waking up and hearing her doctor say, "I'm so sorry, she didn't make it." The umbilical cord, wrapped tightly four times around the baby's neck and once around her arm, had cut off her blood supply. Melina "made the kind of sound you never want to hear," says Tom. "Not really a scream, but almost. A moan." And then she started to cry.

Clark was nervous. "I remember standing outside the door before I went in and I prayed," she says. "I wanted to make photos they would cherish." She also remembers a sense of peacefulness as she worked. It was a sacred time, and she was buoyed by the gratitude shown by Tom and Melina. But she was also profoundly saddened. At times, she had to put her camera down to wipe the tears from her eyes as she captured the images. Amy touching Ella's fingers. Mae, in her pink-and-yellow kitty-cat pajamas, a pacifier in her mouth, peering at the baby's face. Jack, who had accompanied his mother to every doctor's appointment. Tom and Melina looking at their daughter's face.

The next day Tom carried his daughter to a hospital exit next to the ER, far from the place where new mothers are wheeled out with newborns in their arms and smiles on their faces. A mortuary attendant strapped Ella onto a gurney and drove off in a big white van. In the weeks after Ella's burial, Melina suffered both physical and emotional pain. Her breasts had to be bandaged to stop the milk from coming in—a poignant reminder of what should have been. Pregnant women brought tears to her eyes; new babies made her think about the milestones she was missing with Ella. But tangled up in the sadness was the conviction that Ella needed to be remembered. Clark's images allowed Melina to savor a face that was fading from her memory. And the Andersons' tributes to their daughter now assure her a constant place in the family. On the first anniversary of Ella's birth, the Anderson family held hands at her grave and sang "Happy Birthday." Then they went out for dinner and shared a birthday cake.

When Clark first heard about Now I Lay Me Down to Sleep, she felt a powerful urge to participate, but she never imagined that she'd find herself on the other side of the lens. Last year Clark was overjoyed to discover she was pregnant. Her first three babies were healthy. This time, Clark's fetus was diagnosed with trisomy 18, a genetic disorder so catastrophic that less than 10 percent of babies make it to their first birthday. The Clarks, devout Mormons, never considered terminating the pregnancy. Above all else, they prayed that their little boy would be born alive and that he would live for some time—hours, days, weeks, maybe even long enough to go home.

Connor Clark was born on Dec. 22 at 5:54 p.m. For just over an hour, his parents, his siblings —Ellison, 10, Sydney, 7, and Hayden, 2—his grandparents and some of his many aunts and uncles held him, talked to him, rejoiced in him. Two photographers from Now I Lay Me Down to Sleep shot the sobbing and the smiles, the kisses, the hugs, the gentle cradling and the embrace between Jennifer and her husband, Spencer, when they realized they were losing their son. At 7:20 p.m., Connor took his last breath. At his funeral service two days after Christmas, the Clarks showed a powerful video compilation of black-and-white photographs set to music for their family and friends. A life deeply mourned, a life lovingly celebrated.

To learn more about Now I Lay Me Down to Sleep, visit their website. For additional information on stillbirth and to find support resources for families, visit the M.I.S.S. Foundation and First Candle. LINKwww.firstcandle.org And for more on research conducted by the National Institute of Child Health and Development, you can visit their site.

With Andy Murr

URL: http://www.newsweek.com/id/182572

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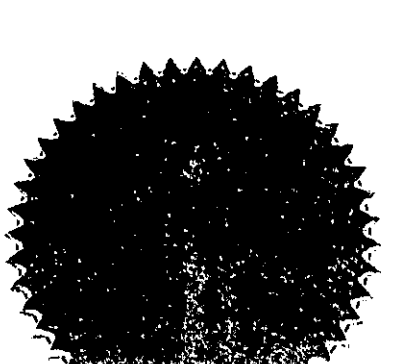
Department of Health and Social Services
Alaska Bureau of Vital Statistics

Certificate of Birth Resulting in Stillbirth

According to Alaska State Records
Bump Nevels Was Delivered on August 1, 2002
In Cicely, Alaska
To Carolyn Anne Puckett and John Earl Nevels



Date Issued: 11/29/2005

FD Number: 2002999999

This certificate is not proof of live birth

Alaska State Legislature

Interim:
600 E. Railroad Ave
Wasilla, AK 99654

Phone: (907) 376-3725
Fax: (907) 376-4768

Session:
Alaska State Capitol, Rm 108
Juneau, AK 99801-1182

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Fax: (907) 465-2381
Toll Free: (800) 565-3743
Rep_Carl_Gatto@legis.state.ak.us

Representative Carl Gatto

Chair, House Military and Veteran Affairs Committee
District 13 - Palmer

Witness list:

- Michelle Hoyt
- Richard Olson
- Phillip Mitchell
- Joann Cacciatore
- Rhonda Crawford
- Amber Ohnemus
- Dayna Murphy

List of Sites:

- Mat-Su
- Anchorage
- Soldotna
- Kenai

HB

35

26-LS0192\S
Mischel
4/15/09

SENATE CS FOR CS FOR HOUSE BILL NO. 35(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, Neuman, Keller, Dahlstrom, Millett, Kelly, Harris, Lynn, Wilson, Ramras, Gatto, Johansen, Johnson

SENATORS Therriault, Dyson, Olson, Meyer, Huggins, Stevens, Wagoner, Menard

A BILL

FOR AN ACT ENTITLED

"An Act removing the requirement of parental consent for a minor's abortion; relating to notice of a minor's abortion; relating to judicial bypass of notice for a minor's abortion; relating to coercion of a minor to have an abortion; relating to reporting of abortions performed on minors; and amending Rule 220, Alaska Rules of Appellate Procedure, and Rule 20, Alaska Probate Rules, relating to judicial bypass of notice for an abortion."

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

*** Section 1.** AS 18.16.010(a) is amended to read:

(a) An abortion may not be performed in this state unless

(1) the abortion is performed by a physician licensed by the State Medical Board under AS 08.64.200;

(2) the abortion is performed in a hospital or other facility approved for the purpose by the Department of Health and Social Services or a hospital operated by the federal government or an agency of the federal government;

(3) before an abortion is knowingly performed or induced on **a pregnant,** [AN] unmarried, unemancipated woman under 17 years of age, **notice** [CONSENT] has been given as required under AS 18.16.020 or a court has authorized the minor to consent to the abortion **without parental notice** under AS 18.16.030 and the minor consents; for purposes of enforcing this paragraph, there is a rebuttable presumption that a woman who is unmarried and under 17 years of age is unemancipated;

(4) the woman is domiciled or physically present in the state for 30 days before the abortion; and

(5) the applicable requirements of AS 18.16.060 have been satisfied.

*** Sec. 2.** AS 18.16.010(g) is amended to read:

(g) It is **a** [AN AFFIRMATIVE] defense to a prosecution or claim for violation of (a)(3) of this section that**, in the clinical judgment of the physician or surgeon,** compliance with the requirements of (a)(3) of this section was not possible because**, in the clinical judgment of the physician or surgeon,** an immediate threat of serious risk to the life or physical health of the pregnant minor from the continuation of the pregnancy created a medical emergency necessitating the immediate performance or inducement of an abortion. In this subsection,

(1) "clinical judgment" means a physician's or surgeon's subjective professional medical judgment exercised in good faith;

(2) "defense" has the meaning given in AS 11.81.900(b);

(3) "medical emergency" means a condition that, on the basis of the physician's or surgeon's good faith clinical judgment, so complicates the medical condition of a pregnant minor that [(1)] an immediate abortion of the minor's pregnancy is necessary to avert the minor's death [;] or **serious risk to the minor's physical health** [(2) A DELAY IN PROVIDING AN ABORTION WILL CREATE SERIOUS RISK OF SUBSTANTIAL AND IRREVERSIBLE IMPAIRMENT OF A MAJOR BODILY FUNCTION OF THE PREGNANT MINOR].

*** Sec. 3.** AS 18.16.020 is repealed and reenacted to read:

Sec. 18.16.020. Notice required before minor's abortion. (a) A person may not knowingly perform or induce an abortion on a minor who is known to the person

to be pregnant, unmarried, under 17 years of age, and unemancipated unless, before the abortion, at least one of the following applies:

(1) one of the minor's parents, the minor's legal guardian, or the minor's custodian has been given notice of the planned abortion not less than 48 hours before the abortion is performed;

(2) a court issues an order under AS 18.16.030 authorizing the minor to consent to the abortion without notice to a parent, guardian, or custodian, and the minor consents to the abortion;

(3) a court, by its inaction under AS 18.16.030, constructively has authorized the minor to consent to the abortion without notice to a parent, guardian, or custodian, and the minor consents to the abortion; or

(4) the minor is the victim of physical abuse, sexual abuse, or a pattern of emotional abuse committed by one or both of the minor's parents or by a legal guardian or custodian of the minor and the abuse is documented by a declaration of the abuse in a signed and notarized statement by

(A) the minor; and

(B) another person who has personal knowledge of the abuse who is

(i) the sibling of the minor who is 21 years of age or older;

(ii) a law enforcement officer;

(iii) a representative of the Department of Health and Social Services who has investigated the abuse;

(iv) a grandparent of the minor; or

(v) a stepparent of the minor.

(b) In (a)(1) of this section, actual notice must be given or attempted to be given in person or by telephone by either the physician who has referred the minor for an abortion or by the physician who intends to perform the abortion. An individual designated by the physician may initiate the notification process, but the actual notice shall be given by the physician. The physician giving notice of the abortion must document the notice or attempted notice in the minor's medical record and take

reasonable steps to verify that the person to whom the notice is provided is the parent, legal guardian, or custodian of the minor seeking an abortion. Reasonable steps to provide notice must include

(1) if in person, requiring the person to show government-issued identification along with additional documentation of the person's relationship to the minor; additional documentation may include the minor's birth certificate or a court order of adoption, guardianship, or custodianship;

(2) if by telephone, initiating the call, attempting to verify through a review of published telephone directories that the number to be dialed is that of the minor's parent, legal guardian, or custodian, and asking questions of the person to verify that the person's relationship to the minor is that of parent, legal guardian, or custodian; when notice is attempted by telephone but the physician or physician's designee is unsuccessful in reaching the parent, legal guardian, or custodian, the physician's designee shall continue to initiate the call, in not less than two-hour increments, for not less than five attempts, in a 24-hour period.

(c) If actual notice is attempted unsuccessfully after reasonable steps have been taken as described under (b) of this section, the referring physician or the physician intending to perform an abortion on a minor may provide constructive notice to the minor's parent, legal guardian, or custodian. Constructive notice is considered to have been given 48 hours after the certified notice is mailed. In this subsection, "constructive notice" means that notice of the abortion was provided in writing and mailed by certified mail, delivery restricted to addressee only, to the last known address of the parent, legal guardian, or custodian after taking reasonable steps to verify the mailing address.

(d) A physician who suspects or receives a report of abuse under this section shall report the abuse as provided under AS 47.17.020.

(e) A physician who is informed that the pregnancy of a minor resulted from criminal sexual assault of the minor must retain, and take reasonable steps to preserve, the products of conception and evidence following the abortion for use by law enforcement officials in prosecuting the crime.

* **Sec. 4.** AS 18.16.030(a) is amended to read:

(a) A woman who is pregnant, unmarried, under 17 years of age, and unemancipated who wishes to have an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian may file a complaint in the superior court requesting the issuance of an order authorizing the minor to consent to the performance or inducement of an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian.

*** Sec. 5.** AS 18.16.030(b) is amended to read:

(b) The complaint shall be made under oath and must include all of the following:

(1) a statement that the complainant is pregnant;

(2) a statement that the complainant is unmarried, under 17 years of age, and unemancipated;

(3) a statement that the complainant wishes to have an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian;

(4) an allegation of either or both of the following:

(A) that the complainant is sufficiently mature and well enough informed to decide intelligently whether to have an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian; or

(B) that one or both of the minor's parents or the minor's guardian or custodian was engaged in physical abuse, sexual abuse, or a pattern of emotional abuse against the minor, or that **notice to** [THE CONSENT OF] a parent, guardian, or custodian otherwise is not in the minor's best interest;

(5) a statement as to whether the complainant has retained an attorney and, if an attorney has been retained, the name, address, and telephone number of the attorney.

*** Sec. 6.** AS 18.16.030(c) is amended to read:

(c) The court shall fix a time for a hearing on any complaint filed under (a) of this section and shall keep a record of all testimony and other oral proceedings in the action. The hearing shall be held at the earliest possible time, but not later than the **third** [FIFTH] business day after the day that the complaint is filed. The court shall

enter judgment on the complaint immediately after the hearing is concluded. If the hearing required by this subsection is not held by the **third** [FIFTH] business day after the complaint is filed, the failure to hold the hearing shall be considered to be a constructive order of the court authorizing the complainant to consent to the performance or inducement of an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian, and the complainant and any other person may rely on the constructive order to the same extent as if the court actually had issued an order under this section authorizing the complainant to consent to the performance or inducement of an abortion without such **notice** [CONSENT].

*** Sec. 7.** AS 18.16.030(j) is amended to read:

(j) If the complainant files a notice of appeal authorized under this section, the superior court shall deliver a copy of the notice of appeal and the record on appeal to the supreme court within **three** [FOUR] days after the notice of appeal is filed. Upon receipt of the notice and record, the clerk of the supreme court shall place the appeal on the docket. The appellant shall file a brief within **three** [FOUR] days after the appeal is docketed. Unless the appellant waives the right to oral argument, the supreme court shall hear oral argument within five days after the appeal is docketed. The supreme court shall enter judgment in the appeal immediately after the oral argument or, if oral argument has been waived, within five days after the appeal is docketed. Upon motion of the appellant and for good cause shown, the supreme court may shorten or extend the maximum times set out in this subsection. However, in any case, if judgment is not entered within five days after the appeal is docketed, the failure to enter the judgment shall be considered to be a constructive order of the court authorizing the appellant to consent to the performance or inducement of an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian, and the appellant and any other person may rely on the constructive order to the same extent as if the court actually had entered a judgment under this subsection authorizing the appellant to consent to the performance or inducement of an abortion without **notice to** [CONSENT OF] another person. In the interest of justice, the supreme court, in an appeal under this subsection, shall liberally modify or dispense with the formal requirements that normally apply as to the contents and form of an appellant's brief.

* **Sec. 8.** AS 18.16.030(n) is amended to read:

(n) Blank copies of the forms prescribed under (*l*) of this section and information on the proper procedures for filing a complaint or appeal shall be made available by the court system at the official location of each superior court, district court, and magistrate in the state. The information required under this subsection must also include notification to the minor that

(1) there is no filing fee required for either form;

(2) no court costs will be assessed against the minor for procedures under this section;

(3) an attorney will be appointed to represent the minor if the minor does not retain an attorney;

(4) the minor may request that the superior court with appropriate jurisdiction hold a telephonic hearing on the complaint so that the minor need not personally be present;

(5) the minor may request that the superior court with appropriate jurisdiction issue an order directing the minor's school to excuse the minor from school to attend court hearings held under this section and to have the abortion if one is authorized by the court and directing the school not to notify the minor's parent, legal guardian, or custodian that the minor is pregnant, seeking an abortion, or is absent for purposes of obtaining an abortion.

* **Sec. 9.** AS 18.16 is amended by adding new sections to read:

Sec. 18.16.035. Coercion of a minor prohibited; emancipation. (a) A person may not coerce a minor who is pregnant to have an abortion.

(b) In addition to emancipation by other means provided by law, denial of financial support by a parent, legal guardian, or custodian who has a legal duty of support for purposes of coercing a minor to have an abortion shall be sufficient evidence of emancipation status of the minor for purposes of AS 18.16.010 - 18.16.090.

(c) In this section, "coercion" means to restrain or dominate a minor by force, threat of force, or deprivation of food, support, or shelter.

Sec. 18.16.040. Reports. For each month in which an abortion is performed on

a minor by a physician, the physician shall file a report with the Department of Health and Social Services indicating the number of abortions performed on a minor for that month, the age of each minor, the number of previous abortions performed on each minor, if any, and the number of pregnancies of each minor, if any, and the number of abortions provided under each of the exceptions enumerated under AS 18.16.020(a)(1) - (4). A report filed under this section may not include identifying information of the minor other than the minor's age.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 220(a), Alaska Rules of Appellate Procedure, is amended to read:

(a) **Scope.** This rule applies to an appeal from an order denying or dismissing a petition filed by a minor under age 17 to bypass **notice to a parent, guardian, or custodian for** [PARENTAL CONSENT TO] an abortion under AS 18.16.030. In such appeals, this rule supersedes the other appellate rules to the extent they may be inconsistent with this rule. It also supersedes the procedure for bypass appeals established by AS 18.16.030(j).

*** Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 220(c)(1), Alaska Rules of Appellate Procedure, is amended to read:

(1) A minor may appeal an order denying or dismissing a petition to bypass **notice to a parent, guardian, or custodian** [PARENTAL CONSENT] by filing a notice of appeal in any district or superior court, or directly with the clerk of the appellate courts. The notice of appeal may be filed in person, by mail, or by fax, and must be accompanied by a copy of the order from which the appeal is taken. No filing fee will be charged. If the notice of appeal is filed in a district or superior court, the clerk or magistrate shall immediately notify the clerk of the appellate courts that the appeal has been filed.

*** Sec. 12.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 220(h), Alaska Rules of Appellate Procedure, is amended to read:

(h) **Constructive Order.** If the court fails to enter an order within **three** [FIVE] days after the date the clerk of the appellate courts receives the record on appeal, the clerk shall issue a certificate stating that (1) no order was entered within **three** [FIVE] days after the appeal was docketed; and (2) under AS 18.16.030(j), the failure to enter an order constitutes a constructive order of the court authorizing the minor to consent to an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian. For purposes of AS 18.16.030(j), an appeal is deemed to be docketed on the date the clerk of the appellate courts receives the record on appeal.

*** Sec. 13.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 20(a), Alaska Probate Rules, is amended to read:

(a) **Petition.** An action for an order authorizing a minor under age 17 to consent to an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian is commenced by filing a petition. The petition must be under oath and must include the information required by AS 18.16.030(b). The petitioner is not required to provide an address or telephone number. Blank petition forms will be available at all court locations and will be mailed or faxed to a petitioner upon request. No fee will be charged for this service or other services provided to a petitioner.

*** Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 20(e), Alaska Probate Rules, is amended to read:

(e) **Findings and Order.** The court shall enter an order immediately after the hearing is concluded. The court shall grant the petition if the court finds by clear and convincing evidence that one of the statutory grounds for dispensing with **notice to a parent, guardian, or custodian** [PARENTAL CONSENT] exists. Otherwise, the court shall deny the petition. If the petition is denied, the court shall inform the petitioner of her right to an expedited appeal to the supreme court.

*** Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 20(f), Alaska Probate Rules, is amended to read:

(f) **Constructive Order.** If the court fails to hold a hearing within **three** [FIVE] days after the petition is filed, the presiding judge of the judicial district, or another judge designated by the presiding judge, shall issue a certificate stating that (1) no hearing was held within **three** [FIVE] business days after the petition was filed; and (2) under AS 18.16.030(c), the failure to hold a hearing constitutes a constructive order of the court authorizing the minor to consent to an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian. A certificate should not be issued if the hearing was not held because it was postponed at the petitioner's request or because the petitioner failed to appear at the hearing.

*** Sec. 16.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SEVERABILITY. If any provision of this Act is held to be invalid or unenforceable by its terms or as applied to any person or circumstance, the remainder of the provisions shall be construed to give the maximum effect permitted by law, unless the holding shall be of utter invalidity or unenforceability, in which event, the provision shall be considered severable and does not affect the remaining provisions or the application of the severed provision to other persons who are not similarly situated or to other dissimilar circumstances.

Alaska State Legislature
State Capitol
Juneau, AK 99801
907 465-3822 office
907 465-3756 fax
From the Office of Senator Bettye Davis

To: Legal Services **Fax:** 465-2029; phone: 465-2450

From: Thomas S. Obermeyer **Date:** 4/7/2009

Re: Request CS for HB 35 for Senate HSS Committee **Pages:** __19_ page(s) including cover

CC:

Urgent **[X] For Review** **☐ Please Comment** **Please Reply** **☐ Please Recycle**

To Whom It May Concern:

At the request of Rep. Coghill, Senator Davis, who possesses the CS for HB 35, 26-LS0192\R.A (attached) in Senate HSS, wishes to remove the "consent" provisions of the bill to make the bill a "notice" statute, not a "notice and/or consent" statute. These changes would for the most part mirror the "notice" provisions in (at least for the first 8 pages) SB 179, 26-LS0802\R (attached). To avoid duplicative work, it is my understanding from Senator Davis that the same drafter prepared both HB 35 and SB 179.

<u>Please prepare 1) a CS for SB 35 for Senate HSS; and 2) a sectional summary.</u> The last sectional summary for HB 35 refers to the "A" version, which had more sections and has since changed in many ways.

Sincerely,

TOM

Tom Obermeyer
465-3762
Cc: Lynda Zaugg

SENATE BILL NO. 179

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY SENATORS HUGGINS, Menard, Olson

Introduced: 4/3/09
Referred: Health and Social Services, Judiciary

A BILL

FOR AN ACT ENTITLED

"An Act relating to notice of a minor's abortion; relating to judicial bypass of notice for a minor's abortion; relating to coercion of a minor to have an abortion; relating to reporting of abortions performed on minors; and amending Rule 220, Alaska Rules of Appellate Procedure, and Rule 20, Alaska Probate Rules, relating to judicial bypass for an abortion."

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

*** Section 1.** AS 18.16.010(a) is amended to read:

(a) An abortion may not be performed in this state unless

(1) the abortion is performed by a physician licensed by the State Medical Board under AS 08.64.200;

(2) the abortion is performed in a hospital or other facility approved for the purpose by the Department of Health and Social Services or a hospital operated by the federal government or an agency of the federal government;

(3) before an abortion is knowingly performed or induced on **a pregnant,** [AN] unmarried, unemancipated woman under 17 years of age, **notice** [CONSENT] has been given as required under AS 18.16.020 or a court has authorized the minor to consent to the abortion **without parental notice** under AS 18.16.030 and the minor consents; for purposes of enforcing this paragraph, there is a rebuttable presumption that a woman who is unmarried and under 17 years of age is unemancipated;

(4) the woman is domiciled or physically present in the state for 30 days before the abortion; and

(5) the applicable requirements of AS 18.16.060 have been satisfied.

*** Sec. 2.** AS 18.16.010(g) is amended to read:

(g) It is **a** [AN AFFIRMATIVE] defense to a prosecution or claim for violation of (a)(3) of this section that**, in the clinical judgment of the physician or surgeon,** compliance with the requirements of (a)(3) of this section was not possible because**, in the clinical judgment of the physician or surgeon,** an immediate threat of serious risk to the life or physical health of the pregnant minor from the continuation of the pregnancy created a medical emergency necessitating the immediate performance or inducement of an abortion. In this subsection,

(1) "clinical judgment" means a physician's or surgeon's subjective professional medical judgment exercised in good faith;

(2) "defense" has the meaning given in AS 11.81.900(b);

(3) "medical emergency" means a condition that, on the basis of the physician's or surgeon's good faith clinical judgment, so complicates the medical condition of a pregnant minor that

(A) [(1)] an immediate abortion of the minor's pregnancy is necessary to avert the minor's death; or

(B) [(2)] a delay in providing an abortion will create serious risk of **medical instability caused by a** substantial and irreversible impairment of a major bodily function of the pregnant minor.

*** Sec. 3.** AS 18.16.020 is repealed and reenacted to read:

Sec. 18.16.020. Notice required before minor's abortion. (a) A person may

not knowingly perform or induce an abortion on a minor who is known to the person to be pregnant, unmarried, under 17 years of age, and unemancipated unless, before the abortion, at least one of the following applies:

(1) one of the minor's parents, the minor's legal guardian, or the minor's custodian has been given notice of the planned abortion not less than 48 hours before the abortion is performed;

(2) a court issues an order under AS 18.16.030 authorizing the minor to consent to the abortion without notice to a parent, guardian, or custodian, and the minor consents to the abortion;

(3) a court, by its inaction under AS 18.16.030, constructively has authorized the minor to consent to the abortion without notice to a parent, guardian, or custodian, and the minor consents to the abortion; or

(4) the minor is the victim of physical abuse, sexual abuse, or a pattern of emotional abuse committed by one or both of the minor's parents or by a legal guardian or custodian of the minor and the abuse is documented by a declaration of the abuse in a signed and notarized statement by

(A) the minor; and

(B) another person who has personal knowledge of the abuse who is

(i) the sibling of the minor who is 21 years of age or older;

(ii) a law enforcement officer;

(iii) a representative of the Department of Health and Social Services who has investigated the abuse;

(iv) a grandparent of the minor; or

(v) a stepparent of the minor.

(b) In (a)(1) of this section, actual notice must be given or attempted to be given in person or by telephone by either the physician who has referred the minor for an abortion or by the physician who intends to perform the abortion. An individual designated by the physician may initiate the notification process, but the actual notice shall be given by the physician. The physician giving notice of the abortion must

document the notice or attempted notice in the minor's medical record and take reasonable steps to verify that the person to whom the notice is provided is the parent, legal guardian, or custodian of the minor seeking an abortion. Reasonable steps to provide notice must include

(1) if in person, requiring the person to show government-issued identification along with additional documentation of the person's relationship to the minor; additional documentation may include the minor's birth certificate or a court order of adoption, guardianship, or custodianship;

(2) if by telephone, initiating the call, attempting to verify through a review of published telephone directories that the number to be dialed is that of the minor's parent, legal guardian, or custodian, and asking questions of the person to verify that the person's relationship to the minor is that of parent, legal guardian, or custodian; when notice is attempted by telephone but the physician or physician's designee is unsuccessful in reaching the parent, legal guardian, or custodian, the physician's designee shall continue to initiate the call, in not less than two-hour increments, for not less than five attempts, in a 24-hour period.

(c) If actual notice is attempted unsuccessfully after reasonable steps have been taken as described under (b) of this section, the referring physician or the physician intending to perform an abortion on a minor may provide constructive notice to the minor's parent, legal guardian, or custodian. Constructive notice is considered to have been given 48 hours after the certified notice is mailed. In this subsection, "constructive notice" means that notice of the abortion was provided in writing and mailed by certified mail, delivery restricted to addressee only, to the last known address of the parent, legal guardian, or custodian after taking reasonable steps to verify the mailing address.

(d) A physician who suspects or receives a report of abuse under this section shall report the abuse as provided under AS 47.17.020.

(e) A physician who is informed that the pregnancy of a minor resulted from criminal sexual assault of the minor must retain, and take reasonable steps to preserve, the products of conception and evidence following the abortion for use by law enforcement officials in prosecuting the crime.

* **Sec. 4.** AS 18.16.030(a) is amended to read:

(a) A woman who is pregnant, unmarried, under 17 years of age, and unemancipated who wishes to have an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian may file a complaint in the superior court requesting the issuance of an order authorizing the minor to consent to the performance or inducement of an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian.

* **Sec. 5.** AS 18.16.030(b) is amended to read:

(b) The complaint shall be made under oath and must include all of the following:

(1) a statement that the complainant is pregnant;

(2) a statement that the complainant is unmarried, under 17 years of age, and unemancipated;

(3) a statement that the complainant wishes to have an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian;

(4) an allegation of either or both of the following:

(A) that the complainant is sufficiently mature and well enough informed to decide intelligently whether to have an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian; or

(B) that one or both of the minor's parents or the minor's guardian or custodian was engaged in physical abuse, sexual abuse, or a pattern of emotional abuse against the minor, or that **notice to** [THE CONSENT OF] a parent, guardian, or custodian otherwise is not in the minor's best interest;

(5) a statement as to whether the complainant has retained an attorney and, if an attorney has been retained, the name, address, and telephone number of the attorney.

* **Sec. 6.** AS 18.16.030(c) is amended to read:

(c) The court shall fix a time for a hearing on any complaint filed under (a) of this section and shall keep a record of all testimony and other oral proceedings in the action. The hearing shall be held at the earliest possible time, but not later than the

third [FIFTH] business day after the day that the complaint is filed. The court shall enter judgment on the complaint immediately after the hearing is concluded. If the hearing required by this subsection is not held by the **third** [FIFTH] business day after the complaint is filed, the failure to hold the hearing shall be considered to be a constructive order of the court authorizing the complainant to consent to the performance or inducement of an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian, and the complainant and any other person may rely on the constructive order to the same extent as if the court actually had issued an order under this section authorizing the complainant to consent to the performance or inducement of an abortion without such **notice** [CONSENT].

*** Sec. 7.** AS 18.16.030(j) is amended to read:

(j) If the complainant files a notice of appeal authorized under this section, the superior court shall deliver a copy of the notice of appeal and the record on appeal to the supreme court within **three** [FOUR] days after the notice of appeal is filed. Upon receipt of the notice and record, the clerk of the supreme court shall place the appeal on the docket. The appellant shall file a brief within **three** [FOUR] days after the appeal is docketed. Unless the appellant waives the right to oral argument, the supreme court shall hear oral argument within five days after the appeal is docketed. The supreme court shall enter judgment in the appeal immediately after the oral argument or, if oral argument has been waived, within five days after the appeal is docketed. Upon motion of the appellant and for good cause shown, the supreme court may shorten or extend the maximum times set out in this subsection. However, in any case, if judgment is not entered within five days after the appeal is docketed, the failure to enter the judgment shall be considered to be a constructive order of the court authorizing the appellant to consent to the performance or inducement of an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian, and the appellant and any other person may rely on the constructive order to the same extent as if the court actually had entered a judgment under this subsection authorizing the appellant to consent to the performance or inducement of an abortion without **notice to** [CONSENT OF] another person. In the interest of justice, the supreme court, in an appeal under this subsection, shall liberally modify or dispense with the formal

requirements that normally apply as to the contents and form of an appellant's brief.

*** Sec. 8.** AS 18.16.030(n) is amended to read:

(n) Blank copies of the forms prescribed under (*l*) of this section and information on the proper procedures for filing a complaint or appeal shall be made available by the court system at the official location of each superior court, district court, and magistrate in the state. The information required under this subsection must also include notification to the minor that

(1) there is no filing fee required for either form;

(2) no court costs will be assessed against the minor for procedures under this section;

(3) an attorney will be appointed to represent the minor if the minor does not retain an attorney;

(4) the minor may request that the superior court with appropriate jurisdiction hold a telephonic hearing on the complaint so that the minor need not personally be present;

(5) the minor may request that the superior court with appropriate jurisdiction issue an order directing the minor's school to excuse the minor from school to attend court hearings held under this section and to have the abortion if one is authorized by the court and directing the school not to notify the minor's parent, legal guardian, or custodian that the minor is pregnant, seeking an abortion, or is absent for purposes of obtaining an abortion.

*** Sec. 9.** AS 18.16 is amended by adding new sections to read:

Sec. 18.16.035. Coercion of a minor prohibited; emancipation. (a) A person may not coerce a minor who is pregnant to have an abortion.

(b) In addition to emancipation by other means provided by law, denial of financial support by a parent, legal guardian, or custodian who has a legal duty of support for purposes of coercing a minor to have an abortion shall be sufficient evidence of emancipation status of the minor for purposes of AS 18.16.010 - 18.16.090.

(c) In this section, "coercion" means to restrain or dominate a minor by force, threat of force, or deprivation of food, support, or shelter.

Sec. 18.16.040. Reports. For each month in which an abortion is performed on a minor by a physician, the physician shall file a report with the Department of Health and Social Services indicating the number of abortions performed on a minor for that month, the age of each minor, the number of previous abortions performed on each minor, if any, and the number of pregnancies of each minor, if any, and the number of abortions provided under each of the exceptions enumerated under AS 18.16.020(a)(1) - (4). A report filed under this section may not include identifying information of the minor other than the minor's age.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 220(a), Alaska Rules of Appellate Procedure, is amended to read:

(a) **Scope.** This rule applies to an appeal from an order denying or dismissing a petition filed by a minor under age 17 to bypass **notice to a parent, guardian, or custodian for** [PARENTAL CONSENT TO] an abortion under AS 18.16.030. In such appeals, this rule supersedes the other appellate rules to the extent they may be inconsistent with this rule. It also supersedes the procedure for bypass appeals established by AS 18.16.030(j).

*** Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 220(c)(1), Alaska Rules of Appellate Procedure, is amended to read:

(1) A minor may appeal an order denying or dismissing a petition to bypass **notice to a parent, guardian, or custodian** [PARENTAL CONSENT] by filing a notice of appeal in any district or superior court, or directly with the clerk of the appellate courts. The notice of appeal may be filed in person, by mail, or by fax, and must be accompanied by a copy of the order from which the appeal is taken. No filing fee will be charged. If the notice of appeal is filed in a district or superior court, the clerk or magistrate shall immediately notify the clerk of the appellate courts that the appeal has been filed.

*** Sec. 12.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

DIRECT COURT RULE AMENDMENT. Rule 220(h), Alaska Rules of Appellate Procedure, is amended to read:

(h) **Constructive Order.** If the court fails to enter an order within **three** [FIVE] days after the date the clerk of the appellate courts receives the record on appeal, the clerk shall issue a certificate stating that (1) no order was entered within **three** [FIVE] days after the appeal was docketed; and (2) under AS 18.16.030(j), the failure to enter an order constitutes a constructive order of the court authorizing the minor to consent to an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian. For purposes of AS 18.16.030(j), an appeal is deemed to be docketed on the date the clerk of the appellate courts receives the record on appeal.

*** Sec. 13.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 20(a), Alaska Probate Rules, is amended to read:

(a) **Petition.** An action for an order authorizing a minor under age 17 to consent to an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian is commenced by filing a petition. The petition must be under oath and must include the information required by AS 18.16.030(b). The petitioner is not required to provide an address or telephone number. Blank petition forms will be available at all court locations and will be mailed or faxed to a petitioner upon request. No fee will be charged for this service or other services provided to a petitioner.

*** Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 20(e), Alaska Probate Rules, is amended to read:

(e) **Findings and Order.** The court shall enter an order immediately after the hearing is concluded. The court shall grant the petition if the court finds by clear and convincing evidence that one of the statutory grounds for dispensing with **notice to a parent, guardian, or custodian** [PARENTAL CONSENT] exists. Otherwise, the court shall deny the petition. If the petition is denied, the court shall inform the

petitioner of her right to an expedited appeal to the supreme court.

*** Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to read:

DIRECT COURT RULE AMENDMENT. Rule 20(f), Alaska Probate Rules, is amended to read:

(f) **Constructive Order.** If the court fails to hold a hearing within **three** [FIVE] days after the petition is filed, the presiding judge of the judicial district, or another judge designated by the presiding judge, shall issue a certificate stating that (1) no hearing was held within **three** [FIVE] business days after the petition was filed; and (2) under AS 18.16.030(c), the failure to hold a hearing constitutes a constructive order of the court authorizing the minor to consent to an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian. A certificate should not be issued if the hearing was not held because it was postponed at the petitioner's request or because the petitioner failed to appear at the hearing.

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SEVERABILITY. If any provision of this Act is held to be invalid or unenforceable by its terms or as applied to any person or circumstance, the remainder of the provisions shall be construed to give the maximum effect permitted by law, unless the holding shall be of utter invalidity or unenforceability, in which event, the provision shall be considered severable and does not affect the remaining provisions or the application of the severed provision to other persons who are not similarly situated or to other dissimilar circumstances.

Lynda – Sen. Davis asks 4/11
that you distribute
attached to all members
of HSS
Re: HB35 LOM

ALASKA STATE HOUSE OF REPRESENTATIVES

Contact:
Interim Address:
3340 Badger Road
North Pole, AK 99705
(907)-488-5725
Fax# (907)-488-4271

Session

(907)-465-3719
FAX# (907)-465-3258
State Capitol
Room 504

SENATOR JOHN COGHILL

Date: March 3, 2010

To: Senator Bettye Davis, Chair
Senate Health & Social Services Committee

From: Senator John Coghill

Re: HB 35 Parental Consent

I respectfully request HB 35, "An Act relating to notice and consent for a minor's abortion; relating to penalties for performing an abortion; relating to a judicial bypass procedure for an abortion; relating to coercion of a minor to have an abortion; and relating to reporting of abortions performed on minors," be heard in your committee at your earliest convenience.

I have attached back up information for you and will have it sent to you in electronic form.

As of yesterday, the Division of Elections has qualified 36,307 signatures from the initiative drive for the parental notification. The initiative required 32,734 signatures. Division of Elections estimates they are about three-quarters of the way through the signatures.

Thank you for your consideration.

ALASKA STATE HOUSE OF REPRESENTATIVES

Contact:
Interim Address:
3340 Badger Road
North Pole, AK 99705
(907)-488-5725
Fax# (907)-488-4271

Session

(907)-465-3719
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State Capitol
Room 504

SENATOR JOHN COGHILL

SPONSOR STATEMENT
HB 35 Parental Notification and Consent for a Pregnant Minor Aborting an Unborn Child

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HB 35 requires parental consent unless the minor chooses a judicial bypass and enacts a notification process that the Court determined is the least restrictive means of achieving the State's compelling interest. It leaves intact the four exemptions from parental consent: *married minors, minors who have been legally emancipated, minors who have entered the armed services of the United States, and minors who have become employed and self-subsisting.*

On November 2, 2007 in *State of Alaska v. Planned Parenthood of Alaska*, the Alaska Supreme Court, in a 3 – 2 decision, has once again undermined a long history of social law, the intent of the Constitution, and the will of the people of Alaska.

The legislature passed the Parental Consent Act (PCA) in 1997. In July of that same year, Alaska Superior Court Judge Sen Tan ruled the law was unconstitutional because "the privacy clause of the Alaska Constitution protects minors as well as adults." The Superior Court did not address whether or not the PCA violated the privacy clause. The State appealed the decision and the Supreme Court ruled that the privacy clause extends to minors unless **there is a compelling state interest using the least restrictive means available**. The Supreme Court remanded the case back to Sen Tan to hold an evidentiary hearing to determine if PCA furthered a compelling state interest.

In January 2003 the Superior Court held a bench trial spanning almost three weeks to hear evidence regarding the constitutionality of the PCA. In October 2003, Judge Sen Tan ruled the PCA was **unconstitutional because it did not further a compelling state interest while using the least restrictive means available**. In January 2004 the Superior Court enjoined the State from enforcing the PCA declaring the PCA was unconstitutional under the equal protection and privacy clauses of the Alaska Constitution.

On November 2, 2007, the court agreed with the State that *"protecting minors from their own immaturity and aiding parents in fulfilling their parental responsibilities"* are *"compelling interests."* So the issue at hand for the court was whether the PCA was the least restrictive means of achieving the State's compelling interests.

HB 35 addresses the legal issues of parental consent in a practical manner based on the historical beliefs of our forefathers. The Parental Consent Act of 1997 was fully compliant with the U.S. Supreme Court precedent *Bellotti v. Baird,* (443 U.S. 622 1979). In essence, the Alaska Supreme Court in its November 2, 2007 decision struck down a decision of the U.S. Supreme Court. Justice Carpeneti eloquently wrote the dissenting decision stating the following:

> *"Because this court's rejection of the legislature's thoughtful balance is inconsistent with our own case law and unnecessarily dismissive of the legislature's role in expressing the will of the people, I respectfully dissent."*

The dissent opinion brought to light the lack of consideration or recognition in case law that *"children are not generally considered competent to consent to medical procedures."* It brought to light the four exemptions in the PCA, *"married minors, ... minors who have been legally emancipated, ...minors who have entered the armed services of the United States ,and ...who have become employed and self-subsisting."* For those pregnant minors who did not fall into the four exempt categories a judicial bypass provision was provided for appropriate circumstances. It was a process designed to be speedy and cost-free to the child. The PCA called for a five-day response of the court; HB 35 calls for a three-day response. Failure by the court to respond in time would be construed as an act constructive authorization. The judicial bypass requires a sworn statement from the pregnant minor and an adult family member or state agent such as an Office of Children's Services caseworker or law enforcement officer.

Carpeneti discussed the fact that the Court quickly recognized that there was a compelling State interest but failed *to "look closely at the nature of the state's and parents' interests"* leaving *"its constitutional 'balance' one-sided."* Carpeneti continues in his dissent to outline case law that creates a judicial history of *"treating minors differently from adults," "protecting twelve-year-olds from older teenagers and from their own immaturity in choosing to participate in harmful activity,"* prohibiting minors from making contract to *"smoke cigarettes or drink alcoholic beverages or consent to sexual intercourse. Without a parent's consent they may not become licensed drivers or get married or obtain general medical or dental treatment."*

> *"In sum, the Alaska Parental Consent Act appears to be the product of a concerted effort to make certain that those pregnant girls who are sufficiently mature to make the decision to obtain an abortion on their own are allowed to do so while those who are not sufficiently mature either obtain a parent's consent or, in the case of parental abuse, a judicial determination that the procedure is in their best interest."*

In his dissenting opinion, Carpeneti uses the litmus test for parental consent that is required for participation in school field trips to demonstrating the extent to which the State must go to terminate parental rights is his argument:

> *"In addition to society's interest in protecting children from their own immaturity, we have long held that parents have a fundamental right in raising of their children."*

Carpeneti's dissenting opinion determines that the State's compelling interest does outweigh the equal protection and privacy clauses because:

"In sum, the norm in American, and Alaskan, life and law is that the parents are a child's first and most important resource for assistance in decision-making. For that reason, the state's interest in protecting children from the consequences of their own immaturity, and in so doing protecting the health of its children, and its interest in supporting parents' right and duty to guide the upbringing of their children is particularly compelling."

I believe parental consent can still recognize the State's compelling interest in *"protecting minors from their own immaturity and aiding parents in fulfilling their parental responsibilities."* In addition to **parental consent,** HB 35 provides for a judicial bypass for sexual abuse cases using a ***lower standard than the 1997 PCA Act's clear and convincing*** provision, and a **provision prohibiting the parents from coercing a pregnant minor to have an abortion.**

26-LS0192\E
Mischel
4/8/09

SENATE CS FOR CS FOR HOUSE BILL NO. 35(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, Neuman, Keller, Dahlstrom, Millett, Kelly, Harris, Lynn, Wilson, Ramras, Gatto, Johansen, Johnson

SENATORS Therriault, Dyson

A BILL

FOR AN ACT ENTITLED

"An Act relating to notice and consent for a minor's abortion; relating to penalties for performing an abortion; relating to a judicial bypass procedure for an abortion; relating to coercion of a minor to have an abortion; and relating to reporting of abortions performed on minors."

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

*** Section 1.** AS 18.16.010(a) is amended to read:

(a) An abortion may not be performed in this state unless

(1) the abortion is performed by a physician licensed by the State Medical Board under AS 08.64.200;

(2) the abortion is performed in a hospital or other facility approved for the purpose by the Department of Health and Social Services or a hospital operated by the federal government or an agency of the federal government;

(3) before an abortion is knowingly performed or induced on **a pregnant,** [AN] unmarried, unemancipated woman under 17 years of age, **notice**

[CONSENT] has been given as required under AS 18.16.020 or a court has authorized the minor to consent to the abortion **without parental notice** under AS 18.16.030 and the minor consents; for purposes of enforcing this paragraph, there is a rebuttable presumption that a woman who is unmarried and under 17 years of age is unemancipated;

(4) the woman is domiciled or physically present in the state for 30 days before the abortion; and

(5) the applicable requirements of AS 18.16.060 have been satisfied.

*** Sec. 2.** AS 18.16.010(g) is amended to read:

(g) It is **a** [AN AFFIRMATIVE] defense to a prosecution or claim for violation of (a)(3) of this section that**, in the clinical judgment of the physician or surgeon,** compliance with the requirements of (a)(3) of this section was not possible because**, in the clinical judgment of the physician or surgeon,** an immediate threat of serious risk to the life or physical health of the pregnant minor from the continuation of the pregnancy created a medical emergency necessitating the immediate performance or inducement of an abortion. In this subsection,

(1) "clinical judgment" means a physician's or surgeon's subjective professional medical judgment exercised in good faith;

(2) "defense" has the meaning given in AS 11.81.900(b);

(3) "medical emergency" means a condition that, on the basis of the physician's or surgeon's good faith clinical judgment, so complicates the medical condition of a pregnant minor that [(1)] an immediate abortion of the minor's pregnancy is necessary to avert the minor's death [;] or **serious risk to the minor's physical health** [(2) A DELAY IN PROVIDING AN ABORTION WILL CREATE SERIOUS RISK OF SUBSTANTIAL AND IRREVERSIBLE IMPAIRMENT OF A MAJOR BODILY FUNCTION OF THE PREGNANT MINOR].

*** Sec. 3.** AS 18.16.020 is repealed and reenacted to read:

Sec. 18.16.020. Notice required before minor's abortion. (a) A person may not knowingly perform or induce an abortion on a minor who is known to the person to be pregnant, unmarried, under 17 years of age, and unemancipated unless, before the abortion, at least one of the following applies:

(1) one of the minor's parents, the minor's legal guardian, or the minor's custodian has been given notice of the planned abortion not less than 48 hours before the abortion is performed;

(2) a court issues an order under AS 18.16.030 authorizing the minor to consent to the abortion without notice to a parent, guardian, or custodian, and the minor consents to the abortion;

(3) a court, by its inaction under AS 18.16.030, constructively has authorized the minor to consent to the abortion without notice to a parent, guardian, or custodian, and the minor consents to the abortion; or

(4) the minor is the victim of physical abuse, sexual abuse, or a pattern of emotional abuse committed by one or both of the minor's parents or by a legal guardian or custodian of the minor and the abuse is documented by a declaration of the abuse in a signed and notarized statement by

(A) the minor; and

(B) another person who has personal knowledge of the abuse who is

(i) the sibling of the minor who is 21 years of age or older;

(ii) a law enforcement officer;

(iii) a representative of the Department of Health and Social Services who has investigated the abuse;

(iv) a grandparent of the minor; or

(v) a stepparent of the minor.

(b) In (a)(1) of this section, actual notice must be given or attempted to be given in person or by telephone by either the physician who has referred the minor for an abortion or by the physician who intends to perform the abortion. An individual designated by the physician may initiate the notification process, but the actual notice shall be given by the physician. The physician giving notice of the abortion must document the notice or attempted notice in the minor's medical record and take reasonable steps to verify that the person to whom the notice is provided is the parent, legal guardian, or custodian of the minor seeking an abortion. Reasonable steps to

provide notice must include

(1) if in person, requiring the person to show government-issued identification along with additional documentation of the person's relationship to the minor; additional documentation may include the minor's birth certificate or a court order of adoption, guardianship, or custodianship;

(2) if by telephone, initiating the call, attempting to verify through a review of published telephone directories that the number to be dialed is that of the minor's parent, legal guardian, or custodian, and asking questions of the person to verify that the person's relationship to the minor is that of parent, legal guardian, or custodian; when notice is attempted by telephone but the physician or physician's designee is unsuccessful in reaching the parent, legal guardian, or custodian, the physician's designee shall continue to initiate the call, in not less than two-hour increments, for not less than five attempts, in a 24-hour period.

(c) If actual notice is attempted unsuccessfully after reasonable steps have been taken as described under (b) of this section, the referring physician or the physician intending to perform an abortion on a minor may provide constructive notice to the minor's parent, legal guardian, or custodian. Constructive notice is considered to have been given 48 hours after the certified notice is mailed. In this subsection, "constructive notice" means that notice of the abortion was provided in writing and mailed by certified mail, delivery restricted to addressee only, to the last known address of the parent, legal guardian, or custodian after taking reasonable steps to verify the mailing address.

(d) A physician who suspects or receives a report of abuse under this section shall report the abuse as provided under AS 47.17.020.

(e) A physician who is informed that the pregnancy of a minor resulted from criminal sexual assault of the minor must retain, and take reasonable steps to preserve, the products of conception and evidence following the abortion for use by law enforcement officials in prosecuting the crime.

*** Sec. 4.** AS 18.16.030(a) is amended to read:

(a) A woman who is pregnant, unmarried, under 17 years of age, and unemancipated who wishes to have an abortion without **notice to** [THE CONSENT

OF] a parent, guardian, or custodian may file a complaint in the superior court requesting the issuance of an order authorizing the minor to consent to the performance or inducement of an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian.

*** Sec. 5.** AS 18.16.030(b) is amended to read:

(b) The complaint shall be made under oath and must include all of the following:

(1) a statement that the complainant is pregnant;

(2) a statement that the complainant is unmarried, under 17 years of age, and unemancipated;

(3) a statement that the complainant wishes to have an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian;

(4) an allegation of either or both of the following:

(A) that the complainant is sufficiently mature and well enough informed to decide intelligently whether to have an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian; or

(B) that one or both of the minor's parents or the minor's guardian or custodian was engaged in physical abuse, sexual abuse, or a pattern of emotional abuse against the minor, or that **notice to** [THE CONSENT OF] a parent, guardian, or custodian otherwise is not in the minor's best interest;

(5) a statement as to whether the complainant has retained an attorney and, if an attorney has been retained, the name, address, and telephone number of the attorney.

*** Sec. 6.** AS 18.16.030(c) is amended to read:

(c) The court shall fix a time for a hearing on any complaint filed under (a) of this section and shall keep a record of all testimony and other oral proceedings in the action. The hearing shall be held at the earliest possible time, but not later than the **third** [FIFTH] business day after the day that the complaint is filed. The court shall enter judgment on the complaint immediately after the hearing is concluded. If the hearing required by this subsection is not held by the **third** [FIFTH] business day after

the complaint is filed, the failure to hold the hearing shall be considered to be a constructive order of the court authorizing the complainant to consent to the performance or inducement of an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian, and the complainant and any other person may rely on the constructive order to the same extent as if the court actually had issued an order under this section authorizing the complainant to consent to the performance or inducement of an abortion without such **notice** [CONSENT].

*** Sec. 7.** AS 18.16.030(j) is amended to read:

(j) If the complainant files a notice of appeal authorized under this section, the superior court shall deliver a copy of the notice of appeal and the record on appeal to the supreme court within **three** [FOUR] days after the notice of appeal is filed. Upon receipt of the notice and record, the clerk of the supreme court shall place the appeal on the docket. The appellant shall file a brief within **three** [FOUR] days after the appeal is docketed. Unless the appellant waives the right to oral argument, the supreme court shall hear oral argument within five days after the appeal is docketed. The supreme court shall enter judgment in the appeal immediately after the oral argument or, if oral argument has been waived, within five days after the appeal is docketed. Upon motion of the appellant and for good cause shown, the supreme court may shorten or extend the maximum times set out in this subsection. However, in any case, if judgment is not entered within five days after the appeal is docketed, the failure to enter the judgment shall be considered to be a constructive order of the court authorizing the appellant to consent to the performance or inducement of an abortion without **notice to** [THE CONSENT OF] a parent, guardian, or custodian, and the appellant and any other person may rely on the constructive order to the same extent as if the court actually had entered a judgment under this subsection authorizing the appellant to consent to the performance or inducement of an abortion without **notice to** [CONSENT OF] another person. In the interest of justice, the supreme court, in an appeal under this subsection, shall liberally modify or dispense with the formal requirements that normally apply as to the contents and form of an appellant's brief.

*** Sec. 8.** AS 18.16.030(n) is amended to read:

(n) Blank copies of the forms prescribed under (*l*) of this section and

information on the proper procedures for filing a complaint or appeal shall be made available by the court system at the official location of each superior court, district court, and magistrate in the state. The information required under this subsection must also include notification to the minor that

(1) there is no filing fee required for either form;

(2) no court costs will be assessed against the minor for procedures under this section;

(3) an attorney will be appointed to represent the minor if the minor does not retain an attorney;

(4) the minor may request that the superior court with appropriate jurisdiction hold a telephonic hearing on the complaint so that the minor need not personally be present;

(5) the minor may request that the superior court with appropriate jurisdiction issue an order directing the minor's school to excuse the minor from school to attend court hearings held under this section and to have the abortion if one is authorized by the court and directing the school not to notify the minor's parent, legal guardian, or custodian that the minor is pregnant, seeking an abortion, or is absent for purposes of obtaining an abortion.

*** Sec. 9.** AS 18.16 is amended by adding new sections to read:

Sec. 18.16.035. Coercion of a minor prohibited; emancipation. (a) A person may not coerce a minor who is pregnant to have an abortion.

(b) In addition to emancipation by other means provided by law, denial of financial support by a parent, legal guardian, or custodian who has a legal duty of support for purposes of coercing a minor to have an abortion shall be sufficient evidence of emancipation status of the minor for purposes of AS 18.16.010 - 18.16.090.

(c) In this section, "coercion" means to restrain or dominate a minor by force, threat of force, or deprivation of food, support, or shelter.

Sec. 18.16.040. Reports. For each month in which an abortion is performed on a minor by a physician, the physician shall file a report with the Department of Health and Social Services indicating the number of abortions performed on a minor for that

month, the age of each minor, the number of previous abortions performed on each minor, if any, and the number of pregnancies of each minor, if any, and the number of abortions provided under each of the exceptions enumerated under AS 18.16.020(a)(1) - (4). A report filed under this section may not include identifying information of the minor other than the minor's age.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SEVERABILITY. If any provision of this Act is held to be invalid or unenforceable by its terms or as applied to any person or circumstance, the remainder of the provisions shall be construed to give the maximum effect permitted by law, unless the holding shall be of utter invalidity or unenforceability, in which event, the provision shall be considered severable and does not affect the remaining provisions or the application of the severed provision to other persons who are not similarly situated or to other dissimilar circumstances.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 8, 2009

SUBJECT: Parental Notice of Abortion (SCS CSHB 35(HSS);
Work Order No. 26-LS0192\E)

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Amends current abortion restrictions to require parental notice under AS 18.16.020, repealed and reenacted in sec. 3 of the bill.

Section 2. Amends the defense to a criminal prosecution or civil claim against a physician who performs an abortion without notice as required in sec. 1 of the bill in a medical emergency, as defined.

Section 3. Repeals and reenacts the restrictions related to an abortion on a minor who is under 17 and unemancipated to delete the parental consent requirement and to require (1) notification of a parent, legal guardian, or custodian of the minor at least 48 hours before the abortion; (2) a court order; (3) or a witnessed and notarized statement alleging parental abuse. Describes a detailed notification procedure by a physician and provides for "constructive notice" if notice is mailed. Requires a physician to report alleged abuse and to retain the products of conception and other evidence for alleged sexual abuse investigation by law enforcement.

Section 4. Amends the court procedure to bypass parental notice required under secs. 2 and 3 of the bill by deleting references to consent that have been found by the Alaska Supreme Court to be unconstitutional.

Section 5. Amends the court procedure to bypass parental notice required under secs. 2 and 3 of the bill by deleting references to consent that have been found by the Alaska Supreme Court to be unconstitutional.

Section 6. Amends the court procedure to bypass parental notice required under secs. 2 and 3 of the bill by deleting references to consent that have been found by the Alaska Supreme Court to be unconstitutional and to reduce the number of business days from five to three for a default order permitting an abortion on a minor.

Section 7. Amends the court procedure to bypass parental notice required under secs. 2 and 3 of the bill by deleting references to consent that have been found by the Alaska Supreme Court to be unconstitutional and to reduce the number of business days from five to three for a default order permitting an abortion on a minor.

Section 8. Amends the court procedure to bypass parental notice required under secs. 2 and 3 of the bill by providing notice to a minor that she may request an order excusing her from school attendance.

Section 9. Prohibits coercion, as defined, for a minor to have an abortion. Provides for emancipation by failure to provide financial support if required by law to a pregnant minor for purposes of an abortion. Requires physicians who perform an abortion on a minor in the state to submit reports pertaining to the abortions to the Department of Health and Social Services.

Section 10. Provides for severability of any provision held to be invalid or unenforceable.

JMM:ljw
09-223.ljw

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HB 35
(H) Publish Date: 3/16/09

Identifier (file name): HB035-LAW-CIV-3-6-09
Dept. Affected: LAW
Title: An Act relating to notice and consent for a minor's abortion.
RDU: CIVIL
Component: HUMAN SERVICES
Sponsor: REPRESENTATIVE(s) COGHILL, Neuman, et al.
Requester: Judiciary
Component Number: 2208

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*
See attached page...

Prepared by: Robert Meiners, Deputy Director — Phone 907-465-5427
Division: Administrative Services Division — Date/Time 3/9/09 10:20 PM
Approved by: Richard Svobodny, Acting Attorney General — Date 3/9/2009
Department of Law

(Revised 9/10/2008 OMB)

5583

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. HB 35

ANALYSIS CONTINUATION

HB35 would amend existing state statutes regarding the requirement of parental notice and consent to be given if a person under age 17, who is unmarried, unemancipated, and pregnant, intends to obtain an abortion. The bill prohibits a person from performing an abortion unless the requisite parental notice and consent is provided or the person qualifies for an exception to those requirements. The bill also enacts new provisions of law regarding coercion of a minor who is pregnant and regarding certain reports that must be filed by physicians.

If this bill is enacted there would be a zero cost of implementation to the department. Should a legal challenge be mounted, especially of a constitutional nature, there would be costs in defending the provisions of this bill. Costs of defending legislation may arise with any legislature and often can not be anticipated; however, the department has previously defended the constitutionality of similar legislation. Those efforts approached $500,000 in addition to the payment of a court ordered award of $940,000 in costs and fees to the plaintiffs in the case.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: HB 35
(H) Publish Date: 3/16/09

Identifier (file name): HB035-DHSS-MS-03-09-09
Dept. Affected: Health & Social Services
Title: Notice & Consent for Minor's Abortion
RDU: Health Care Services
Component: Medicaid Services
Sponsor: Coghill
Requester: House JUD
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	***	***	***	***	***	***	***
Miscellaneous							
TOTAL OPERATING	***	***	***	***	***	***	***
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match	***	***	***	***	***	***	***
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	***	***	***	***	***	***	***

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This fiscal note is indeterminate (***).

There is no way to determine which minors enrolled in Medicaid had consent from a parent or guardian for abortions because the department does not require a consent form to process claims.

Expenditures for abortions are made from general fund dollars. These claims are paid pursuant to an Alaska Supreme Court decision that requires state funding of medically necessary abortions for low-income women eligible for Medicaid. (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 269-7827
Division: Health Care Services
Date/Time 3/9/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 3/9/2009
DHSS Finance & Management Services

FISCAL NOTE #2

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. HB 35

ANALYSIS CONTINUATION

The only abortion services eligible for federal financial participation are those that the department is required to cover under the federal Hyde amendment. To qualify under the Hyde amendment, the abortion must be the result of rape or incest, or the life of the mother must be endangered if the pregnancy were carried to term. Hyde amendment qualifying abortion claims are rare—in FY 2008, there were no Hyde amendment claims.

HB 190

5587

Alaska State Legislature

Representative Anna Fairclough – House District 17

Waived out of Committee

Date: April 10, 2010

To: Senator Bettye Davis
Chair – Senate Health & Social Services

From: Representative Anna Fairclough

Re: HB 190 "An Act amending the Alaska children's trust and relating to the trust; relating to special request Alaska children's trust plates; and amending State Procurement Code to exempt the Alaska children's trust and the Alaska Children's Trust Board."

I am requesting a hearing for HB 190 "An Act amending the Alaska children's trust and relating to the trust; relating to special request Alaska children's trust plates; and amending State Procurement Code to exempt the Alaska children's trust and the Alaska Children's Trust Board." at your earliest convenience.

Thank you in advance for your consideration.

Anna

Representative Anna Fairclough

Session: Alaska State Capitol • Juneau, AK 99801 • 907-465-3777 • Fax 907-465-2819
Interim: 10928 Eagle River Road, Suite 238 • Eagle River, AK 99577 • 907-694-8944 • Fax 907-694-8945
Representative_Anna_Fairclough@legis.state.ak.us

Alaska State Legislature

Representative Anna Fairclough – House District 17

CS for House Bill 190 (FIN) (26-LS0502\K)

"An Act amending the Alaska children's trust and relating to the trust; relating to special request Alaska children's trust plates; and amending State Procurement Code to exempt the Alaska children's trust and the Alaska Children's Trust Board."

House Bill 190 establishes an Alaska Children's Trust (ACT) grant account in the general fund and provides for private restricted-use donations, and an annual legislative appropriation of five percent average market value (preceding three years) of the trust account into the grant account. In addition it exempts the ACT and the ACT board from the state procurement code and would require the board to establish regulations as required by state statute.

It would preserve the present revenue sources of children's trust license plates, birth and marriage certificates annually appropriated by the legislature into the grant account for child abuse and neglect prevention activities and programs.

The ACT board of directors is given the authority to enter into a joint arrangement with a non-profit entity or entities for grant-making and fundraising without delegating its duties or authority. ACT will continue to be managed by seven board of directors; including the Governor or designee, Commissioners of the Departments of Health and Social Services and Education and Early Development, four public members appointed by the Governor with expertise in children's or prevention programs including child abuse and neglect prevention programs.

In summary, HB 190 provides ACT and the ACT board with greater flexibility to create a more stable, streamlined and simplified administrative structure that would greatly enhance the Trust's ability to pursue its mission efficiently and effectively.

I urge your support on this piece of legislation.

Session: Alaska State Capitol • Juneau, AK 99801 • 907-465-3777 • Fax 907-465-2819
Interim: 10928 Eagle River Road, Suite 238 • Eagle River, AK 99577 • 907-694-8944 • Fax 907-694-8945
Representative_Anna_Fairclough@legis.state.ak.us

Alaska State Legislature

Representative Anna Fairclough – House District 17

CS for House Bill 190 (FIN) (26-LS0502\K)

"An Act amending the Alaska children's trust and relating to the trust; relating to special request Alaska children's trust plates; and amending State Procurement Code to exempt the Alaska children's trust and the Alaska Children's Trust Board."

Sectional Analysis

Section 1, 2, 3. Amends AS 18.50.225(d); 18.50.272(e); 28.10.421(d)(14)

Allows the legislature to appropriate funds generated from birth certificates and heirloom marriage certificates suitable for display; and Alaska children's trust license plates to the Alaska children's trust grant account.

Section 4. Amends AS 36.30.990(1)

Exempts the Alaska children's trust and the Alaska Children's Trust Board from the State Procurement Code.

Section 5. Amends AS 37.14.200(b)

Defines the assets of the trust to include appropriations, donations to the trust, and income earned on investments of trust assets.

Section 6. Repeals and reenacted AS 37.14.200(c)

Provides for the commissioner of revenue to manage the trust as an endowment.

Section 7. Amends AS 37.14.200 by adding new subsections AS 37.14.200(d)(e)(f)(g)

The commissioner of revenue shall provide reports to the board on condition and investment of the trust.

Allows the legislature to annually appropriate 5% of the market value, as calculated on a three year average, of the Alaska Children's Trust to the grant account.

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Representative_Anna_Fairclough@legis.state.ak.us

Allows the legislature to appropriate from the principal of the trust up to $150,000 for administrative expenses of the board; and appropriate expenses related to the commissioner of revenue's management of trust assets.

Explains that this section does not create a dedicated fund.

Section 8. Amends AS 37.14 by adding new section AS 37.14.205

Creates an Alaska children's trust grant account as an account in the general fund and allows the legislature to appropriate funds from the trust to the grant account.

Defines uses of the grant account to include making grants; obtaining private and federal; solicit contributions, gifts and bequests for the trust and grant accounts; and expend private restricted-use donations from the grant account without further appropriation.

Section 9. Amends AS 37.14.225

Defines the membership of the ACT board, and their qualifications.

Section 10. Amends AS 37.14.230

Describes the powers and duties of the ACT board, to include awarding grants, maintaining records of all donations to the trust and grant account; apply for and use funds from grant account to obtain private and federal grants for child abuse & neglect prevention programs; solicit donations to the grant account; account for interest earned on private restricted donations not fully expended.

Section 11. Amends AS 37.14.230 by adding new subsection AS 37.14.230(b)

Allows the Alaska Children's Trust Board to enter into joint arrangement with a private non-profit entity or entities for grant-making and fundraising without delegating its duties or authority.

Section 12. Amends AS 37.14 by adding new section AS 37.14.245

Allows the Alaska Children's Trust Board to adopt regulations not subject to the requirements of the Administrative Procedures Act.

Section 13. Amends AS 37.14.270 is repealed and reenacted

Defines board, grant account, private restricted-use donation, and trust.

Section 14. Amends AS 37.14.210, 37.14.240, 37.14.250, and 37.14.260 are repealed

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Representative_Anna_Fairclough@legis.state.ak.us

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: CSHB 190(FIN)
(H) Publish Date: 4/6/10

Identifier (file name): CSHB190-REV-TRS-04-04-10
Dept. Affected: Revenue

Title: Alaska Children's Trust
RDU: Taxation and Treasury
Component: Treasury Division

Sponsor: Representative Fairclough
Requester: House Finance Committee
Component Number: 121

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CHANGE IN REVENUES ( )	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
FUND SOURCE		(Thousands of Dollars)					
1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Part-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Temporary	0.0	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: *(Attach a separate page if necessary)*

The Committee Substitute Bill is an amendment to the Alaska Children's Trust statute which allow the legislature to appropriate funds generated from birth and heirloom marriage certificates and trust license plates to the Alaska Children's Trust Grant Account and defines the assets of the trust to include appropriations, donations and income earned on investments of trust assets. Treasury would continue to invest the assets of the Trust and would calculate 5% of market value of the Trust on a three year average for appropriation to the grant fund. No appropriation is required as implementation will be carried out through existing personal services and custodial resources. The effect this bill will have on investment performance is unknown.

Prepared by: Pamela Leary, Comptroller
Phone 465-2300
Division: Treasury Division
Date/Time 04-02-10; 3:55pm
Approved by: Ginger Blaisdell, Director
Date 04-04-10; 4:04pm
Administrative Services Division

(Revised 11/6/2009 OMB)

5592

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: CSHB 190(FIN)
(H) Publish Date: 4/6/10

Identifier (file name): HB 190CS(FIN)-DHSS-CSM-04-03-10
Title: Alaska Children's Trust
Sponsor: Representative Fairclough
Requester: House Finance Committee

Dept. Affected: Health & Social Services
RDU: Children's Services
Component: Children's Services Management
Component Number: 2666

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							
FUND SOURCE		(Thousands of Dollars)					
1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other-AHFC Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS							
Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Prepared by: Co-Chair Rep. Stoltze
House Finance Committee
Phone 465-4958
Date/Time 4/5/2010 12:00PM

Co-Chair Rep. Hawker
House Finance Committee
Date 4/5/2010

(Revised 9/10/2008 OMB)

5593

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: CSHB 190(FIN)
(H) Publish Date: 4/6/10

Identifier (file name): HB190CS(HSS)-CED-CRA-04-5-10
Title: Alaska Children's Trust
Sponsor: Representative Fairclough
Requester: House Finance Committee

Dept. Affected: DCCED
RDU: Comm. Assist. and Econ. Dev.
Component: Community and Regional Affairs
Component Number: 2879

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

HB 190 makes several changes to the Alaska Children's Trust (ACT) board and trust account management. The Trust is to be managed by the Commissioner of Revenue with five percent of the market value of the unencumbered balance of the trust to be appropriated for awarding a named recipient grant by the Department of Commerce, Community and Economic Development to be used by the non-profit selected by the board to award subgrants to organizations and projects designed to prevent child abuse and neglect in Alaska.

The Department does not expect to need additional funds to manage this grant.

Prepared by: Tyson Fick, Legislative Liaison — Phone 465-2503
Division: Department of Commerce, Community and Economic Development — Date/Time 4/5/10 12:00 AM
Approved by: Emil Notti, Commissioner — Date 4/5/2010
Department of Commerce, Community and Economic Development

(Revised 9/10/2008 OMB)

5594

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHB 190(HSS)
(H) Publish Date: 4/15/09

Identifier (file name): CSHB190(HSS)-DOR-TRS-4-14-09
Dept. Affected: Revenue
Title: Amendment to Alaska Children's Trust
RDU: Taxation and Treasury
Component: Treasury
Sponsor: Rep Fairclough, Hawker, Holmes, Wilson
Requester: House H&SS
Component Number: 121

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CHANGE IN REVENUES ( )	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Part-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Temporary	0.0	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: *(Attach a separate page if necessary)*

The Committee Substitute Bill is an amendment to the the Alaska Children's Trust statute which would divest funds from the existing ACT Income fund managed by Treasury and transfer them to a 501(c)3 entity. Treasury would continue to invest the assets of the ACT Principal fund and would calculate 5% of market valu of the Principal fund balance for appropriation to the new 501(c)3 entity. No operating appropriation is required as implementation will be carried out through existing personal services and custodial resources. The effect this bill will have on investment performance is unknown.

Prepared by: Pamela Green, Comptroller — Phone 465-2300
Division: Treasury Division — Date/Time Monday; 4 pm
Approved by: Jerry Burnett, Deputy Commissioner — Date 4/13/2009
Department of Revenue

(Revised 9/10/2008 OMB)

5595

Alaska State Legislature

Representative Anna Fairclough – House District 17

Teleconference Request and Potential List of Witnesses
Senate Health & Social Services Committee Hearing Request

CS for House Bill 190 (FIN) (26-LS0502\K)

"An Act amending the Alaska children's trust and relating to the trust; relating to special request Alaska children's trust plates; and amending State Procurement Code to exempt the Alaska children's trust and the Alaska Children's Trust Board."

Teleconference –

– Anchorage Location

Potential Witnesses to Testify –

- Mike Barnhill – State of Alaska, Department of Law
- Alison Elgee – Assistant Commissioner, Department of Health & Social Services
- Diane Kaplan – Executive Director, Rasmuson Foundation
- Panu Lucier – Executive Director, Alaska Children's Trust/Friends of Alaska Children's Trust

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Representative_Anna_Fairclough@legis.state.ak.us

RASMUSON FOUNDATION

April 5, 2010

301 W. Northern Lights Blvd.
Suite 400
Anchorage, AK 99503

907.297.2700 *tel*
907.297.2770 *fax*
877.366.2700 *toll-free in Alaska*
rasmusonfdn@rasmuson.org *email*
www.rasmuson.org

The Honorable Anna Fairclough
Alaska State Legislature
State Capitol, Room 421
Juneau, AK 99801-1182

Dear Representative Fairclough:

As a trustee of the Alaska Children's Trust (ACT) and a longtime supporter and former member of the Friends of the Alaska Children's Trust (FACT), I want to thank you for your leadership in sponsoring House Bill 190, an act amending the Alaska Children's Trust. Your attention and diligence to this matter could result in significantly impacting the incidence of child abuse and neglect in Alaska.

The Finance Committee Substitute for HB190 addresses head-on many of the issues that have made the FACT fundraising and ACT grantmaking processes cumbersome. In particular, the creation of a grant account within the general fund allows FACT volunteers to raise funds from individual Alaskans to support issue-specific grants. If enacted, Alaskans will for the first time have assurances that their gifts to ACT can be directed to a specific purpose.

The ACT and FACT have struggled to find a way to meet the original intent of donors and ensure that their gifts are treated with the highest level of stewardship. While the trustees and friends continue to believe that privatization of the Trust through a public-private sector partnership is still the best approach, this CS to HB190 goes a long way toward resolving issues that have confounded advocates for prevention of child abuse and neglect for many years.

I hope this legislation is favorably considered by your colleagues in the Alaska State Legislature.

Best regards,

Diane Kaplan
President

BOARD of DIRECTORS
Edward B. Rasmuson *Chairman*
Morgan Christen
Jeff Cook
Douglas Eby
Adam Gibbons
Lile R. Gibbons
Anthony Mallott
Roberta Quintavell
Cathryn Rasmuson
Judy Rasmuson
Mary Louise Rasmuson
Natasha von Imhof

PRESIDENT
Diane Kaplan

HB 349

SENATE COMMITTEE REPORT

DATE: 3/15/10

FURTHER:

DATE TURNED IN TO OFFICE: 3/22/10

Health and Social Services Committee considered HOUSE BILL NO. 349

HB 349 SUICIDE PREVENTION COUNCIL MEETINGS

"An Act relating to the Statewide Suicide Prevention Council."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
Health	3/8/10			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	F

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AME
	Thomas	✓			
	PASKVAN	X			
	Dyson	✓			
CHAIR: Betty Davis	DAVIS	✓			

Alaska State Legislature

Representative Anna Fairclough – House District 17

House Bill 349

"An Act Statewide Suicide Prevention Council"

House Bill 349 allows the Suicide Prevention Council to participate in a meeting either in person or by teleconference. Suicide is a very serious public health concern in Alaska, particularly among young males and the Alaska native population. Extension of the Statewide Suicide Prevention Council is important in curtailing this avoidable loss of life. The mission of the Statewide Suicide Prevention Council is to advise the governor and the legislature on issues relating to suicide. In collaboration with communities, faith-based organizations, and public-private entities, the Council works to improve the health and wellness of Alaskans by reducing suicide and its effect on individuals and communities.

The council serves in an advisory capacity to the Legislature and governor with respect to what actions can and should be taken to improve health and wellness throughout the state by reducing suicide and its effect on individuals, families and communities; broaden the public's awareness of suicide and the risk factors related to suicide; enhance suicide prevention services and programs throughout the state; develop healthy communities through comprehensive, collaborative, community-based approaches; develop and implement a statewide suicide prevention plan; and strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

Thank you for your consideration and I urge your support on the passage of legislation.

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Representative_Anna_Fairclough@legis.state.ak.us

5600

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB349
() Publish Date:

Identifier (file name): HB349-DHSS-SPC-03-08-10
Dept. Affected: Health & Social Services

Title: Suicide Prevention Council Meetings
RDU: Behavioral Health
Component: Suicide Prevention Council

Sponsor: Fairclough

Requester: House STA
Component Number: 2651

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation would not have a fiscal impact on the Division of Behavioral Health. The proposed legislation would allow Council members participating by teleconference to count towards the required quorum.

Prepared by: Melissa Stone, Director
Division: Behavioral Health
Phone: (907) 269-3410
Date/Time: 3/3/10 5:00pm

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 3/8/2010

5601

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

SUICIDE PREVENTION COUNCIL

SEAN PARNELL, GOVERNOR

350 Main Street, Suite 214
PO Box 110620
Juneau, AK 99811-0620
PHONE: (907) 465-8536
FAX: (907) 465-1189
TOLL FREE: (877) 393-2287

Date: February 19, 2010

Dear Representative Anna Fairclough,

Re: HB 349

At our last meeting on January 13, the Statewide Suicide Prevention Council had reviewed its By-laws, which dually requires Council members to be present at meetings but also allows telephonic representation in order to be counted for a quorum. Due to the history of the Council attendance at meetings as indicated during the last legislative audit, it is the intent of the Council to allow for more flexibility in assembling a quorum. Therefore, we support amending the language in AS 4429.340 to allow a broader interpretation as it is written in the By-laws to include telephonic representation at our meetings.

We respectfully request that the Legislature agrees with the Council's desire to hold telephonic conferencing as an avenue to conduct the State's business as it relates to the important issue of suicide.

Sincerely,

Brenda Moore

Brenda Moore
Statewide Suicide Prevention Council, Chair

HJR

10

Session:
State Capitol
Juneau, Alaska 99801
(907) 465-4457 Office
(907) 465-3519 Fax
(800) 928-4457 Toll Free

Alaska House of Representatives
David Guttenberg

District 8

Interim:
1292 Sadler Way
Suite 304
Fairbanks, Alaska 99701-3171
(907) 456-8172
(907) 456-2490 Fax

MEMO

To: **Senator Bettye Davis**
Senate Health & Social Services Committee

From: Representative David Guttenberg

Date: March 30, 2009

Re: HJR 10- Veterans' Health Care

I respectfully request that you schedule HJR 10- Veterans' Health Care for the Health and Social Services Committee's consideration at your earliest convenience.

Enclosed are:

- A copy of the most recent version of the bill
- Sponsor statement
- Letters of support and other backup information
- Fiscal note

I look forward to discussing the merit of this resolution in the Senate. My staff, Chris Reid, is assigned to this legislation if there are any questions, 465-4457. Any additional materials we wish to place before the committee will be submitted no later than 24 hours prior to the scheduled hearing.

Anderson • Cantwell • Chena • Denali Park • Ester • Geist • Goldstream • Healy • Pike
University Campus • University Hills • University West
Representative_David_Guttenberg@legis.state.ak.us

SENATE COMMITTEE REPORT

DATE: 3/27/09

FURTHER: State Affairs

DATE TURNED IN TO OFFICE: _____

Health and Social Services Committee considered CS FOR HOUSE JOINT RESOLUTION NO. 10(HSS)

HJR 10 VETERANS' HEALTH CARE

Urging the United States Congress to improve health care for veterans.

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
MVA	3/25			✓	

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
		✓			
		X			
CHAIR: Betty Davis	DAVIS	X			

ALASKA STATE LEGISLATURE

SESSION:
Alaska State Capitol, Room 418
Juneau, AK 99801
(907) 465-4457 Office
(907) 465-3519 Fax
(800) 928-4457 Toll Free

INTERIM:
1292 Sadler Way, Suite 304
Fairbanks, AK 99701
Office (907) 456-8172
Fax (907) 456-2490

Representative David Guttenberg

CSHJR 10 (MVA)
Sponsor Statement

CSHJR 10 (MVA) urges the United States Congress to provide the United States Department of Veterans Affairs (VA) with the funding and resources necessary to enable the Veterans Health Administration to provide sufficient, timely and predictable health care for all veterans.

The Partnership for Veterans Health Care Budget Reform, an association of national veterans groups, has found that the current funding mechanism for veterans' health care is "unreliable" and subject to "great political wrangling." Without a streamlined, comprehensive and accessible health care system, many veterans are denied the health care they are entitled to.

As the number of veterans returning from Afghanistan and Iraq suffering from traumatic brain injury, post traumatic stress syndrome and other combat-related injuries is increasing, the need for access to quality health care, including mental health and substance abuse treatment, is increasing as well. Veterans returning from these wars are entitled to five years of health care from the VA without charge, regardless of the priority group to which they are assigned. However, they are only reimbursed for the cost of traveling to access that care if they meet certain eligibility criteria.

Many Alaskan veterans have access to outpatient care at a variety of urban facilities – including the Veterans Affairs Healthcare System facility in Anchorage, the Veterans Affairs Community-based Outpatient Clinics at Fort Wainwright and in Kenai, and the soon-to-open facilities in the Matanuska-Susitna Borough, Juneau, and Homer. There is also a system in place that allows Alaskan veterans living in outlying areas to access quality health care at local community health centers. However, there are still many veterans living in rural areas that are unable to access health care in their communities, resulting in costly travel to central locations to receive that care.

CSHJR 10 (MVA) supports efforts to ensure that veterans across Alaska have access to quality health care in the outlying areas where the VA does not have clinics, including at Community Health Centers, community mental health centers, substance abuse treatment centers, tribal health organizations, and other appropriate local providers. It also supports increased funding for research into traumatic brain injuries and encourages the Veterans Health Administration to improve its electronic claims process and ability to use information contained in military records in order to provide a more efficient health care delivery system.

Representative.David.Guttenberg@legis.state.ak.us
http://guttenberg.akdemocrats.org

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHJR 10(MLV)
(H) Publish Date: 2/25/2009

Identifier (file name):
Title CSHJR 10 VETERANS' HEALTH CARE
Sponsor Representative David Guttenberg
Requester Military and Veterans' Affairs Committee

Dept. Affected:
RDU
Component
Component Number

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Prepared by: House Military and Veterans' Affairs Committee
Division
Phone
Date/Time
Approved by: Represtative Carl Gatto
Date 2/24/2009

(Revised 9/16/2002 OMB)

5607

abha

Alaska Behavioral Health Association

alaskabehavioralhealth.net

March 12, 2009

The Honorable Representative David Guttenberg
State Capital
Juneau, Alaska

Support for CSHJR 10 Improve Health Care for Veterans

Dear Representative Guttenberg;

On behalf of the members of the Alaska Behavioral Health Association, I am writing to pledge our support for CSHJR 10. The members of this association provide mental health and substance abuse treatment and services across this state. We support federal and state funding and other efforts to ensure that veterans across the state have access to quality health care. We would also ask for an increase in funding and emphasis on suicide prevention. This is health crisis of epidemic proportions and a bright spotlight needs to be shone upon this issue to bring attention to a problem that we could solve.

Thank you for bringing this issue to the attention of the legislature and I trust we will see something good come from this effort.

In Health,

Steve Horn
Executive Director

5608

abha

Alaska Behavioral Health Association

alaskabehavioralhealth.net

abha

2009

The Alaska Behavioral Health Association (abha) is a statewide trade association whose members are the primary providers of behavioral health services in Alaska. The mission of abha is to enhance behavioral health and quality of life for all Alaskans by providing leadership which insures high quality, affordable behavioral health services.

Members of abha support the following principles:

- Ensure that beneficiaries of services have access to a community-based continuum of care that provides individualized comprehensive treatment.

- Promote community-based behavioral health services as the most appropriate, clinically effective, and cost sensitive method for providing care to individuals in need.

- Advocate for appropriate public policy and adequate funding for each service by working with the administration and legislature at both the state and national levels.

- Serve as a forum for the exchange of ideas and information among providers and their constituents.

- Work to ensure our members are positioned as mainstream healthcare providers in any state or national healthcare system reforms.

- Support education, research and evaluation, technical assistance, professionalism, family/consumer involvement, and outcome-oriented services.

5609

2009 abha Membership

Organization	Community
Akeela	Anchorage
Alaska Children's Services	Anchorage
Alaska Family Services	Palmer
Alaska Island Community Services	Wrangell
Alaska Youth & Family Network	Anchorage
Anchorage Community Mental Health Services (Southcentral Counseling)	Anchorage
Arc of Anchorage	Anchorage
Assets, Inc.	Anchorage
Mat-Su Health Services	Wasilla
Bristol Bay Counseling Center (BBAHC)	Dillingham
Boys and Girls Home of Alaska	Fairbanks
Catholic Community Service	Juneau
The Center	Homer
Community Connections, Inc.	Ketchikan
Denali Family Services	Anchorage
Edgar Nollner Health Center	Galena
Fairbanks Community Behavioral Health Center, Inc.	Fairbanks
Fairbanks Native Association	Fairbanks
Family Centered Services of Alaska	Fairbanks

Organization	Community
Frontier Community Services	Soldotna
Gateway Center for Human Services	Ketchikan
Impact Counseling	Haines
Juneau Alliance for Mental Health, Inc.	Juneau
Juneau Youth Services	Juneau
Kenai Peninsula Care Center	Kenai
Lynn Canal Counseling	Haines
Maniilaq Association	Kotzebue
North Star Behavioral Health System	Anchorage
Peninsula Community Health Services	Soldotna
Petersburg Mental Health Services, Inc.	Petersburg
Railbelt MH and Addictions	Nenana
SEARHC - Behavioral Health Service Division	Sitka
SeaView Community Services	Seward
Sitka Counseling and Prevention Services	Sitka
Southcentral Foundation Behavioral Health Services	Anchorage
Volunteers of America of AK	Anchorage
Yukon-Kuskokwim Health Corporation	Bethel

Military Order of the Purple Heart
Department of Alaska

Date: March 6, 2009

The Honorable David Guttenberg
House Military and Veterans Affairs
Alaska State Capitol, Room 418
Juneau, AK 99801-1182

Subject: Support for HRJ 10.

Dear Representative Guttenberg, and other sponsors/supporters of HJR 10.

The MOPH, Department of Alaska, is in full support of HJR 10 and its intent to provide the best health care available to our veterans. Those who answered the call to defend our country have fully earned the right to have the country be there for them in their time of need.

As the current military conflict continues there will be an ongoing need to care for those who will stand among others who served previously. It is only fair for our nation to provide the care and assistance that our veterans have rightfully earned. Reasonable access to that health care is equally important, especially to those who suffer the most and often need special assistance just to get to the location providing that health care. While many veterans are fortunate to be able to drive to and walk to the point of health care assistance, it is important to not forget about those who need wheel chairs or other special assistance. The need to reach out to provide adequate care can be stated like this "LET NO VETERAN BE LEFT BEHIND" and that responsibility falls on the system charged with providing the health care that has already been paid for by our nations veterans.

HRJ 10 is a commendable approach in proving that Alaska truly cares about its veteran population. As such HRJ 10 has the support of the MOPH, Department of Alaska.

Ron Siebels

Ron Siebels
MOPH, Department Commander, Alaska

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ALASKA PRIMARY CARE ASSOCIATION, INC.

"... Uncompromising in the pursuit of access to primary care for all Alaskans."

Honorable Mike Chenault
Honorable Members of the House of Representatives
Juneau, Alaska 99801

March 12, 2009

Re: Support of CSHJR 10 (HSS) *Veterans' Health Care*

Dear Speaker of the House Chenault and Members of the House of Representatives,

The Alaska Primary Care Association (APCA) works to promote primary care access for all Alaskans and is strongly in support of CSHJR 10 (HSS) *Veterans' Health Care*. Many of the veterans in Alaska reside in outlying areas where they are unable to access VA health care facilities. Veterans need and deserve high quality health care that is readily accessible.

When veterans' medical conditions are not service-related and do not meet certain criteria, veterans in outlying areas have three choices: 1) cover their own expenses to travel to access VA care; 2) go without needed care; or 3) access services at a non-VA clinic, very likely to be one of the 141 Community Health Center (CHC) sites in the state. Many veterans cannot afford the first choice; in addition, paying for plane fare for a strep test or a bout with the flu is unreasonable. Sadly, the second choice – not receiving needed care – is far too common; our veterans deserve better.

For those veterans who opt for the third choice, often, the CHC does not receive reimbursement because the veteran did not file the necessary paperwork in advance. The CHC typically eats the cost. Although the APCA has been working with the Alaska VA Health Care System to increase access for veterans who live outside the vicinity of the VA clinics, little progress has been made due to federal barriers. Currently, veterans cannot readily use their VA health benefits to receive care at CHCs because a national policy advocating VA-CHC collaboration has not emerged in an effective way. CSHJR 10 (HSS) would encourage such collaboration.

The APCA urges the VA system to utilize the CHC infrastructure across Alaska rather than duplicate services by establishing new VA clinics where CHCs already exist. CHCs are well-positioned to provide access to cost-effective, quality care for Alaska's veterans whether through a Community Based Outpatient Clinic (CBOC) arrangement, a network arrangement, or individual arrangements with individual CHCs

Lastly, it is very important that Congress adequately fund VA health care so that veterans from every corner of Alaska have access – all veterans, those returning from the current conflict with pressing issues as well as those who served previously and have increasing health care needs as they age.

The Alaska Primary Care adamantly supports CSHJR 10 (HSS) *Veterans' Health Care* and appreciates the Alaska State Legislature working to promote health care access for veterans throughout the state by passing this important resolution in order to communicate this priority to the U.S. Congress.

Supporting health care for Alaska's veterans,

Shelley S. Hughes
Government Affairs Director

Phone 907 929-3702 Fax 907 929-3734 www.alaskapca.org alaskapca@alaskapca.org
3203 West Northern Lights Blvd. Suite 200 Anchorage AK 99503-2400

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SARAH PALIN, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

February 23, 2009

The Honorable Carl Gatto
House Military and Veterans' Affairs
Alaska State Capitol, Room 108
Juneau, Alaska 99801-1182

Subject: Support for HJR 10

Dear Chair Gatto:

The Alaska Commission on Aging (ACoA) encourages support for HJR 10 sponsored by Representative Guttenberg, Representative Kawasaki, Representative Salmon, Representative Kerttula, Representative Gruenberg, and Representative Cissna that encourages the United States Congress to improve health care and access for veterans. ACoA supports this resolution and its intent for Congress to provide sufficient, timely, and stable funding for veterans' health programs and to improve service delivery.

Health care is a key benefit of the services provided to persons who served in the armed forces. The number of veterans returning from military duty, in addition to veterans who are aging, is increasing along with the associated health care expenses. Although Alaska has the highest per capita population of veterans in the nation, our state remains as one of three states in the nation without a veterans' hospital that provides acute care inpatient services.

Moreover, Alaskan veterans come from all areas of the state. Veteran clinic facilities are located only in Anchorage, Fairbanks, Juneau, and Kenai. If a veteran lives outside of these areas and his/her medical condition is not 51% or more service-related, that individual is responsible for paying their own travel expenses. The Commission on Aging supports the Resolution's recommendation of a special "Heroes Health Card" to provide veterans access to health care in communities where they live, including those without veteran clinic facilities, by coordinating care provided by local medical providers and community health care facilities with care provided by military doctors and medical facilities.

ACoA supports HJR 10 and believes that veterans who served our country deserve decent health care. It is our responsibility and obligation to provide quality and accessible health care for veterans who joined the armed forces to serve and protect our nation. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879), should you have any questions regarding our position. Thank you for your consideration.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerel

Denise Daniello,
ACoA Executive Director

Cc: Representative Harris
Representative Olson
Representative Buch

Representative Lynn
Representative Ramras
Representative Kawasaki

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SARAH PALIN, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
and ALASKA MENTAL HEALTH BOARD

P.O. BOX 110608
431 N. Franklin Street Suite 200
JUNEAU, ALASKA 99811-0608
PHONE: (907) 465-8920
FAX: (907) 465-4410
TOLL FREE: (888) 464-8920

March 6, 2009

Representative David Guttenberg
Alaska State Capitol, Room 418
Juneau, Alaska 99801

Re: Support for CSHJR 10

Representative Guttenberg:

The Advisory Board on Alcohol and Drug Abuse and the Alaska Mental Health Board appreciate your recognition of our nation's responsibility to our returning veterans and military service members. We support CSHJR 10 calling for a comprehensive response to our service members' health care needs, including the behavioral health needs of veterans and returning service members.

We support expanded cooperation between the Veteran's Administration and Alaska's community health care providers to increase access for returning veterans with service-connected disabilities. Many veterans are returning to rural communities. The most effective and efficient way for them to access needed health care is through community mental health centers, substance abuse treatment centers, community health centers, and tribal health organizations. By expanding partnerships between the Veteran's Administration and local health care providers, we can insure that veterans with service-connected disabilities receive the health care they need as close to home as possible.

We appreciate your advocacy on behalf of our military service members and look forward to continuing work with you on this issue.

Sincerely,

L S Walters

Lonnie Walters, Chair
ABADA

Debi Keith

Debi Keith, Chair
AMHB

5614

brain injury
network

Jill Hodges
Alaska Brain Injury Network
3745 Community Park Loop #140
Anchorage, Alaska 99501
March 6, 2009

Representative David Guttenburg
Alaska State Legislature
State Capitol Building
Juneau, Alaska 99801

Dear Representative Guttenberg:

Thank you for your continued concern for returning service members in Alaska, as well as traumatic brain injury research. The Alaska Brain Injury Network supports HJR 10 – Veterans Health Care.

The Alaska Brain Injury Network is a non-profit 501 (c) 3 whose mission is to educate, plan, coordinate, and advocate for a comprehensive service delivery system for survivors of traumatic brain injury and their families.

ABIN supports the need for traumatic brain injury research; yet also requests the committees take into consideration equal access to rehabilitation and ongoing support programs for all Alaskans with cognitive disabilities.

Recent studies show at least 20% of service members will return from war with a traumatic brain injury. Additionally, there are 800 Alaskans each year hospitalized for more than 24 hours with a moderate to severe traumatic brain injury (Alaska Trauma Registry). There is an estimated 3000 Alaskans that visit the Emergency Department each year (CDC). Falls, motor vehicle crashes, assault, ATV/Snowmachine and bicycle crashes are the leading causes of traumatic brain injury in Alaska. The Alaska Brain Injury Network, "10 Year Plan for TBI in Alaska" highlights the many recommendations needed to provide information and referral, case management, acute and post-acute rehabilitation, educational supports, vocational supports, and long-term care to all Alaskans with brain injuries. (http://www.alaskabraininjury.org/documents/akbrain10%20Year%20TBI%20Plan.pdf)

It is important to understand brain injury affects Civilians and Military Members alike. The health care issue is a matter of access, as well as availability of services locally and payment for those serves. Currently the Alaska VA Health Systems and the Department of Defense, 3rd Medical Unit are developing TBI clinics, polytrauma clinics and brain injury rehabilitation and ongoing support services which will benefit both active duty and veterans; however these programs are being built with little coordination among the state and community providers. At the same time Alaska community providers are planning the development of brain injury residential programs because currently there are civilians who are not receiving the care they need to recover and or

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best learn to live with their cognitive disability. Alaska does not have the workforce to operate three separate brain injury service delivery systems (including the Tribal system).

ABIN Activities Promoting Coordination among Military, State, Tribal, and Community
ABIN has been meeting with military partners since October 2007 for the purposes of determining the impact of returning service members with brain injuries and the impact it will have on state and community providers and resources. Participants have included 3rd medical unit, Elmendorf, TBI Clinic; Alaska VA Health Systems Polytrauma and Neuropsychology program; National Guard; Service and Family Assistance Center-Warrior Transition Battalion; Marines; Vet Center representatives; and Alaska Federal Health Care Partnership. We have learned that we can share outreach and awareness resources, but with program planning and implementation there has been little collaboration.

Potential Challenges
It is important to recognize how service members with brain injury may have challenges without the proper services and supports and are at risk for additional brain injuries. Highest rates of brain injury in civilians are among rural Alaskans and Alaska Natives. Many national guardsmen/women live in rural Alaska. A risk factor for a brain injury is history of brain injury; i.e. A national guardsperson is in an IED blast in Afghanistan. He/she returns to Alaska and may have challenges with balance, memory, attention, etc. He is riding his snowmachine and crashes, no helmet or maybe even with a helmet, he sustains an additional brain injury. There is potential for an influx of brain injuries in the next 5-20 years; a coordinated TBI prevention program and service delivery system would benefit all Alaskans.

Recommendations
The leadership and collaboration among State Government, Tribal Systems, Military and Veterans, and Community Providers is key to developing appropriate, timely, and coordinated brain injury services in Alaska.

If we do not have the essential brain injury awareness and treatment in Alaska

- Alaskans are at risk for bankruptcy, homelessness, divorce, or institutional care.
- This impacts State and local behavioral health, corrections, and educational systems greatly.

The Alaska Brain Injury Network encourages coordination in planning and implementation of brain injury programs in-state, as well as a state funding source to support the payment of brain injury rehabilitation and long-term care for both military and civilians.

The Alaska Brain Injury Network supports HJR 10-Veterans Health Care. We also support collaboration efforts in the planning and implementation of the services that are needed in both rural and urban Alaska to support veterans and civilians.

Sincerely,

Jill Hodges

ALASKA PRIMARY CARE ASSOCIATION, INC.

"... Uncompromising in the pursuit of access to primary care for all Alaskans."

Honorable Betty Davis, Senate HSS Chair
Honorable Joe Paskvan, Senate HSS Vice-Chair
Honorable Members of the Senate Health & Social Services Committee
Juneau, Alaska 99801

April 3, 2009

Re: Support of CSHJR 10 (HSS) *Veterans' Health Care*

Dear Senator Davis, Senator Paskvan and Members of the Senate Health & Social Services Committee:

The Alaska Primary Care Association (APCA) works to promote primary care access for all Alaskans and is strongly in support of CSHJR 10 (HSS) *Veterans' Health Care*. Many of the veterans in Alaska reside in outlying areas where they are unable to access VA health care facilities. Veterans need and deserve high quality health care that is readily accessible.

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Supporting health care for Alaska's veterans,

Shelley S. Hughes
Government Affairs Director

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903 West Northern Lights Blvd. Suite 200 Anchorage AK 99503-2400